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Review Article

Patient Safety and the Importance of Team work Training in Health Care Organizations

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Received: December 12, 2019; **Published:** January 06, 2020

Abstract

The first awareness to patient safety started by IOM report in December 1999, "To Error Is Human: Building a Safer Healthcare System".

The author estimated that 44,000 to 98,000 Americans die each year from medical errors. This is equivalent of a jumbo jet crashing each and every day in US and later we know that the problem of medical errors is not fundamentally one of "bad apples", but rather one of the competent providers working in a chaotic system that hasn't prioritize safety. Most errors are made by good, but fallible people working in dysfunctional systems.

Keywords: *Patient Safety; Medical Errors; System*

Introduction

What is safety? The WHO definition is the prevention of error and adverse effects to patient that are associated with healthcare.

Patient safety depend on the Basic Ethical principle; Non maleficence, do no harm. First created by Abocrates, raising awareness of patient safety could be achieved by two things:

1. First- Engagement of Leadership and Front-line staff which include the all heath care providers
2. Second: Education of the Patient Safety Science which include:
    a. Standardization
    b. Checklists
    c. Error reporting and near miss reporting
    d. Learning from error
    e. Human Factor
    f. Team work training
    g. Disclosure and apology
    h. Health Literacy

And in this article, I will speak in details about the Importance of Team work in relation to patient safety and the principles of Team work Training.

Discussion

- It is easy getting good players, the hard part is getting them to play with each other.
- What is the difference between team and group?
  - Team is a group of people sharing the same goal.
- Why we need a team?
  - Due to human mental processing deficit.
  - No individual can achieve what the team is required to achieve.

Team work training

Team

Group I: We show the a crossed square.

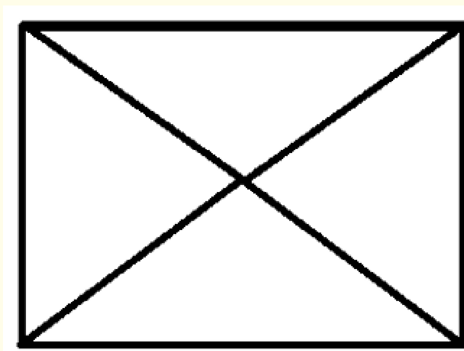

Figure 1

Group II: We show them a triangle

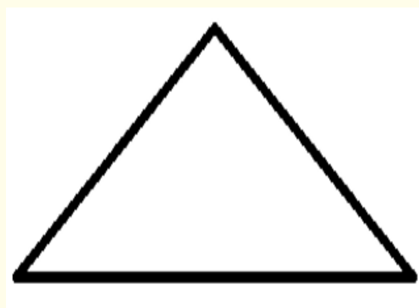

Figure 2

Group I and II: we can tell that you have seen two views of the same thing, what is it? (Team).

- It is two views of a pyramid
- So always the team see the matter from different views and give a more successful resolution of the problems.

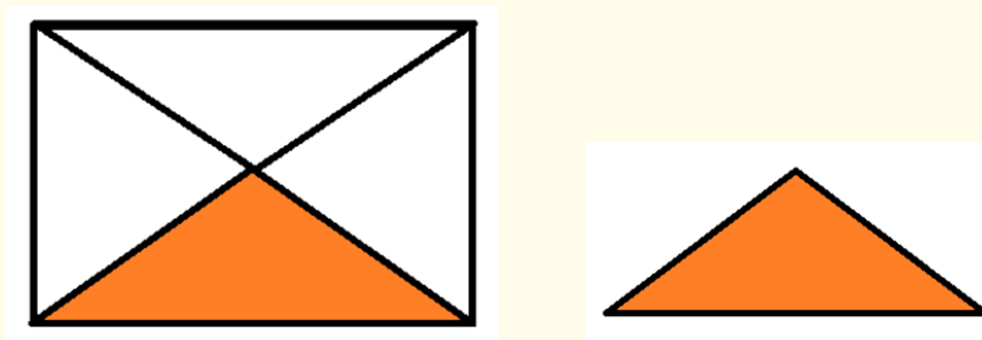

Figure 3

Katzenbach and Simith have summarized the factors that explain the superior performance inherent in Teams:

1. No single individual can possess the complementary skills and experience required to respond efficiently to operation changes such as Innovations, Quality, Customer Service or Patient Care Emergencies.
2. Communication established between professionals during Team Formation creates the basis for efficient real-time problem solving.
3. Team builds Trust and Confidence in each member's information, Intellectual challenge and differing adaptability to change.
4. Importantly, working in teams that achieve significant performance goals provides personal satisfaction and fun.

In relation to patient safety

Team work helps to ensure the three (3) core outcomes of Patient Safety:

- Unity
- Reduction of Error (Slips-Laps-Mistakes)
- Improved patient and staff satisfaction.

Team work mitigates the three (3) key issues that undermine Patient Safety:

- Unclear rules
- Lack of Accountability
- Humans providing care in poorly designed and organized complex system.

What is a team?

Team: Team is a discrete unit of performance, not a positive set of values.

True Team can be identified by following Five (5) Operational principles.

Consensus (Agreeing to agree)

- Mission, vision, goals and objectives.
- It may not be possible or desirable to gain complete consensus for each decision.

- The concept of consensus is sometimes used by those who refuse to agree to anything, as a barrier to stop the group from moving forward (Constipator).
- As an alternate, the use of consensus is to indicate that the majority of the team agrees to agree and acknowledge that complete consensus may not always be possible and therefore not necessary for the group to go forward.
- This is considered a critical step toward successful team work.

Mutual accountability

Every member must be willing to hold the team accountable for success or failure.

