

## Mindfulness

I recently had a chance to listen to an OR team discuss a wrong surgery event. “I don’t get it, we did the time out and everything we were supposed to do,” was the surgeon’s response. I could really identify with his disillusionment. Mind you, this guy is no slouch. He is highly respected by his colleagues, staff and patients. The OR team could also be a dream team: experienced, clinical experts, thoughtful and caring clinicians who did what they were “supposed to do.”

So what went wrong? Can you feel the frustration? The disbelief?

This situation perfectly describes a fundamental disconnect between clinical practice today and quality initiatives. In fact, many providers have been quick to point out to me that the after many years of using The Joint Commission time out there hasn’t been any reduction in wrong surgeries associated with that procedure. So what gives?

My observations in ORs and other procedural settings is that the time out is performed in a perfunctory manner, with little to no engagement of the team. It’s a “check in the block.” Why? I often hear several reasons.

*“I’ve never had a wrong procedure, so what I’m doing must be working.”*

This is a very normal human and institutional response, believing that because things don’t normally go wrong, they couldn’t go wrong. Nassim Taleb deflates this fallacy in his book, *The Black Swan*. To wit, the observation of a million white swans does not justify the statement “all

swans are white” — they’re not. Most OR teams who are involved in a wrong surgery or any other sentinel event haven’t been involved in one before. What are you doing to prevent a wrong procedure? Hint: “being really careful” is not a successful strategy.

*“This is another solution created by so-called ‘experts’ who never see a patient.”*

This is just another way of saying “not invented here”: using the technique of questioning the source rather than addressing the issue. The Joint Commission time out is the absolute minimum standard for all of the issues that should be discussed prior to a procedure. The organizations that are getting the most out of the intent of the time out are those who are including the time out elements in a more comprehensive briefing for the team. Does it make a difference? For the past ten years we’ve had results that verify that the aviation model for team communication and collaboration works in healthcare. An article in a recent issue of JAMA (Neily, et al.) simply adds to this evidence.

*“This is a waste of time.”*

Those who’ve been using an expanded briefing consider it an *investment* of time because they find that there’s less guessing, less rework, and better preparedness on the part of the whole OR team.

While this discussion has largely centered on wrong surgery, the basic principles are the same in any clinical setting. Demanding rote compliance without thoughtful engagement is unlikely to change behaviors or outcomes. Front-line clinicians can learn best practices

from high reliability organizations and thoughtfully implement them into the system of care. Including specific questions to engage clinicians in a thoughtful dialogue is essential to invoke mindfulness and actively “do no harm.”

— Steven Montague, Vice President, [LifeWings](http://LifeWings.com), [lifewings@verizon.net](mailto:lifewings@verizon.net).

## References

Hines S, Luna, K, Lofthus J, et al. *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. (Prepared by the Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 08-0022. Rockville, MD: Agency for Healthcare Research and Quality. April 2008. [www.ahrq.gov/qual/hroadvice/hroadvice.pdf](http://www.ahrq.gov/qual/hroadvice/hroadvice.pdf)

Neily J, Mills PD, Young-Xu Y, et al. Association between implementation of a medical team training program and surgical mortality. *JAMA : the journal of the American Medical Association*. 2010;304(15):1693-700.

## About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website ([www.chpso.org](http://www.chpso.org)).

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## Double-Checks Work, Often

In [last month's CHPSO Patient Safety News](#), we discussed cultural differences and the detrimental effect on teamwork if not addressed. In the *Cosco Busan* accident, the inexperienced ship's captain felt inhibited from speaking up about the experienced harbor pilot's aberrant behavior. However, even in the absence of culture differences inappropriate deference to authority (perceived or actual) can cause teamwork breakdowns.

Double checks often are used to reduce the risk of human error at critical points in patient care. Whether it is two nurses confirming the correct unit of blood or a surgical time-out to confirm the correct procedure, healthy teamwork is needed for the double-check to succeed.

Teams usually work well when things go well — for example, if both nurses are sure that the unit of blood is the correct one. However, when the double-check is most important — when one person makes an error or there is an ambiguous situation — the team is most likely to fail.

What if one nurse is a new hire and the other is a respected “house expert?” What if the blood order is scribbled and difficult to read? Will the new nurse stifle any objections if he first hears the expert say that everything looks fine? Will doubting his own expertise cause him to remain silent?

Anyone, even an experienced reliable nurse, *will* make a mistake on occasion. And the deference to experience and reputation can make those mistakes, mistakes by the “stars,” more likely to result in bad outcomes.

For a double-check to work properly, team members must be comfortable

disagreeing and know how to constructively resolve those differences. Differences of opinion or even something less, such as ambiguity, should be seen as a warning sign that something may be going wrong with the patient's care.

For many, constructive disagreement is not intuitive, but rather a learned skill. Successful double-checking is a team sport, and successfully instituting the double-check or checklist requires instituting effective team-work as well.

— Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## Joint Commission Program for Improving Hand-Offs

In October 2010, The Joint Commission Center for Transforming Healthcare announced targeted solutions for its second improvement project on improving the quality of hand-off communications.

