



Participant WebEx Training

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Project Coordinator

WebEx Interaction Features

- Raise hand feature
- Yes/No feature
- Full screen view feature

Virtual Agreement

- Turn off cell phone and beepers.
- Avoid and eliminate all interruptions:
 - Send calls to voice mail, turn down ringers
 - Close other applications on the desktop
- Do not put your phone on hold as your hold music will play.
- Please mute yourself if you are having side conversations or have other background noise by using the mute button on your phone or highlight your name in WebEx and click “mute”.
- Please turn up the volume on your phone/speakers.
- To ask a question:
 - Raise your hand, wait to be recognized, unmute your phone line, and the Host will unmute you on our end, if necessary.
 - Chat to “All Participants”. Please be ready to elaborate on your question verbally and unmute your phone line.
- This session is being recorded.

**DO YOU AGREE TO THE TERMS OF THIS SLIDE?
PLEASE SELECT YES OR NO.**

John W. Whittington, MD

- John is Medical Director of Knowledge Management/Patient Safety Officer at OSF Healthcare System. Prior to holding his present position, he worked for many years as a family physician. He has been involved with patient safety work with the Institute for Healthcare Improvement (IHI) for several years and has been a patient safety scholar with IHI. Dr. Whittington is presently serving as faculty with the IHI, involved with safety and hospital mortality reduction. He received his undergraduate degree and medical degree from the University of Illinois and completed his residency in family practice at Saint Francis Medical Center in Peoria, Illinois.

Janet Nagamine, RN, MD

- Janet works in the areas of Patient Safety, Safe and Reliable Healthcare, consults with hospitals on teamwork, communication, safety culture, and implementation of a wide range of patient safety best practices. She recently transitioned out of her clinical and administrative roles at Kaiser Permanente to focus more exclusively on patient safety. Dr. Nagamine has over 20 years of clinical experience in hospitals and has been extensively involved in quality and patient safety at local, regional, and national levels. Her combined experience as an ICU nurse, hospitalist, patient safety leader, and assistant chief of quality gives her a unique perspective. She is also an assistant editor of the *Journal of Hospital Medicine*.

Michael Leonard, MD

- Physician Leader for Patient Safety, Kaiser Permanente, leads the national Kaiser Human Factors Patient Safety effort. Prior to his current position, he has served as Chief of Anesthesia, Chief of Surgical Services and Chairman of the Board of Directors. Dr. Leonard is a cardiac anesthesiologist by training and continues to actively practice medicine. He has also worked with the University of Texas Human Factors Research Project to incorporate the human factors lessons learned in other high-risk industries into medical patient safety. Dr. Leonard has lectured widely and worked with many health care systems to improve the safety and quality of medical care.



