2008 Share Conference
Working Together for Quality and Service

New York Presbyterian Hospital

Columbia University Medical Center

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Surgical Team Training

Project Start Date: February 2007

Project Participants

Co-Sponsors:

- *Joyce Neil Executive Vice President, 1199/SEIU /UHWE*
- *Dr. Dennis Fowler, MD Medical Director & Vice-President of Perioperative Services, NYP-C*

Co-Leads:

- *Fernando Wilson Organizer, 1199 /SEIU/UHWE*
- *Vicki Fox, RN Director, Perioperative Services, NYP-C*

Team Members:

Ansel Graham, ORT, Delegate

Mary Ann Abuedo, Patient Care Director

Renee Ellerbe, ORT, Delegate

Priscilla Ramirez, Patient Care Director

Angela McCoy, ORT, Delegate

Angela Wilson, Nursing Coordinator

Leisa Witter, ORT, 1199 Member

Allison Eagan, Nursing Coordinator

Shawn McCollister, Manager, HR

Samantha Morales, Labor-Management Consultant

Goal of Surgical Team Training

To provide the entire surgical team with leadership and communication skills fostering collaboration, respect, and mutual support.

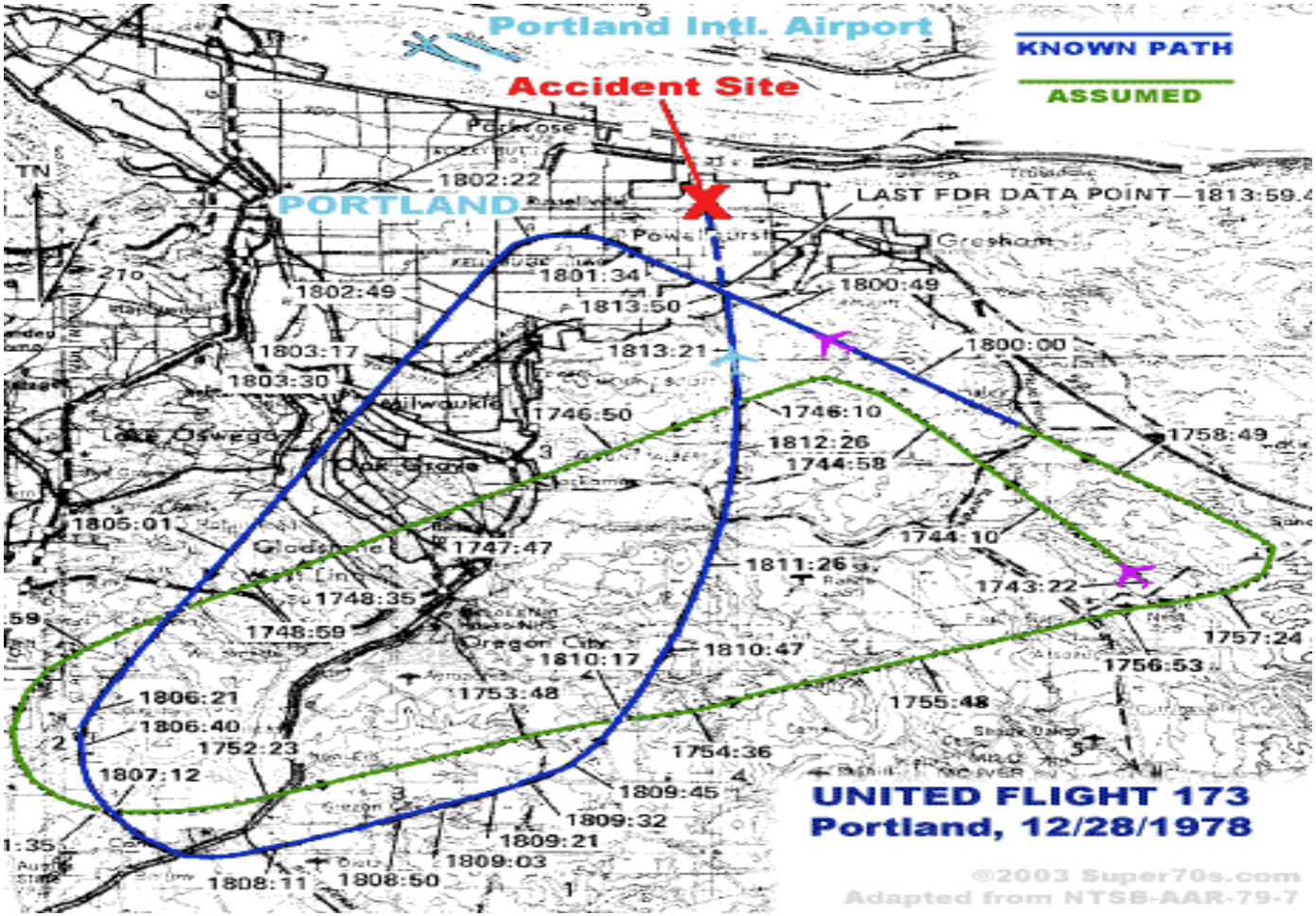
Why Team Training?

