Pathways for Patient Safety™

Module One:

Working as a Team

A Partnership:

Health Research & Educational Trust

Institute for Safe Medication Practices

Medical Group Management Association
Center for Research

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Supported by a grant from The Commonwealth Fund

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Development of Pathways for Patient Safety *was made possible by a grant from The Commonwealth Fund.*

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Overview

The first step toward ensuring patient safety in a physician practice is creating an environment that supports teamwork and good communication. The information, strategies and tools presented in this first module, *Working as a Team*, are designed to improve teamwork and communication attitudes, knowledge, and skills for you and your fellow staff members. These Module One activities are essential to accomplishing the objectives of Module Two, *Assessing Where You Stand*, and Module Three, *Creating Medication Safety*. Working toward the goals in Modules Two and Three will, in turn, encourage and strengthen effective teamwork and communication within your practice and with your patients.

Here is what you will learn in each section of this module:

Build an Effective Team

- Characteristics of high-performing teams
- Specific TeamSTEPPS™ teamwork techniques:
  - leadership
  - mutual performance monitoring
  - mutual support
  - situational awareness

Enhance Team Communication

- Communication techniques that promote safer care: DESC, CUS, and SBAR
- Group communication tools: daily huddles, weekly patient safety meetings

Involve the Patient as Part of the Team

- Importance of involving patients in the team process
- How to encourage active involvement of patients and their families

Additional readings and resources are included at the end of the module.

Why Teamwork and Communication Matter

Effective teamwork and communication are associated with better patient outcomes, higher patient satisfaction, and lower malpractice claims.

For over two decades, research and training programs in high-risk industries such as the military, commercial aviation, and nuclear energy have recognized the crucial role of teamwork and communication. Informed by these industries Pathways for Patient Safety™ has identified or developed practical tools and techniques that will help you build an effective team in the physician practice setting. Effective teamwork and communication are associated with better patient outcomes, higher patient satisfaction, and lower malpractice claims.[1] Recent studies by the Institute of Medicine found that quality and effectiveness of care vary greatly depending on how well a healthcare team functions, and that system failures rather than individual performance account for more errors or adverse events.[2-3]

Did You Know?

From 1995 to 2005, ineffective communication was identified as a root cause for nearly two-thirds of all sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations, a statistic supported by analyses of closed malpractice claims.[4] An estimated 1.74 billion dollars in malpractice claims are associated with ambulatory care settings. Four of the top six case areas that make up a majority of lawsuits are, in some way, associated with a failure in teamwork. System errors, including failures in teamwork, contribute to almost one-third of settled malpractice claims. The government and other third party payers are moving towards not paying for a select set of medical errors referred to as "never events" or "serious reportable events."

When it comes to practice management, where do you *think* your practice stands? After taking the PPPSA assessment where does your practice *actually* stand? It is important to look at the tables below in the context of your own practice and to remember that there is always room for improvement.

PPPSA Items Related to Team & Communication Training	NONE PARTIAL FULL
Item 33.20: The practice provides training to all staff in team communication including methods to ensure efficient and effective communication.	21% 39% 40%
PPPSA Items Related to Job Descriptions & Safety	
Item 33.8: Job descriptions for all office personnel include requirements to speak up about safety issues, change practices to enhance safety, talk about errors, ask for help when needed, and other elements of shared accountability for safe practices.	25% 28% 47%
Item 33.9: Job descriptions for all clinical personnel include requirement to speak up about safety issues, change practices to enhance safety, talk about errors, ask for help when needed, and other elements of shared accountability for safe practices.	24% 27% 49%
PPPSA Items Related to Patient Communication & Safety	
Item 33.11: The practice documents all patients' complaints and/or concerns about their care or outcomes including problems with communication between patients and clinicians and staff within the practice and/or consulting or testing center staff. All complaints are periodically reviewed, shared with staff, and responses and resolutions are documented.	10% 36% 54%

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PPPSA Items Related to Patient Communication & Safety *continued*	NONE PARTIAL FULL
Item 33.12: The practice encourages patients by verbal or written surveys to share any safety concerns they may have while at the practice, with staff, or at outside referral centers.	31% 28% 41%
Item 34.4: Diagnostic and treatment care plans are communicated to patients and caregivers in an understandable manner and provided in a written format if required. For example, patients and/or caregivers are asked if they would like to receive a written care plan. A process is in place to communicate diagnostic and treatment care plans in a way that is understood by patients, and when appropriate, by their families.	23% 43% 34%
Item 34.6: Patients are routinely asked to repeat back what they hear to help the clinician clarify any instructions.	29% 57% 14%
Item 34.7: For Limited English Proficiency (LEP) or hearing impaired patients, the practice provides qualified medical interpretation services.	17% 31% 52%

Story:

The nurse had questions and did bring them to my attention, but [only] after the medicine had been given. [After the wrong dose had already been administered] she said that she had asked me as well before she gave it. But she certainly asked me in a much different way after she gave it. So she could have come to me and been a little bit more forceful about how it didn't make sense. Thankfully the patient was OK, but we were worried there for a while.[6]

Benefits of Effective Teamwork and Communication

For organizations, an environment centered on effective teamwork and communication:

- *contributes to the consistent delivery of patient care;*
- *is essential for managing the complexity of patient care in a setting that often exceeds the capabilities of an individual clinician;*
- *ensures staff safety;*
- *allows staff to learn from mistakes rather than place blame;*
- *provides a more satisfying and rewarding work environment for staff; and*
- *fosters an environment in which healthcare organizations can attract and retain high-performing employees.*

Leonard, Frankel, Simmonds, 2007[5]

Steps To Success

Proficient teamwork and communication skills do not come naturally—they need to be learned and continuously practiced. The consistent application of these skills can be impeded by the realities of day-to-day office practice—high workload volumes, patients with multiple care givers, and the complexity of the steps involved in care processes—and by habits of training and culture that actually discourage teamwork and communication. However, investing in your staff with education and training in proven teamwork and communication techniques will reap numerous rewards including safer care to your patients, greater patient and staff satisfaction.