SBAR: Being Successful and Sustaining the Change

Michael Leonard, MD

Janet Nagamine, RN MD

John Whittington, MD

Our Discussion

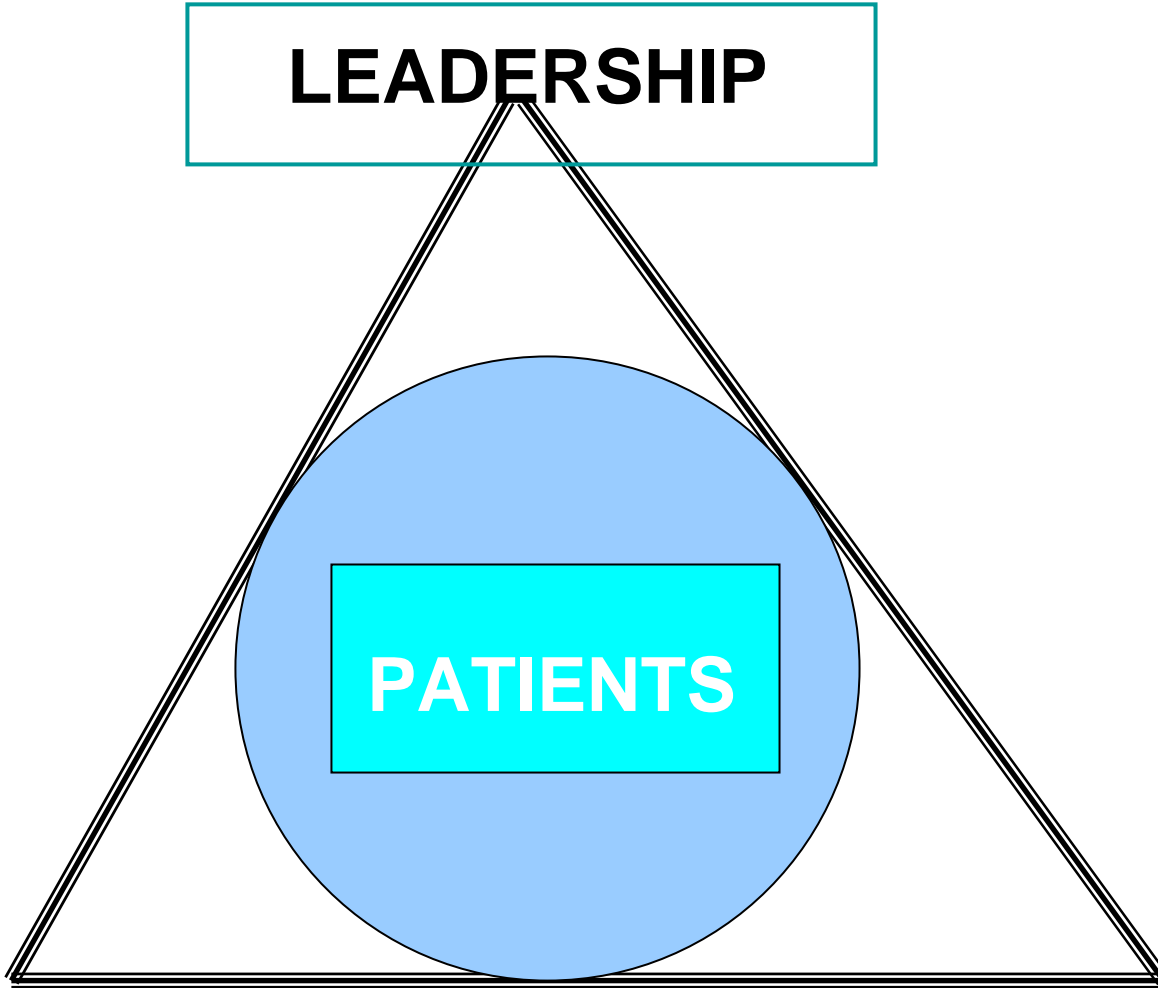
- Implementing SBAR in high risk areas
- Addressing your questions
- Implementation success factors
- How has it gone for you?

LEADERSHIP

PATIENTS

HUMAN FACTORS

RELIABILITY



Effective Communication Requires:

- Structured communication – SBAR
- Assertion/ Critical Language – key words, the ability to speak up and stop the show
- Psychological safety – an environment of respect – effective leadership

Real Risk Management

- Catastrophic birth injury
- Missing MI's in clinics and ERs
- Surgical misadventure
- Failure to diagnose – breast, lung, colon, prostate, skin

The Vertical – High Risk

- OR – briefings, teamwork, observation
- OB – teamwork, standards, simulation
- ICU – daily goals, teamwork
- ED – standardize high risk care, teamwork
- Med- Surg – RRT, teamwork, literacy
- Others

Highly Reliable Perinatal Unit

- SBAR to communicate
- MD always comes when RN/ midwife requests
- Definition of fetal well being
- Common definition of fetal heart tracing
- Practicing for emergencies

Safety and Reliability in the ED

- Discrete list of high risk diagnoses
- Do the basics every time
- Link systematic processes of care with effective teamwork and communication

ICU Safety

- Teamwork and communication
- Where are the pebbles in your shoes?
- Daily goals – are they the same by the next morning
- What are the reliable processes of care
- What does the culture look like?

Surgical Safety

- Human Factors – briefings, critical language, everyone's names on the board, debriefing
- The Glitch Book
- Systematic processes- antibiotics, normothermia, glucose control, DVT, beta blockers

Building and Leading Strong Teams – Implementing & Sustaining Patient Safety Work

Need to Embed SBAR in the Culture

- Leadership
- Education / training
- Buy-in from all the relevant parties
- Wrap the tools and behaviors in something people do all day and is part of their clinical work

Anchoring with Common Goals

- High quality, safe care
- What would optimal care look like?
- What gets in the way today, i.e. the performance gap?
- What can we fix – the quick hits, 3-6 months, 2-5 years?
- How do we know it's better?