Because Healthcare is Inherently Risky

- **Technologically complex (and frequently changing)**
- **Ever expanding knowledge requirements**
- **High pressure work environment**
- **Infrequent intact teams (further complicated by turnover)**
- **Artful nature of surgery requires real-time variance from process**

Lessons Learned from UAL Flight 173

Flight from Denver to Portland Oregon
Star pilot and first rate crew
189 passengers including 6 infants
6 crew members
Ample fuel (45+20 minutes of contingency flight time)



UAL Flight 173 – The Tragedy

UAL Flight 173 – The Tragedy

- **Because of inability to have effective crew communications, Flight 173 crashed into the forest just 6 nautical miles from the runway and safety!**
  - **No fuel**
  - **10 fatalities, including the Flight Engineer**
  - **No malfunction to the landing gear**
  - **Initiation of UAL's CRM program**

Why Team Training?
Impact of Medical Error

- 98,000 Americans die each year as a result of <u>preventable</u> medical errors
- Costs associated with all medical errors is $29 billion annually
- Significant errors 4% of the time
- On average 2 significant errors per day in ICU

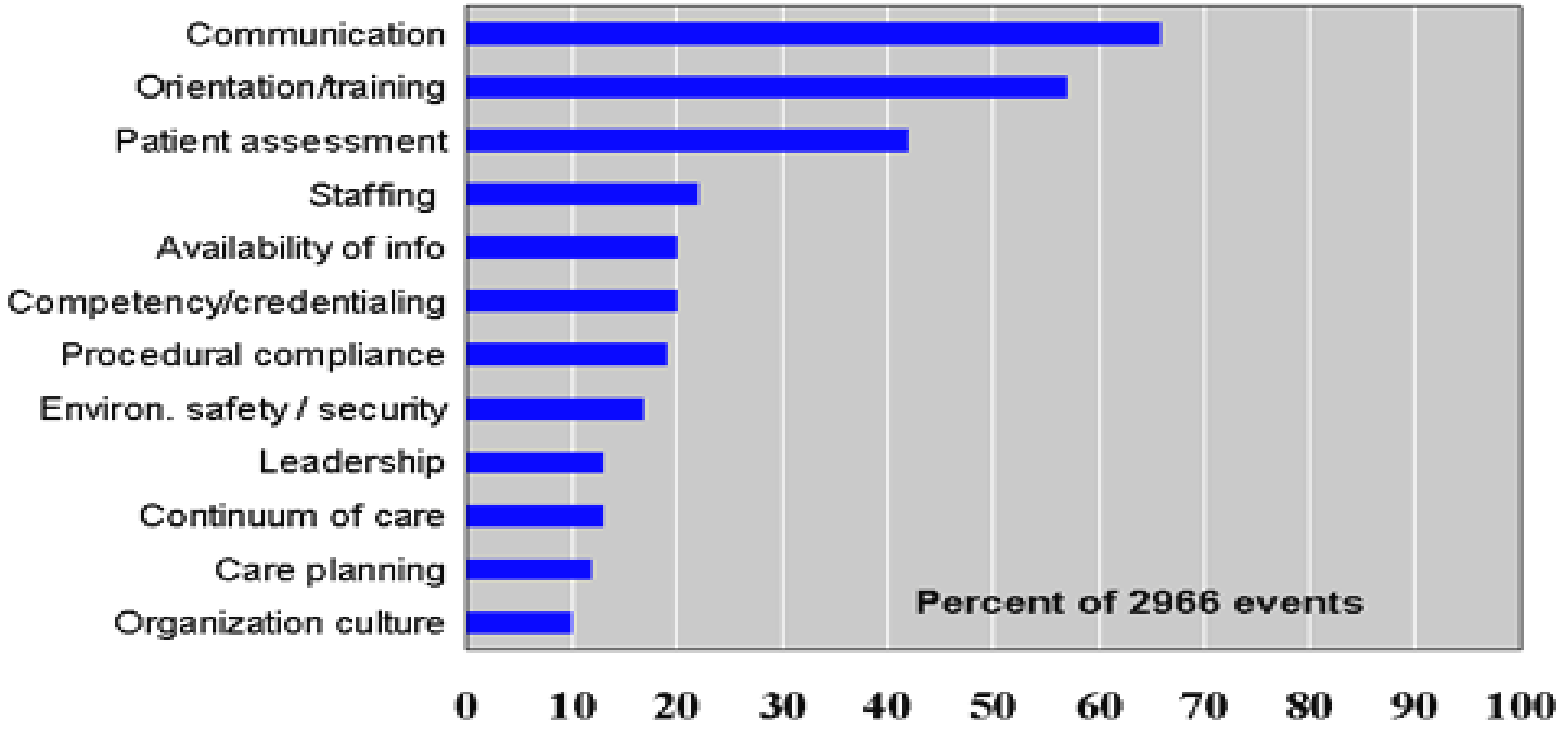
"NATIONAL PROBLEM OF EPIDEMIC PROPORTIONS"**