Tools You Can Use

The TeamSTEPPS™ program is available free of charge at either the Agency for Healthcare Research and Quality (AHRQ) website: ***http://www.ahrq.gov/teamstepps*** or the Department of Defense Patient Safety Program website: ***http://dodpatientsafety.usuhs.mil/teamstepps***

Step One—Build an Effective Team

Introducing the Concept of Teamwork to Your Practice

Being an effective team member will have an immediate and positive effect on patient safety in your practice. Fortunately, researchers studying high-stress, high-risk and complex work environments such as medicine, aviation and the military, have identified important team behaviors, skills and attitudes. The Agency for Healthcare Research and Quality and the Department of Defense have synthesized this research into a set of free, easy to access and use teamwork and communication tools called TeamSTEPPS™. It is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among healthcare professionals. These important tools inform much of this module.

Being an effective team member will have an immediate and positive effect on patient safety in your practice.

General Teamwork Principles

The primary goal of teamwork in the physician practice is to make the best and most timely use of information, skills, and resources by teams of health care providers for the purpose of enhancing the quality and safety of patient care. A team is a group of two or more individuals with specific roles that relate to one another and who share a common goal. Team members are highly interdependent in accomplishing their goals. Their interactions have a strong effect on patient care outcomes. Everyone talks about being a good team player, but how will you really know a good team when you see it? Well-functioning teams possess a number of important characteristics. They are comprised of team members who:

- share a clear vision of their work, which they all value;
- have clearly defined roles and responsibilities;
- understand and take advantage of the expertise distributed among their members;
- exchange information, knowledge, and skills, irrespective of the profession and work background of their members;
- coordinate activities necessary to complete tasks, and easily adapt to task demands by sharing information and resources;
- have strong team leadership;
- engage in a regular discipline of feedback in a blame-free fashion;
- share a strong sense of collective trust and confidence;
- create mechanisms to cooperate and coordinate; and
- manage and optimize performance outcomes to keep patients safe.[6,7]

Building a High-Performing Team

Effective team members understand each others' roles and responsibilities. They are able to predict each other's needs. Conflict is managed early on and effectively. Each team member has a strong sense of being accountable to other members of the team and to the patients they serve. Acquiring the desirable aforementioned characteristics and behaviors will take time, training and practice to become a part of the day-to-day routine in the office. Individuals need to learn to work together as a team.

When mastered and conscientiously practiced by all patient safety team members as well as other practice staff, these four basic TeamSTEPPS principles help build high-performing teams and create a safer office:

- Leadership
- Mutual performance monitoring
- Mutual support
- Situational awareness

The following section briefly discusses each of these principles and provides tips for their successful application.

Leadership—Supporting the Team

Although each member of the team is valued for their contribution to the whole, each team needs a leader. An effective team leader:

- organizes the team by selecting the right personnel to serve on the team;
- articulates clear goals through input of fellow team members;
- makes decisions, again, through collective input of team members;
- empowers members to speak up and challenge when appropriate;
- actively promotes and facilitates good communication;
- holds each himself or herself and fellow team members accountable; and
- skilfully manages conflict resolution between team members.

Team leaders also do not fit into the traditional medical hierarchy. For example, an experienced nurse or nonclinical administrator may be the team leader because other members of the team are less familiar with the demands and resources of the team. Team leaders identify opportunities to share leadership roles, as appropriate, to underscore the reality of shared responsibility for the team's outcomes.

Effective leaders will:

- Use resources efficiently;
- Balance the workload within the team;
- Delegate tasks as appropriate;
- Conduct daily huddles, briefs and debriefs, weekly meetings; and
- Encourage team members to speak freely and ask questions.

Mutual Performance Monitoring—Keeping Track of Yourself and Others

Mutual performance monitoring means that team members are aware of their surroundings and the performance of others. This important patient safety principle requires individuals to keep track of other team members' activities while carrying out their own. By practicing mutual performance monitoring, staff members will be more likely to notice potential errors or missteps by other team members before they occur.

Team members who practice mutual performance monitoring:

- observe the communication and performance of other team members;
- recognize when a team member makes a mistake;
- are aware of other team members' surroundings;
- offer relevant information before it is requested;
- have an accurate understanding of their teammates' workload; and
- are aware of their own surroundings[6].

Mutual Support—Supporting the Needs of Others

Mutual support is the ability to support other team members' needs through knowledge about their workload and responsibilites. Physician practices are busy and often unpredictable. In addition to fluctuations in workload and normal day-to-day operations, individuals are subject to changes in their lives. High-performing teams recognize that both types of circumstances affect team members. Team members who actively seek and willingly provide help to each other are practicing mutual support. Mutual support means that team members:

- provide task-related support and try to protect each other from work overload;
- provide timely, constructive feedback in a positive way that is free from blame;
- advocate effectively for the patient;
- use techniques to resolve conflict such as advocacy and assertion, two challenge rule, CUS and DESC (see page 20); and
- foster a climate where people actively seek assistance and where assistance is willingly provided.

Situational awareness—Ensuring That Everyone is on the Same Page

Situational awareness relates to how team members identify problems and define solutions to them. This principle acknowledges the dynamic nature of an office practice, requiring that each team member be actively aware of their surroundings and the activities that transpire throughout the day. By practicing situational awareness, each team member will know the current conditions affecting the team's work and be able to share relevant facts with the entire team.

Situational awareness also promotes a shared mental model that:

- helps ensure that teams know what to expect and, when necessary, to be able to quickly regroup to get everyone on the same page;
- fosters communication to ensure that patient care is synchronized;
- enables team members to predict and anticipate better; and
- creates commonality of effort and purpose.