Organizational discipline

Team will only succeed ¡n an organization that recognizes the team rather than the individuals as the operating unit.

Tasks

The more demanding the performance challenge the better the resulting team.

Time

Specific time limit.

Causes of team failure:

1. Absence of trust
2. Fear of conflict
3. Lack of commitment
4. Avoidance of accountability
5. Inattention to the results.

High performing team

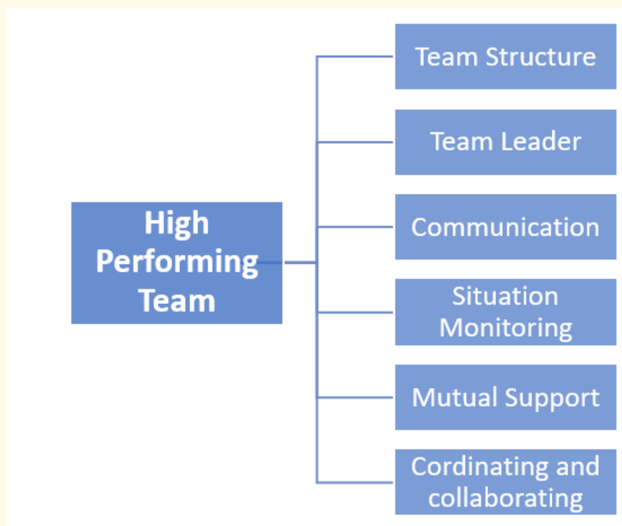

Figure 4

Leadership

1. Leaders need to be ideas coaches, not a key problem solver and rescuer.
2. Leaders are signal generators, who reduce uncertainty and ambiguity about what is important and how to act.
3. Remember, you could in theory be the best team leader in the world, with great ideas, but you will accomplish nothing if you cannot got the team to play together.
4. Style diversity: That is to give the "shy-docile-subordinate-quite" individuals a structured environment that promotes their participation and deal well with dominating individuals.
5. Shared Leadership "circumstances dependent".
6. Native American Proverb: "You don't have to turn the whole herd, just the buffalo in front'.

Team work training

Crew resource management: Considered one of the best team training and consists of the following:

1. Dampen authority gradient
2. Clear roles
3. Language of communication
4. Situation awareness
5. Improving team and individual performances
6. Briefing - debriefing

Dampen authority gradient

- Authority Gradient- is the psychological distance between a worker and a supervisor.
- The overall steepness of this gradient is referred as Hierarchy.

How:

- Introduce yourself
- Ask others to introduce themselves by name
- Tell them about the Imitations of your abilities
- Ask the others to be your eyes and ears in case of any concern for them.

Clear roles

Roles are:

- Agreed
- Allocated
- And Understood

It is important that the team members are flexible.

Language of Communication

Example one- used in less emergent situations: SBAR

S: Situation

B: Background

A: Assessment

R: Recommendation.

Scenario: Post-operative patient with new chest pain:

- Traditional nursing assessment when calling the doctor.
- Hi doctor, "Mr. Chow is having some chest pain".
- He was walking around the floor earlier and he ate good dinner.
- ‘I don’t really know what is going on, but I am getting ECG.
- He was a little sweaty when he had his pain, but I gave him the rest of his medicines, including his insulin and his antibiotics.
- He had surgery earlier and he is on PCA pump right now.

SBAR nursing assessment when calling the doctor.

Situation: This is Grace Jones, I am a nurse on 7 north and I am seeing your patient Mr. Edward Chow, he developed 8 out of 10 chest pain about 5 minutes ago, associated with shortness of breath, diaphoresis and some palpitations.

Background: He is a 68 years old prior history of cardiac disease who had an uncomplicated abdominal-Peritoneal resection yesterday.

Assessment: I am obtaining an ECG and my concern is that he might be having Cardiac Ischemia or pulmonary embolism.

Recommendation: I am giving him a nitroglycerin and would really appreciate if you could be here in the five minutes.

Example 2 and 3 are used in more critical situations:

C: Concerned

U: Uncomfortable

S: Safety issue, secured.

Example 3: PACE: scenario of ER doctor dealing with a child who is in impending Respiratory Failure and Failed to notice of responding to this ominous sign.

P-Probe

The nurse: "you need to know what is happening".

"Have you noticed that this child is cyanotic?"

A-Alert

The nurse: "I think something bad might happen?"

Dr. Brown: I am concerned the child is deeply cyanosed, should we will start BVM ventilation?"

C-Challenge

The nurse: "I know something bad will happen".

Dr. Brown: you must listen to me now, this patient need help with his ventilation".

E-Emergency

The nurse: "I will not let it happen".

Dr. Brown: "Please move out of the way as I am going to ventilate him".

Situational awareness

A big picture in mind even during Crisis.

- Level 1: What is going on?
- Level 2: So what?
  - Decision Making which should be familiar to everyone
- Level 3: Now what?
  - Plan Forward.

Improving team and individual performance

- Awareness of situation when errors are more likely to occur.
  - HALT: hungry-angry-late-tired
- Awareness of Error trap.
  - Confirmation Bias- a common trap that people fall into is only seeing or registering the information that fit in with their current mental model.
- Cognitive Aides
  - Checklist, guidelines and protocols.
- Calling for help early.
- Using all available resources.

Briefing debriefing

After the task is finished.

"Always start with positive things" [1-5].

Conclusion

Patient safety has the priority in health care organizations and teamwork is essential for safety.

The team should be a working unit that could achieve the goal with least errors.

Team leader plays and important role in the team dynamics and control, and every team member should feel responsible for the team failures or success.

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Volume 9 Issue 2 February 2020
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