*** To Err Is Human: Building a Safer Health System- IOM 1999**
**** Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact**

Source: www.jcaho.com

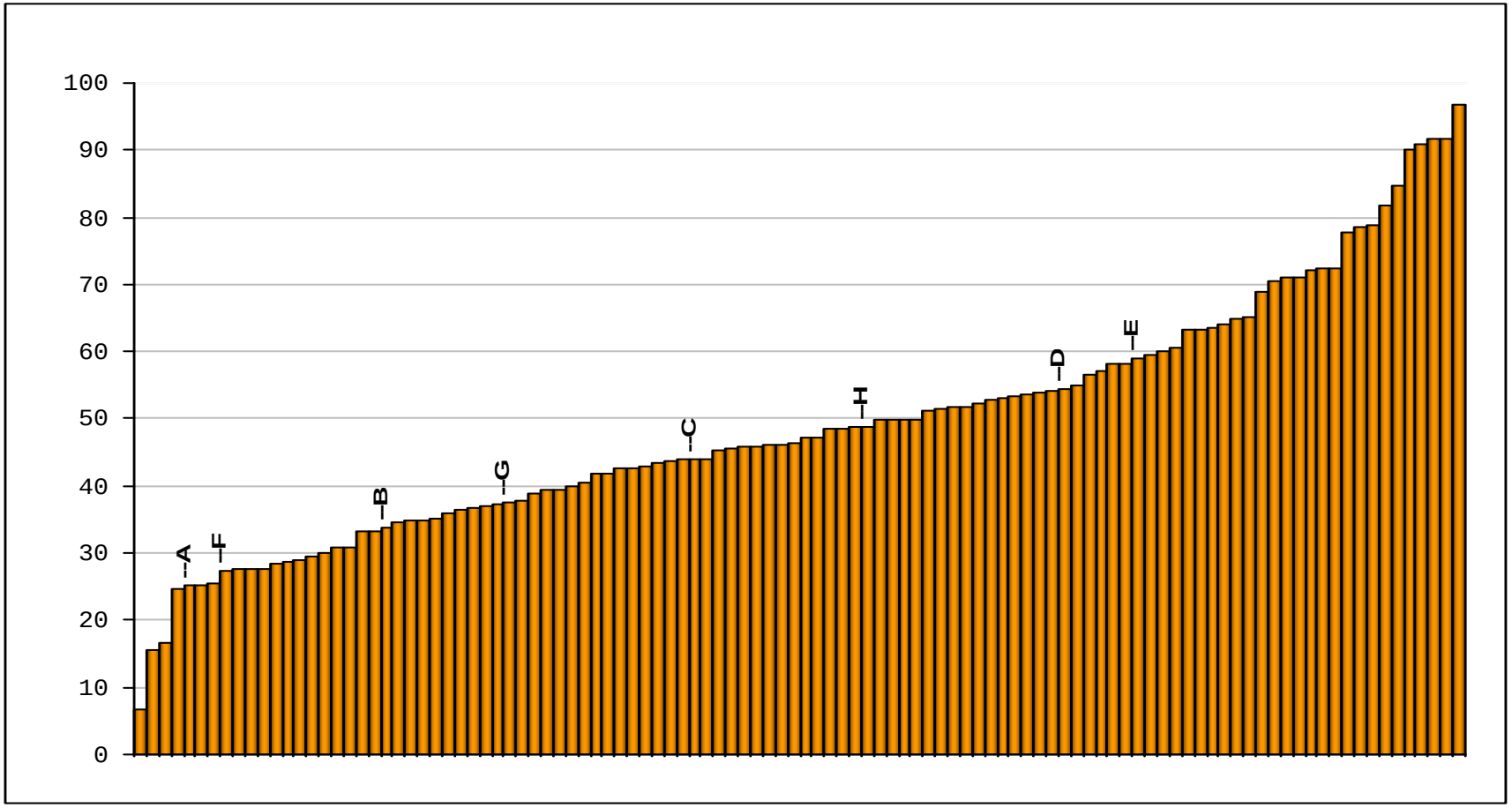