Barriers to Effective Teamwork

It is helpful to be on the lookout for factors that can disrupt good teamwork and derail team development. Some of the common teamwork barriers identified by TeamSTEPPS™ are:

- inconsistency in team leaders
- lack of time to meet and interact as a team
- hierarchy
- defensiveness
- not speaking up
- conventional thinking
- varying communication styles
- unresolved conflict
- distractions
- fatigue
- heavy workload
- misinterpreting cue
- lack of role clarity[6]

The tools outlined in Step 2, starting on page 18, will provide you with materials a nd worksheets that can help address some of these barriers through improved communication.

Physician practice teams that carry out the principles discussed above will go a long way to creating a safe office for patients and staff. There are a number of team check-up tools available, including the TeamSTEPPS™ Team Performance Observation Tool which helps teams rate on a five-point scale how well they think the their team is doine in terms of team structure, leadership, situation monitoring, mutual support and communication. Using this Tool on a monthly basis to assess how well the team or teams are functioning is a good practice to follow. All staff members should complete the form and the results should be discussed at monthly staff meetings.

Tools You Can Use

The TeamSTEPPS Program is full of useful materials to lead a team development program for your practice:

Ambulatory Care Instructor Guide

Video Vignette for the Office Practice:

- Opportunities
- Success

Teamwork Principles Presentation

Team Performance Observation Tool

Tools You Can Use

Sources of Information About Patient Safety

Many practitioners learn about error by hearing about it happening elsewhere. Yet in the physician practice, networking may not exist to nurture a broad-based awareness of medical error as it happens. Here are some easy strategies and accessible tools to keep your staff informed about medical error, patient safety research, and lessons learned from the field:

- Subscribe to patient safety journals or newsletters for the office.
- ISMP newsletters: Learn more at: ***www.ismp.org/Newsletters***.
- Monitor the literature via free Agency for Healthcare Research and Quality (AHRQ) Patient Safety Net email or RSS service: ***http://psnet.ahrq.gov***.

Applying Teamwork Principles to Patient Safety

The previous section addressed the importance of evidence-based teamwork techniques, in particular, from the TeamSTEPPS™ program. The following section addresses how to apply these evidence-based teamwork principle to patient safety.

Create a Sense of Urgency

It is important to "make the case" within your practice for effective teamwork. Good candidates for creating a sense of urgency about the need for an ongoing patient safety team include:

- results of the PPPSA, which you will learn about in greater detail in Module Two, ***Assessing Where You Stand***;
- closed or open malpractice claims;
- stories about near misses;
- adverse incidents;
- patient and employee satisfaction surveys; and
- staff concerns about quality and patient safety.

John Kotter's book, *Leading Change*, is a useful resource for any size organization embarking on change (see Resources).

Create Your Patient Safety Team

For the average-sized physician practice with 7-10 employees, having all staff members serve on a single patient safety team works best. Larger practices may choose to have more than one patient safety team organized by clinical specialty or sub-specialty. Sending staff to educational programs and/or inviting consultants and educators into the practice can be good ways to improve team member skills in patient safety.

Here are some important points to remember as you form your patient safety team(s):

Patient Safety Officer: We recommend that each practice—whether large or small—have a designated Patient Safety Officer. This formalizes the physician practice's commitment to patient safety and heightens everyone's awareness. In cases where the practice is small enough to accommodate only one Patient Safety Team Leader, this individual will also be the practice's Patient Safety Officer. This individual should possess the following knowledge, attitudes and skills:

- the ability to see the big picture and understand the interrelatedness of health care;
- superior interpersonal skills, including a non-judgmental and non-confrontational communication style; and
- a demonstrated track record of integrity, including the building of trust among colleagues.

Important qualifications for your practice's Patient Safety Officer include:

- ***experience with the organization's quality improvement and patient safety programs;***
- ***knowledge of risk management principles and issues regarding patient safety;***
- ***ability to see the big picture and understand the interrelatedness of health care;***
- ***superior interpersonal skills, including a non-judgmental and non-confrontational communication style;***
- ***demonstrated ability in building effective partnerships and coalitions;***
- ***demonstrated track record of integrity, including the building of trust among colleagues;***
- ***demonstrated understanding in data collection, analysis and reporting, with access to statistical and analytic expertise;***
- ***strong leadership qualities; and***
- ***familiarity with local culture and change management.***[8]

The Patient Safety Officer should receive training in patient safety science and practice and be able to oversee all aspects of the organization's patient safety functions. The Patient Safety Officer must be someone who:

- will be an effective team player;
- will be granted the appropriate authority to ensure that all aspects of the practice's patient safety program are implemented; and
- will support team members toward process improvements through their own mastery of patient safety concepts and practices, and through access to outside expertise as needed.

The Patient Safety Officer spearheads the creation of the Patient Safety Team(s). In smaller practices, the Patient Safety Officer also serves as the day-to-day Team Leader. In larger practices with multiple teams, Team Leaders work closely under the direction and guidance of the Patient Safety Officer.

Patient Safety Team Leader: Each team should have a designated Team Leader. The role of the team leader is to facilitate all aspects of patient safety efforts in the practice. In smaller practices, the patient safety champion may also serve as the patient safety team leader. In turn, this same individual may be the Patient Safety Officer for the practice.

Patient Safety Team: Much of the patient safety science in the past two decades has come from the inpatient setting where multiple patient safety teams are the norm. The patient safety team concept is applicable to the physician practice setting, but depending on the size of the practice, may be a team of all the staff. Each team should include at least one physician, but should not be limited to physicians. If the practice is larger, more than one team can be assembled. Teams should be created based on what makes the most sense clinically and operationally to keep patients and staff safe. Mature, high-performing patient safety teams include these skills among their membership:

- understanding of data collection, analysis, and reporting;
- some knowledge of risk management principles and issues regarding patient safety;
- ability to build effective partnerships and coalitions; and
- familiarity with local culture and change management.

Good communication is at the heart of patient safety.