SBAR Clinical Application

- Structured language can be used in virtually any clinical domain - IT, lab, radiology, senior leaders, cath lab, OR, etc.
- What is key is the conversation of what people need to know from each other – the common agreement and the social experience

SBAR across Hand-offs

- SBAR can be modified to about any clinical situation
- Kaiser uses SBAR for nursing hand-offs at the bedside
- What is key is defining the basic informational elements that providers need to know from each other
- Being organized is a great marketing component

Pilot vs. Hospital Wide

- Take a bite of the elephant: the advantage of pilots is that you begin where you are most likely to be successful – right people, right clinical area, right leaders.
- You will make mistakes. Learn as you go. Get it right in a limited scope before migrating widely – better to do a few things well, you never get a 2nd chance to make a first impression

Follow on

- What is key is sustaining SBAR / critical language and psychological safety over time
- You need to:
 - Embed it in the work people do every day
 - Get people to practice together if possible
 - Get buy-in – common agreement
 - Have the social experience of working together toward a common goal
 - Just dropping it in will not work

Does SBAR help at 2 AM?

- Yes – being structured, crisp and clear is a big hit
- Knowing you have to be organized, state the punch line (Situation) in 5-10 seconds, and close the loop with (Recommendation) , i.e. be clear as to what needs to happen and when
- This is what people want to hear they get called

Real Example

- Using SBAR, the nurse had a very positive response from a surgeon that she called at home at about 5:15 one morning recently concerning a blood bank problem. At the end of the conversation, he said, “These are the types of calls I like to be awakened for.”

Recommendation

- Very key – close the loop – we get into trouble when we assume we are having the same conversation
- What is key for me is to share the movie with the person who is at the bedside – most times they will have the right answer – almost always they will have a pretty good idea as to how they would approach fixing the problem – I'd like to know that every time

Getting Buy-In

- The benefit of using SOAP as an comparable model is that you can say “You guys already know this” –We’re working on everyone speaking a common language
- The agreement – they need to be organized and structured – you need to help them learn and make it safe 100% of the time for them to voice their concerns

Buy-In

- Almost all serious episodes of avoidable harm, lawsuits, sentinel events stem from communication failures
- It is in everyone's interest to create an environment and use structured communication tools (SBAR, critical language) that minimize communication failures that hurt patients and providers

Not Seeing the Need

- People make mistakes – no matter how skilled in complex systems full of surprises
- The model that if “everyone would just do their job well” is asking for big trouble given the complexity, operational pressure and frequent lack of familiarity among clinicians

Resistance

- We don't need this
- I already know how to do this
- We don't have a problem
- It's just more work to do.
- It's too soft and fluffy
- Cultural issues – won't speak up
- Doesn't feel safe – I do it with the people I like – not the people that are hard to talk to - WRONG ANSWER

USE Of SBAR At OSF

- Surgeon was upset recently about receiving extraneous phone calls from our unit. A new process was immediately developed in which staff present to the PCF/Charge Nurse prior to placing calls to physicians. The staff are now putting their concerns in SBAR format to the charge nurse for a “rehearsal” prior to placing the calls. The upshot of the process change is that the surgeon stopped the patient safety officer and stated, “I don’t know what you did, but it worked.” We are continuing to use the process and hopefully also eliminating unnecessary calls to contribute to physician work life balance.

Training

- Relevant – create the space for the conversation – KP Perinatal RN/ MD/midwife/ unit secretary, etc.
- Procedural learning – people need to know how to do it and have done it together
- Leaders model the behavior
- Medicine is a team sport – you need the team in the room - the quickest indicator of success is how many MDs are in the conversation
- Recurrent – need to reinforce – new folks, etc.

Measurement

- SAQ
- RN retention
- Ask the patients
- Look at critical events
- BIDMC example
- Big changes in areas where we have done this well OR, OB , ICU, med-surg

Bottom line

- Pilot – get it right – line up leadership – embed these changes in what people do every day – i.e. where they perceive value – build the social process around this – the conversations are what is key –we’re all here to do the right thing for the patient – how do we make sure that happens every time?