Root Causes of Sentinel Events

(All categories; 1995-2004)



Safety Attitudes Questionnaire

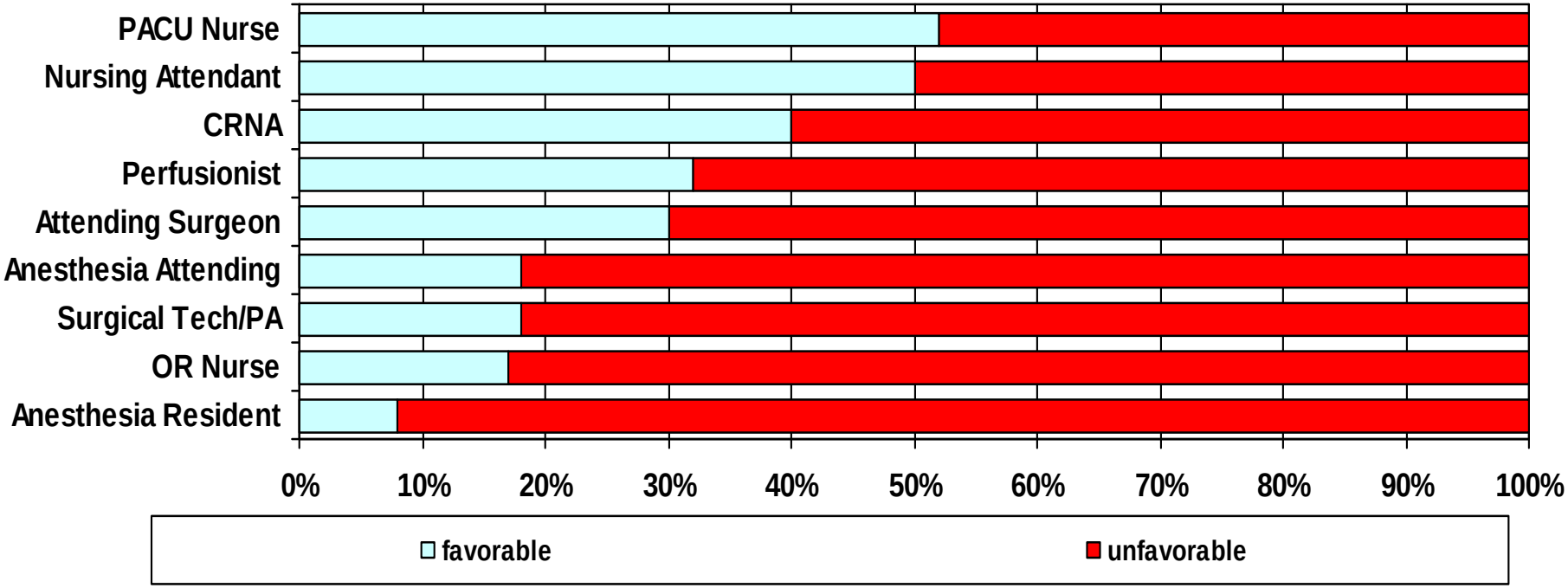
How Did Columbia University Medical Center Rate?