Step Two—Enhance Team Communication

Good communication is at the heart of patient safety. Because patients today are cared for by multidisciplinary teams rather than a single person, accurate and timely communication is central to optimal patient care and safety. Like teamwork, good communication is not a given; rather, effective communication comprises a set of skills that need to be learned and continually reinforced through practice. When critical information about their condition or care does not get to the right person at the right time, patients can suffer the consequences. Potentially harmful communication mishaps include:

- providing care with incomplete or missing information;
- executing poor patient hand-offs with relevant clinical data not clearly communicated;
- failing to share and communicate known information, such as when a team member knows there is a problem but is unable to speak up about it; and
- assuming the right outcome and safety of care.[3]

Story:

A 68-year-old hypertensive patient called our practice expressing concern about feeling weak. Our receptionist did not take down any additional information from the patient. I was busy so, unfortunately, I didn't contact the patient before approaching the patient's doctor about his condition. I reviewed with the doctor the meds that I saw the patient was taking from my look at his charts for the last year. The doctor told me to have the patient stop taking one of the meds and to have him scheduled for a follow-up in a couple of days. I asked whether the patient should be feeling weak after taking the prescription for just a few days, but quickly backed down from this assertion—I felt uncomfortable challenging the doctor's decision as I was new to the practice and he was somewhat old school. So I followed instructions and had our receptionist contact the patient to schedule an appointment for later that week. The next evening, the patient was hospitalized with new onset atrial fibrillation and an irregular heart rhythm.[7]

To facilitate optimal information exchange and problem-solving, team members should:

- use standardized terminology;
- use standardized patterns of communication;
- use concise communication; and
- confirm and cross-check information.[9]

Tools You Can Use

- **AMA Foundation SBAR Handout** (PDF)

Proven Communication Techniques

Presented below are several techniques emphasized by TeamSTEPPS™ and others to support effective communication and conflict resolution, thus building team communcation skills[3, 7]. Insight is provided as to how these techniques might be used in your practice. Links to video materials included here can be used to demonstrate these tools to your staff members to help them become comfortable standardizing their team communication.

SBAR—Situation, Background, Assessment, Recommendation

The **SBAR** technique helps team members accurately share information, ensuring that both the sender and receiver of information place the appropriate focus on what is being communicated. **SBAR** focuses the communication on essential information related to the patient's condition and the communicator's recommendation on needed action.

- **S**ituation: What is going on with the patient?
  Mr. Jones called in saying he feels dizzy and his heart is racing.
- **B**ackground: What is the clinical background or context?
  Mr. Jones is a 72-year-old diabetic who has a history of hypertension.
- **A**ssessment: What do I think the problem is?
  I think the problem is very likely related to Mr. Jones' heart and cardiovascular system.
- **R**ecommendation: What would I do to correct it?
  I think we should have Mr. Jones come in for an appointment immediately to give him a cardiac examination and perform an electrocardiogram.

Empowerment of all staff to speak up is essential to improving patient safety.

CUS—Concerned, **U**ncomfortable, and **S**afety Issue

CUS is shorthand for a three-step process that assists people in stopping the activity when they sense or discover a safety breach. All members of the team need to be familiar with this technique and understand the implications when a fellow team member says:

- I am **C**oncerned.
- I am **U**ncomfortable.
- This is a **S**afety Issue.

Although the *TeamSTEPPS video* illustrates the process in use in the hospital setting, this doctor-nurse encounter could have easily occurred in the ambulatory environment. The nurse speaks up to the doctor using the **CUS** method by expressing that she is concerned, uncomfortable, and that this is safety issue, not a trivial matter. It is important to express all three elements concisely (as demonstrated in the video) because time is often a critical element when dealing with patient safety concerns.

DESC Script—**D**escribe, **E**xpress, **S**uggest, **C**onsequences

The **DESC** Script describes a constructive process for resolving conflicts, where the goal is to reach
consensus:

- **D**escribe the specific situation or behavior and provide concrete evidence or data.
- **E**xpress how the situation makes you feel and what your concerns are.
- **S**uggest other alternatives and seek agreement.
- **C**onsequences should be stated in terms of impact on established team goals or patient safety.

To illustrate this technique, share the *TeamSTEPPS video* with your staff. This demonstration illustrates DESC being used in the physician practice setting where potential errors can be avoided. Here are some key points from the video:

- ***It is important that specific information be collected from all patients***. Because the information provided about Mr. Diaz was incomplete, it was possible that an adverse event could have occurred. The nurse provided the receptionist with a list of questions to ask in the future. This is something that all practices should do.
- The nurse then told the receptionist that is important that she speak up and express her concerns. ***Empowerment of all staff to speak up is essential to improving patient safety.***

Even the briefest of meetings will help you and your staff work together to achieve and sustain a culture of safety…

- Instead of blaming the receptionist, the nurse placed blame on herself for not training the receptionist properly. This helps ***create an environment conducive to learning from mistakes.***
- The nurse was careful to ***frame the issue in the realm of patient safety.*** This resulted in the receptionist recognizing the importance of what happened the day before and immediately "buying in" to the process.

The Video Exercise Attachment is a verbatim copy of the transcript of the TeamSTEPPS material with some suggested teaching points for use as a training tool for your Patient Safety Team.

Group Communication Tools

In addition to strengthening your staff's ability to communicate effectively to support patient care, gathering the Patient Safety Team at defined times is an important strategy. Even the briefest of meetings will help you and your staff work together to achieve and sustain a culture of safety by constantly building awareness of potential problems and concerns and seeking solutions together. The daily huddles and patient safety meetings described below are two important collective communication strategies that you can use to ensure that safety awareness is constantly nurtured as part of your office practice.

Tools You Can Use

As part of its Meeting Tools series, the *Institute for Healthcare Improvement* offers concise directions for using huddles as an alternative to standard one-hour meetings.

- **IHI Huddle Worksheet** (PDF)

Daily Huddles

Lasting from five to seven minutes, daily huddles are a quick, simple, and informal way to become aware of what the staff will face each day, such as staffing shortages and other changes, broken equipment, scheduled patients that may need extra assistance or time, and last-minute scheduling changes. Articulating and anticipating upcoming constraints and challenges will help prepare the team to confront them in the best way possible.