The targeted hand-off solutions from the Center use the acronym SHARE, which addresses the specific reasons why hand-offs are unsuccessful. SHARE refers to:

**Standardize** critical content, including

providing details of the patient's history to the receiver

emphasizing key information about the patient when speaking with the receiver

synthesizing patient information from separate sources before passing it on to the receiver

**Hardware** within your system, including

developing standardized forms, tools and methods, such as checklists

using a quiet workspace or setting that is conducive to sharing information about a patient

stating expectations about how to conduct a successful hand-off identifying new and existing technologies to assist in making the hand-off successful

**Allow** opportunities to ask questions, including

using critical thinking skills when discussing a patient's case

sharing and receiving information as an interdisciplinary team (e.g., a pit crew)

expecting to receive all key information about the patient from the sender

exchanging contact information in the event there are any additional questions

scrutinizing and questioning the data

**Reinforce** quality and measurement, including

demonstrating leadership commitment to successful hand-offs

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holding staff accountable for managing a patient's care

monitoring compliance with use of standardized forms, tools and methods for hand-offs

using data to determine a systematic approach for improvement

**Educate** and coach, including

teaching staff what constitutes a successful hand-off

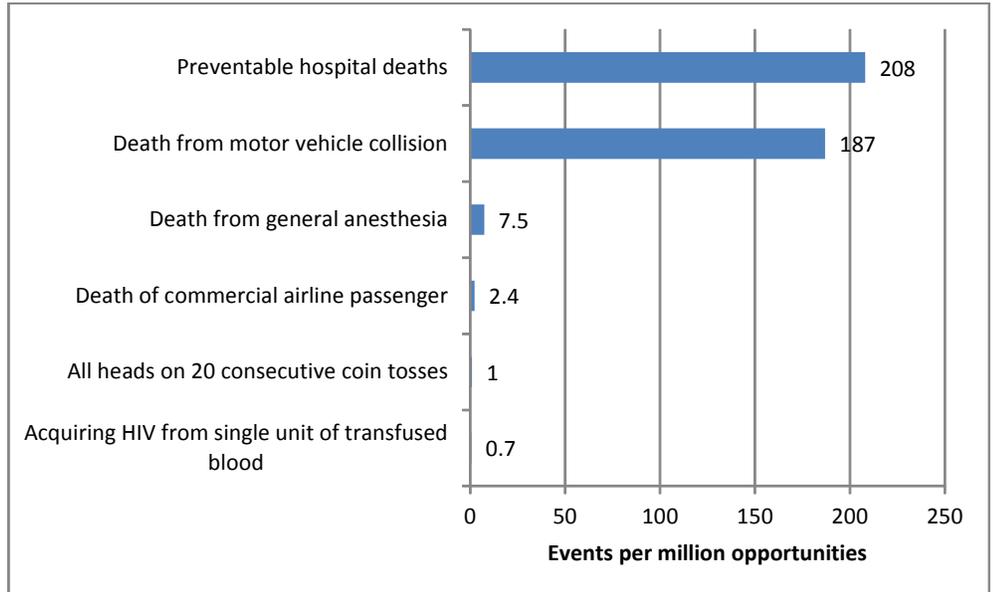
standardizing training on how to conduct a hand-off

providing real-time performance feedback to staff

making successful hand-offs an organization priority

## Patient Safety Tidbit

*Safety hazards and everyday probabilities*



Source: [webmm.ahrq.gov/dykarchivecase.aspx?dykID=1](http://webmm.ahrq.gov/dykarchivecase.aspx?dykID=1)

— Excerpted from [goo.gl/vfvM](http://goo.gl/vfvM)

## Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

### November

- 9:** BEACON: Compass Series 3 of 4. Redwood City.
- 16:** CHPSO: Just Culture Support Call. 11 AM–noon.
- 16:** SCPSAC (Southern California Patient Safety Collaborative): Track I: Surgical Care Improvement Project, Sepsis, Hospital-Acquired Infections in the ICU Setting. City of Industry.
- 19:** BEACON: Practical Skills for Quality Improvement. Fremont.

### December

- 2:** SCPSAC: Track II: Pressure Ulcers. City of Industry.
- 3:** CAPSAC: California Patient Safety Action Coalition Meeting. Torrance.
- 15:** HASD&IC (Hospital Association of San Diego and Imperial Counties): San Diego Patient Safety Council; Sepsis. San Diego.
- 15:** BEACON: Compass Series 4 of 4. South San Francisco.
- 16:** BEACON: Practical Skills for Quality Improvement. Redwood City.
- 21:** CHPSO: Just Culture Support Call. 11 AM–noon.

For further information on these events:

- BEACON: Petrina Aiello [paiello@hospitalcouncil.net](mailto:paiello@hospitalcouncil.net) or [www.beaconcollaborative.org](http://www.beaconcollaborative.org)
- CAPSAC: Theresa Frei [FreiTH@sutter-health.org](mailto:FreiTH@sutter-health.org) or [www.capsac.org](http://www.capsac.org)
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## Articles Welcome

Submit articles to [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org). Typical length is 400–600 words.