% of OR Respondents Reporting Good Teamwork Climate

Team Work climate in the OR at NYP-C

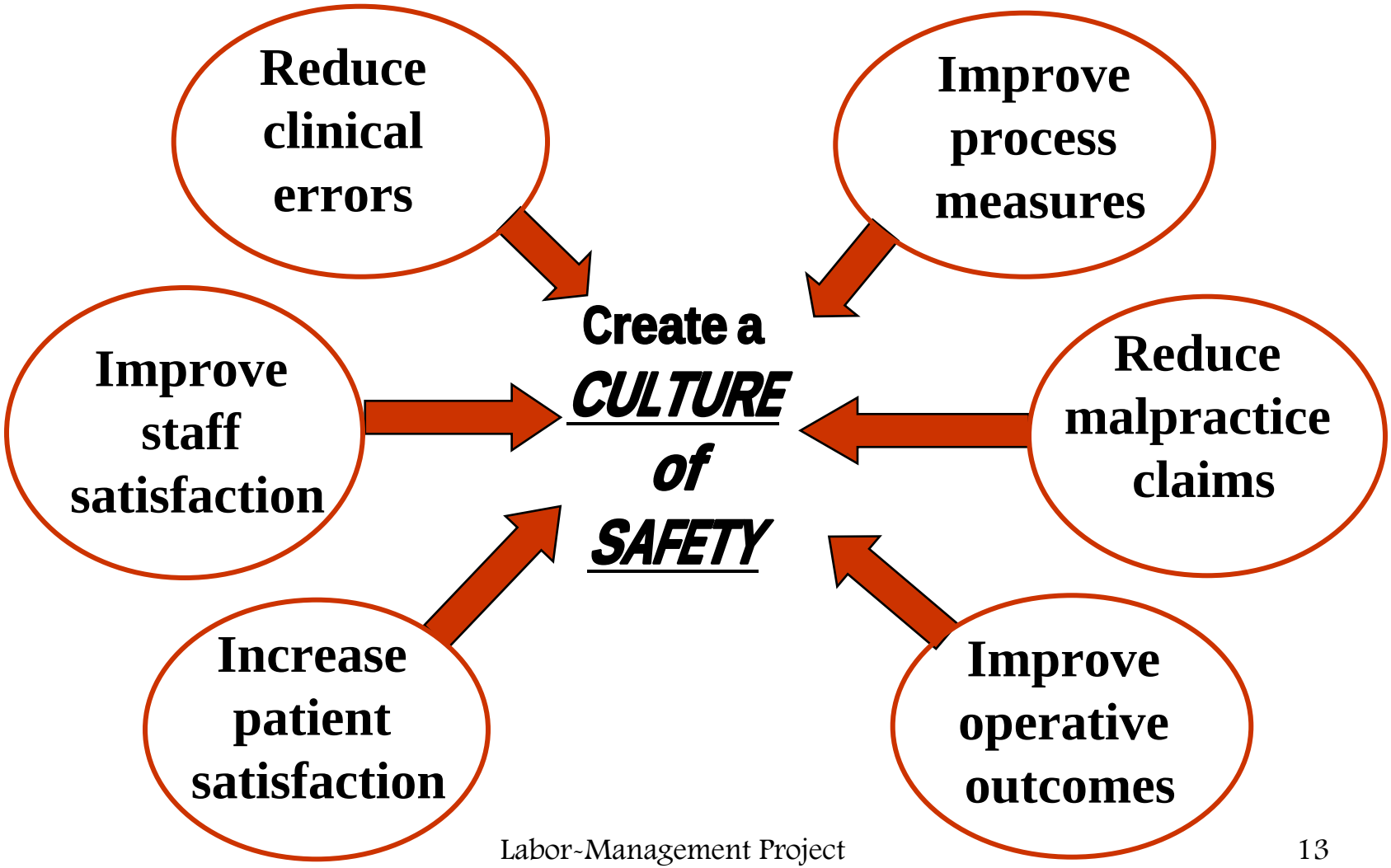
- Out of 8 MCIC hospitals reporting, CUMC ranked *last or next to last* on all measures
- **Under 30%** of respondents reported good teamwork in OR
- Nurses reported their input is <u>not</u> well received
- **Only 30%** of respondents reported good safety climate in OR



Why We Need Teams?