Daily huddles are promoted by the *Institute for Healthcare Improvement* and *The American Academy of Family Physicians' TransforMED* initiative among others.[10] *TransforMED* demonstration sites are finding that huddles are improving efficiency, patient and staff satisfaction, and situation awareness for safer patient care.

Many practices choose to have huddles at the beginning of the day, but it is important that all staff attend. So, if afternoon meetings ensure greater attendance, huddles can be directed at planning for the following day. **Attachment 1B, Daily Huddle Agenda Example** can be used by your practice as a template for these informal meetings:

1. Check provider and staff schedules. Does anyone need to leave early or take a break for a phone call or meeting? Are there any staff shortages due to illness, vacations, family emergencies, etc.?
2. Are there any issues with broken equipment or unavailable labs?
3. Are lab results, test results and notes from other physicians ready in patient's charts? What will be the most efficient path to patient flow?
4. Check for patients on schedule that may require more time and assistance due to age, disability, personality, or language barriers. Any suggestions on how to deal with this?
5. Check for back-to-back lengthy appointments such as physicals. How can they be worked around to prevent backlog?
6. Check for openings that can be filled or chronic no-shows that can be anticipated. Are there any special instructions for the scheduler?
7. Any other expected issues that could cause chaos in the workflow?[11]

Patient Safety Meetings

Your Patient Safety Team should hold regular meetings in which patient safety is the sole or major agenda item. Meetings should occur at least once a month outside of patient visiting hours. Standing agenda items should include:

- updates on patient safety projects or action plans;
- staff reports on any near misses;
- adverse events and responses; and
- consequences of those events.

Below is a sample Patient Safety Meeting agenda that includes a suggested presenter and an approximate time needed for each agenda item:

1. Statement of mission and overview of importance of teamwork and system thinking in organizational operations. (One minute: Chair)
2. Overview of any outstanding issues from previous weeks' meetings or daily huddles and how these issues have been addressed. (Two minutes: Chair)
3. New persisting workflow issues that have come up since the last meeting and have not been appropriately addressed in daily huddles. (Two-three minutes: Everyone)
4. New authority gradient or other staff-to-staff issues that have been persisting over the past week. (Two-three minutes: Everyone)

5. Any issues with staff-patient interactions and relations. (Two-three minutes: Everyone)
6. Outstanding patient-safety issues for front-of-house administrative staff. (One-two minutes: Front-of-house staff)
7. Outstanding patient safety issues for Nurse's Aides, LPNs, Lab Techs or RNs. (One-two minutes: Nursing and Tech Staff)
8. Outstanding patient safety issues for Business or other Administrative Staff. (One-two minutes: Business and other Administrative Staff)
9. Outstanding patient safety issues for PAs, NPs, MDs, or DOs. (One-two minutes: Clinicians)
10. Wrap-up and any announcements for the following week. (One minute: Chair)

More information on the content of safety meetings is addressed in Module Two, ***Assessing Where You Stand***.

Story:

A 9-month-old child was seen by her pediatrician for a fever and decreased appetite. She was found to have otitis media and was prescribed amoxicillin. The doctor gave the first dose to the infant in the office, demonstrating step-by-step how to deliver the medicine via syringe. At home, the father drew up the next dose without removing the syringe cap. He gave the dose to the child, who suddenly had difficulty breathing and collapsed. When emergency medical services (EMS) arrived, the child was intubated and transported to a children's hospital. Despite intubation, she could not be adequately ventilated. The tube was removed and intubation was tried again, still without improvement. The infant was then taken to the operating room to undergo bronchoscopy. The syringe cap was found lodged in her trachea. Evaluation in the subsequent days revealed brain death. The infant was removed from life support and died shortly thereafter.[12]

Step Three—Involve the Patient as Part of the Team

Why Involving the Patient is Important

When patients are informed and involved in all aspects of their own care, they help ensure a safer care experience for themselves. At the most basic level, patients and their families must be actively encouraged to question any procedure or process that does not look or seem right to them. But there are compelling reasons that patients and their families (as well as other caregivers who may not be related to the patient) should be actively involved at multiple levels of the care process:

- Patients and their families help organizations develop new perspectives, as patients experience gaps and fragmentation in systems firsthand.
- Patients and their families keep health care professionals and organizations honest and grounded in reality.
- Because they are recipients of care, patients, by conveying their opinions and feelings, can inspire and energize staff to commit to change.
- Input from patients and families can help improve quality and safety as well as staff satisfaction.[5]

When patients are informed and involved in all aspects of their own care, they help ensure a safer care experience for themselves.

Because they are recipients of care, patients, by conveying their opinions and feelings, can inspire and energize staff to commit to change.

Patients should be involved in decision-making at every step of their care. To enable them to participate fully and effectively, physician practices need to educate their patients on how best to participate in decision-making, how to get information about their condition(s), and how each health care professional will contribute to their safety during each episode of care. (**Attachment 1E, Pathways Suggested Resources—Patient Information**), which contains a select list of resources that your practice may refer patients to or use as part of your practice Web site.)

Potential Barriers Between Patients and Providers

Research literature and everyday practice tell us that poor or inadequate communication between patients and families (as well as other caregivers who may not be related to the patient) can lead to poor quality care and adverse incidents. Thus, clear communication between Patient Safety Team members and their patients is paramount in providing safe patient care. At the most fundamental levels, a patient's communications responsibility centers on:

- clear communications with their physician;
- understanding instructions that are given to them; and
- following through on those instructions.

Earlier in this section, you learned that to facilitate optimal information exchange and problem-solving in the office practice setting, practice staff should:

- use standardized terminology;
- use standardized patterns of communication;
- use concise communication; and
- confirm and cross-check information.[9]

Keep these points in mind as you consider the quality of communications between you and arguably the most important member of the Patient Safety Team: the patient. Bear in mind that patients are:

- generally unfamilar with terminolgy;
- may not use standardized patterns of communication;
- unlikely to communicate concisely; and
- often reluctant to confirm and cross-check information you have given them.

As a caring team member intent on enhancing patient safety, it is up to you to:

- learn to identify barriers that impede effective communication between patient and care giver and care giver and patient;
- identify and remedy deficits within your practice when it comes to communicating with patients, and
- take action to remedy patients' informational deficits where you can and develop techniques to accommodate patient issues that cannot be remedied.

In Module Two, ***Assessing Where You Stand***, you will be introduced to a literacy assessment tool that will help you determine how your practice "measures up" in the area of communicating with patients.

Communication and Health Literacy

Health literacy is one of the major barriers to effective communication between patients and health care professionals. Miscommunication occurs when the level of the patient's health literacy does not match the level of the instructions given by a member of your practice staff. Health literacy issues can be caused by several factors:

- education level,
- age, and
- language comprehension.

> ***Did You Know?***
> ***PPPSA respondents report that 60% of practices don't have patient information available in other languages, and 41% haven't fully trained their staff on health literacy issues.***

Any of these factors, or a combination of them, can cause patients not to understand a staff member's instructions and not to speak up when they do not fully understand. Such miscommunication, unrectified, can be a serious patient safety issue.

Fully grasping potential health literacy issues in your patient base is essential to improving patient safety. There are tools to assist your team members in recognizing those at risk. In Module Two, ***Assessing Where You Stand***, you will be introduced to a tool designed to uncover and identify some of these issues. Using this tool, your Patient Safety Team will be able to identify opportunities for measurement and improvement over time.

There are also strategies that the Patient Safety Team(s) (and any members of your practice who are not assigned to a team) can apply to enhance one-on-one patient communication to assure that it is as clear and

Fully grasping potential health literacy issues in your patient base is essential to improving patient safety.

effective as possible. One method is based on teaching the patient to ask the right questions. Developed by the *Partnership for Clear Health Communication* at the *National Patient Safety Foundation*) the ***Ask Me 3™*** program (***askme3.org***)[13] can be used to coach patients into asking these three simple questions during their encounters with physicians, nurses, and pharmacists:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

(Used with permission; *Partnership for Clear Health Communication*)

In Module Three, ***Creating Medication Safety***, you will find a good example from the field of how health literacy concerns can manifest themselves and contribute to unsafe medication use. ***Creating Medication Safety*** also provides strategies to manage such failures in the process of care.

Five Steps to Improving Interpersonal Communication With Patients

1. ***Slow down. Communication can be improved by speaking slowly and by spending just a small amount of additional time with each patient. This will help foster a patient-centered approach to the clinician-patient interaction.***
2. ***Use plain, non-medical language. Explain things to patients like you would explain them to your grandmother.***
3. ***Show or draw pictures. Visual images can improve the patient's recall of ideas.***
4. ***Limit the amount of information provided—and repeat it. Information is best remembered when it is given in small pieces that are pertinent to the tasks at hand. Repetition further enhances recall.***
5. ***Use the "teach-back" technique. Confirm that patients understand by asking them to repeat back your instructions.***[14]

Cultural Considerations

It is important to understand the cultural make-up of your practice base and to incorporate strategies based on that understanding into any patient training you undertake. Building awareness of cultural issues that are barriers to communication with patients can be accomplished in conjunction with your health literacy awareness efforts. Cultural beliefs influence how patients:

- perceive their health;
- seek health care;
- interact with health professionals; and
- comply with prescribed treatments.

Though it is beyond the scope of this module to fully cover the concept of cultural beliefs, there are several cultural competency resources available to assist you in addressing that issue at. See the "Tools You Can Use" box. ***http://nnlm.gov/mcr/resources/community/competency.html#A4***

Available Patient Communication Tools

To communicate effectively with patients and their families, members of a physician practice require an arsenal of different skills and strategies, including cultural respect and knowledge. There are a number of tools that can help staff members assist patients in:

- communicating their concerns
- learning about their medical conditions, and
- improving their understanding of the clinical process and their role in it.

Tools You Can Use

Consumer information

- ***MedlinePlus*** (Web site)
- ***National Library of Medicine***
- ***Questions are the Answer*** (Web site) Agency for Healthcare Research and Quality

Cultural, literacy and language tools

- ***Ask Me 3*** (Web site)
- ***Addressing Language Barriers between Physician and Patient: What are the Optimal Strategies?*** (video)
- ***Healthtranslations*** (Web site)

The documents and tools listed on this page in *Tools You Can Use* can serve as initial training tools for the Patient Safety Team and provide a source of readings and question guides on a variety of care situations for new and established patients. These tools also suggest questions that patients can be asked to help them be safe. Practices can help their patients become more involved in their own care by providing them with these checklists and other information. Visit the *Questions are the Answer* link in the tool box to view examples of no-cost tools that are available for use in your practice.

Practices can obtain many benefits from involving patients and their families in a more expanded role as team members.

Patient-Family Advisory Councils

Practices can obtain many benefits from involving patients and their families in a more expanded role as team members. Consider involving patients and their families in setting policies, designing programs, and establishing improvement priorities for your practice. One method for doing this is establishing patient and family advisory councils (typically 12-30 people) who meet regularly to propose and develop programs, policies, and services.

An example of a successful patient and family advisory committee is the *Dana-Farber Patient Family Advisory Council (PFAC)*, which was designed to provide input, develop improvement programs, and serve as a resource of patient and family opinion. Among PFAC activities that enhanced communications and shared a commitment to safety among patients and staff members were member participation on clinical quality and safety committees and the creation of a patient-staff newsletter.[5]

Tools You Can Use

Dana Farber resource: ***How to Develop a Community-Based Patient Advisory Council***

Other methods for involving patients and their families in your practice include holding periodic focus groups. For instance, patients with the same chronic illness might meet with members of your Patient Safety Team to discuss ways that patients and families can participate in designing care and self-care that best addresses their needs. Another example of a partnership-oriented program was developed as a part of the *AHRQ Partnerships in Improving Patient Safety (PIPS)* program where a team put in place a patient safety council and empowered them to develop a medication list program for their community. The toolkit for the program is available online at ***http://www.ahrq.gov/qual/pips/***

Summary of Key Points

As a first step toward ensuring patient safety in your physician practice, you have learned how to build a high-performing Patient Safety Team and are familiar with the key skills and characteristics needed by effective Team Leaders and Patient Safety Officers. You have been introduced to techniques for improving teamwork and commuications among the members of your physician practice and with the patients you serve. Using the techniques and tools described in Module One, you now know:

- that teamwork and communication are a primary patient safety strategy;
- the characteristics of good teamwork are essential for safe practice;
- how to facilitate effective communication in your practice;
- the value of making dedicated time to talk in day-to-day practice to recognize opportunities to improve safety; and
- how to support and engage patients and their families to support safe care.