- Improve patient safety and outcomes
- More pleasant less stressful work environment
- Well trained teams manage unexpected events better

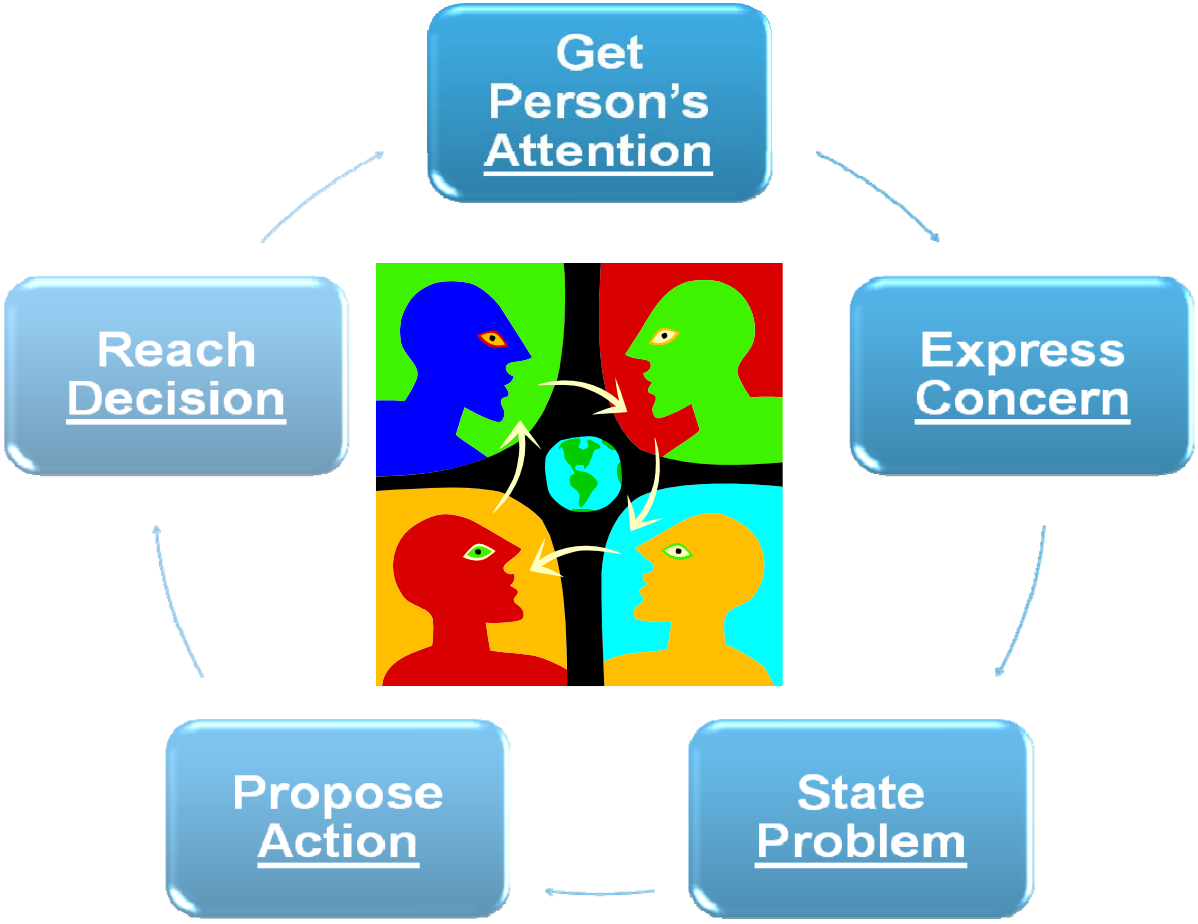
BENEFITS OF TEAMS



Team Training Objectives

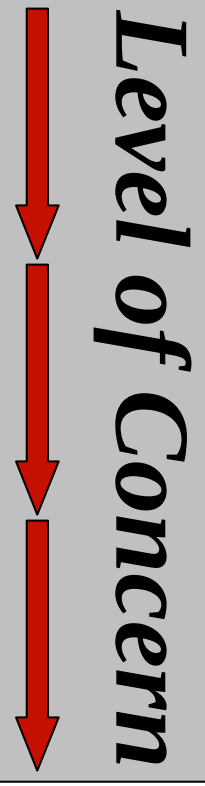
- Develop a model that puts patient needs and safety at the center
- Demonstrate the value of multidisciplinary teamwork
- Train teams to understand the shifting roles of a team leader
- Explore the source of errors and error prevention strategies
- **Teach discreet communication skills for both team building and problem resolution (briefing/debriefing)**

Assertiveness in Communication



Please Use C.U.S. Words

- I am Concerned!
- I am Uncomfortable!
- This is a Safety Issue!



What is Briefing & Debriefing?