Attachments

IA. PPPSA Patient Safety Officer Position Description

Use this language to discuss the role of the Patient Safety Officer with the individual(s) on your staff who will lead the patient safety work in your organization. The language can be used in performance reviews to help articulate what is expected of the person assigned this important job.

Position Summary:

The designated patient safety officer will have primary oversight of and responsibility for the practice's patient safety program to support the reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This individual will be an effective team player who is granted the appropriate authority to ensure that all aspects of the practice's patient safety program are implemented. This person will support team members toward process improvements through their own mastery of patient safety concepts and practices, and through access to outside expertise as needed.

Essential Functions:

- Oversee the creation, review, and refinement of the scope of the Patient Safety Program within the practice on an annual basis.
- Conduct an annual assessment based on the Physician Practice Patient Safety Assessment (PPPSA). This will include assessments in areas such as teamwork, communication, and medication reconciliation.
- Disseminate to all staff patient safety educational materials that relate to the ambulatory setting, including materials from the three PPPSA modules.
- Coordinate the activities of the Patient Safety Committee. This committee is composed of clinician(s), manager(s), and frontline staff and meets at least monthly to review patient safety trending data, particular challenges and opportunities for improvement, and teamwork effectiveness.
- Support and encourage error reporting in the practice through a non-punitive error reporting system.
- Oversee the management and use of medical error information, including rapid communication of patient safety lapses and adverse events to the practice team.
- Investigate patient safety issues within the practice. Participate in root cause analysis of internal error reports.
- Recommend and facilitate change within the practice to improve patient safety based on identified risks.
- Collaborate in the development of policies and procedures effecting safety.
- Create patient safety monitoring and reporting capability to ensure appropriate hand-offs, as well as to take advantage of cross-training in relevant patient safety practices for those practices affiliated with local hospitals and other health care organizations.

Qualifications:

- Experience with the organization's quality improvement and patient safety programs.
- Knowledge of risk management principles and issues regarding patient safety.
- Ability to see the big picture and understand the interrelatedness of health care.
- Superior interpersonal skills, including a non-judgmental and non-confrontational communication style.
- Demonstrated ability in building effective partnerships and coalitions.
- Demonstrated track record of integrity, including the building of trust among colleagues.
- Demonstrated understanding in data collection, analysis and reporting, with access to statistical and analytic expertise.
- Strong leadership qualities.
- Familiarity with local culture and change management.

1B. Daily Huddle Agenda Example

Huddles are a quick, simple, and informal way to become aware of what the staff will face on a particular day. Using this agenda, structure your huddles to give your staff the best possible opportunities to articulate and anticipate the challenges of the day. This will help prepare the team to do their best and work within the day's constraints and challenges. Staff should use the space under each agenda item to make notes

I. **Check provider and staff schedules. Does anyone need to leave early or take a break for a phone call or meeting? Are there any staff shortages due to illness, vacations, family emergencies, etc.?**

II. **Are there any issues with broken equipment or unavailable labs?**

III. **Are lab results, test results and notes from other physicians ready in patient's charts? What will be the most efficient path to patient flow?**

IV. **Check for patients on schedule that may require more time and assistance due to age, disability, personality, or language barriers. Any suggestions on how to deal with this?**

V. **Check for back-to-back lengthy appointments such as physicals. How can they be worked around to prevent backlog?**

VI. **Check for openings that can be filled or chronic no-shows that can be anticipated. Are there any special instructions for the scheduler?**

VII. **Any other expected issues that could cause chaos in the workflow?**

Adapted from: Stewart EE, Johnson BC. Huddles: improve office efficiency in mere minutes," Fam Pract Manage. June2007;Volumne:27-29.
Available at: ***http://www.aafp.org/fpm/20070600/27hudd.pdf.***

IC. Weekly Safety Meeting Agenda Example

It is recommended that a physician practice hold a regular meeting devoted to patient safety improvements in their office and to discuss issues at large.

I. Statement of mission and overview of importance of teamwork and system thinking in organizational operations (1 minute-Chair).

II. Overview of any outstanding issues from previous weeks' meetings or daily huddles and how these issues have been addressed (2 minutes-Chair).

III. New persisting workflow issues that have come up since the last meeting and have not been appropriately addressed in daily huddles (2-3 minutes-Everyone).

IV. New authority gradient or other staff-to-staff issues that have been persisting over the past week (2-3 minutes-Everyone).

V. Any issues with staff-patient interactions and relations (2-3 minutes-Everyone).

VI. Outstanding patient-safety issues for front-of-house administrative staff (1-2 minutes-Front-of-house staff).

VII. Outstanding patient safety issues for Nurse's Aides, LPNs, Lab Techs or RNs (1-2 minutes-Nursing and Tech Staff.)

VIII. Outstanding patient safety issues for Business or other Administrative Staff (1-2 minutes Business and other Administrative Staff).