A dialogue between two or more people using concise information to promote clear mutual understanding

- . **The Briefing:**
  - Who Leads the Briefing? — The Surgeon
  - Who are included in the Briefing? — All Team Members
  - Where & When is Briefing Performed? — In the OR Prior to the Start of the Procedure

- **Elements of the Debriefing:**
  - ✓ **Did we communicate well today?**
  - ✓ **Did we function as a team?**
  - ✓ **Did anything go wrong?**

- **No Assumptions by Silence is Permitted**

- Briefing picture

Status Report & Impact at NYP-CU
Most significant results the team achieved during the project.

Team Training Sessions are Multidisciplinary forums to discuss:

- **barriers to communication**
- **perceptions of the safety climate**
  - **Surgeons' assumption: "staff were empowered to speak up when issues that may affect patient care are identified"**
- **ways to improve**

Everyone is empowered to "stop the line" when a patient care concern is identified

Importance of Teamwork

- **Well trained teams can manage unexpected events**
- **Clear communication promotes collaboration and understanding**
- **Shared accountability**
- **Clear chain of command**

Status Report & Impact at NYP-CU
Measures of Success

Quantitative Indicators	Target	Current State	Post Training
Completion of 3-hr Team Training by all Staff & Physicians	Six (6) Surgical Cores	1 core completed	
"Briefing and Debriefing" performed by teams completing the training	All surgical procedures	Orthopedic procedures	
Improved "First Case On-time" Start	90%	54%	
Decreased Room Turn-Around Time	30 mins.	42 mins.	

Status Report & Impact at NYP-CU
Measures of Success

Qualitative Indicators	Current State	Post Training
Improved Safety Attitudes' Questionnaire (performed in October, 2007. Results pending)		
Improved Employee Satisfaction scores (2008)		
Improved communication as evidenced by decrease in communication-related medical events.		

Status Report & Impact at NYP-CU
Measures of Success

Qualitative Results:

- Improved work patterns, better communications, stronger labor-management relationship

  As evidenced by: Team Shared Mental Model

  - *Expectations for next case start time*
  - *Roles are clear for all team members*
  - *Assumptions never acceptable, must be questioned and confirmed*

- Commitment to teamwork
- Mutual accountability
- Acknowledgement and recognition
- Acknowledgement of human fallibility
- Professional respect

Success Outcomes: Impact of OR Briefing at Johns Hopkins

"My input about patient care was well received in the OR"

- BEFORE implementing OR Briefing process only 70% agreed
- AFTER implementing OR Briefing 90% agreed

Impact of OR Briefing at Johns Hopkins

"The physicians and nurses worked together as a well-coordinated team"

- BEFORE implementing OR Briefing process only 65% agreed
- AFTER implementing OR Briefing process 90% agreed

What we did to achieve results Roll-out plan:

- 2 Joint **presentations** to multi-disciplinary audience. Attendance mandatory.
- Presented to key **Labor Leadership**

  (NYSNA & 1199 SEIU)
- **Key stakeholders** identified to include:
  - Staff
  - Physicians (Surgeons & Anesthesiologist)
  - Nursing & Physician Leadership
  - Hospital Administration
  - HR
  - Union Leadership

What we did to achieve results Roll-out plan:

- Trainers identified within the department & physician volunteers.
  - 5 Physician Trainers
  - 1 Nurse Trainer
  - Plan for additional trainers:
    - Volunteers from Cores that have completed the training
- Training roll-out by specialties (Core)
  - 1st Core: Orthopedics 2007
  - 2nd Core: GYN/GU January 2008
  - Subsequent Cores to be determined by Steering Committee
  - Training Completion Goal: December, 2008

Challenges and Strategies

Challenges:	Strategies:
1. Buy in	• "Town Hall" meeting to present the need and goal of Team Training • Presentation to key Labor Leadership • Presentation to Key Stakeholders • Training sessions started with cores that had the buy-in of the Chairman
2. Scheduling of training sessions	• Sessions scheduled after work hours • Training mandatory for all
3. Rolling-out Briefing prior to the procedure	• Script provided • Briefing observed by a trainer • Timing of Briefing defined by the team

What's Next?

- **Identify and train additional Trainers**
- **Continue roll-out to other cores/services**
  - January 2008 GU/GYN Core
  - March 2008 General Surgery
  - Subsequent Cores to be determined by Steering Committee
  - Training Completion Goal: December, 2008
- **Roll-out to other Operating Rooms**