IX. Outstanding patient safety issues for PAs, NPs, MDs, or DOs (1-2 minutes-Clinicians).

X. Wrap-up and any announcements for the following week (1 minute-Chair).

ID. Team Performance Observation Tool

Date:_____
Unit:_____
Team:_____
Shift:_____

Rating Scale (circle one) *Please comment if 1 or 2*

1 = Very Poor
2 = Poor
3 = Acceptable
4 = Good
5 = Excellent

1. Team Structure	**Rating**
a. Assembles a team	
b. Establishes a leader	
c. Identifies team goals and vision	
d. Assigns roles and responsibilities	
e. Holds team members accountable	
f. Actively shares information among team members	
Comments:	
Overall Rating – Team Structure	
2. Leadership	**Rating**
a. Utilizes resources efficiently to maximize team performance	
b. Balances workload within the team	
c. Delegates tasks or assignments, as appropriate	
d. Conducts brief, huddles, and debriefs	
e. Empowers team members to speak freely and ask questions	
Comments:	
Overall Rating – Leadership	
3. Situation Monitoring	**Rating**
a. Includes patient/family in communication	
b. Cross monitors fellow team members	
c. Applies the STEP process when monitoring the situation	
d. Fosters communication to ensure team members have a shared mental model	
Comments:	
Overall Rating – Situation Monitoring	

4. Mutual Support	**Rating**
a. Provides task-related support	
b. Provides timely and constructive feedback to team members	
c. Effectively advocates for the patient	
d. Uses the Two-Challenge rule, CUS, and DESC script to resolve conflict	
e. Collaborates with team members	
Comments:	
Overall Rating – Mutual Support	
5. Communication	**Rating**
a. Coaching feedback routinely provided to team members, when appropriate	
b. Provides brief, clear, specific, and timely information to team members	
c. Seeks information from all available sources	
d. Verifies information that is communicated	
e. Uses SBAR, call-outs, check-backs, and handoff techniques to communicate effectively	
Comments:	
Overall Rating – Communication	
TEAM PERFORMANCE RATING	

IE. Pathways Suggested Resources—Patient Information

To enable patients to participate fully and effectively as partners in their safe care, physician practices should assist them in being informed. In this way they can actively to participate in decision-making, find credible information about their condition(s) and tests, and work with their health care team to contribute to their safety during each episode of care. The following resources can help both your practice staff and your patients find specific resources to help provide the safest care possible.

Agency for Healthcare Research and Quality (AHRQ).

- Consumer information area
  http://www.ahrq.gov/consumer/
- Questions Are the Answer.
  http://www.ahrq.gov/questionsaretheanswer/

American Academy of Family Physicians.
http://familydoctor.org/

American Association for Clinical Chemistry, Lab Tests Online.
http://www.labtestsonline.org/

Food and Drug Administration, Consumer Health Information web site.
http://www.fda.gov/consumer/

Joint Commission International Center for Patient Safety, Patients and Families web site.
http://www.jcipatientsafety.org/14593/

Institute for Safe Medication Practices, ConsumerMedSafety.org.
http://www.consumermedsafety.org

Missouri Hospital Association, Healthtranslations.
http://www.healthtranslations.com

National Library of Medicine, MedlinePlus.
http://www.medlineplus.org

Nemours Foundation's Center for Children's Health Media, KidsHealth.org.
http://www.kidshealth.org

New York Online Access to Health (in English and Spanish).
http://www.noah-health.org/

Partnership for Clear Health Communication at the National Patient Safety Foundation. Ask Me 3 : ***http://www.npsf.org/askme3***

US Department of Health and Human Services, Healthfinder.gov. ***www.healthfinder.gov***

Additional Resources

Suggested additional resources

In addition to the tools mentioned throughout this module and the references below, the author team suggests the following readings that may be of help in designing your own office staff programs to improve team development and communication skills.

Step One – Buiid an Effective Team

The Role of Teamwork in the Professional Education of Physicians: Current Status and Assessment Recommendations; David P. Baker et al, *Joint Commission Journal on Quality and Patient Safety*, April 2005, Volume 31, Number 4.

Report:
Bodenheimer, T. "Building Teams in Primary Care: Lessons Learned." July 2007. California Health-Care Foundation. Oakland, CA:; Free Full Text (PDF):
http://www.chcf.org/documents/chronicdisease/BuildingTeamsInPrimaryCareLessons.pdf

Report:
Vance, J.E. "A Guide to Patient Safety in the Medical Practice." 2008. Chicago: American Medical Association;

Web Site:
Patient Safety Officer Society
http://www.psos.org/

Step Two – Enhance Team Communication

Article:
Rizer, M.K., and D. Knutson. 2007. "The Makings of a Good Meeting." Family Practice Management 14(10):35-37. Free full text (links to medscape version):
http://www.medscape.com/viewarticle/568078_1 or ***http://www.aafp.org/fpm/20071100/35them.html***

Book:
Patterson, K., J. Grenn, R. McMillan, A. Switzler, abd S. R. Covey. 2002. *Crucial Conversations: Tools for Talking When Stakes are High*. McGraw-Hill.

Book:
Woods, M.S. 2007. *In a Blink: Awareness, Assessment, and Adapting to Patient Communication Needs*, Joint Commission Resources.

Additional Resources

Step Three – Involve the Patient as Part of the Team

Online Training:
"Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency." Health Resources and Services Administration, U.S. Department of Health and Human Services.

Free full text: ***http://www.hrsa.gov/healthliteracy/training.htm***

This web site provides a free set of tools and personlized training to help clinicans and office staff members get up to speed on core concepts involving communications improvement.

Report:
"Tools to Address Disparities in Health: Communications Resources to Close the Gap." May 2006 America's Health Insurance Plans (AHIP).

http://www.ahip.org/content/fileviewer.aspx?docid=10760&linkid=143031

Video clip:
"Patients with Reading Problems." August 2003. FDA Patient Safety News.

http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=18#7

Acknowledgements

Much of the material in this module comes from two primary sources: 1)TeamSTEPPS™, developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense, and 2) the publication, *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. We would like to thank James B. Battles, Ph.D., senior service fellow for patient safety, Center for Quality Management and Improvement, AHRQ for permission to reference so many of the TeamSTEPPS™ tools. We are also grateful to Michael Leonard, M.D., Allen Frankel, M.D., and Terri Simmonds for their fine publication, *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. Dr. Leonard is physician leader of patient safety at Kaiser Permanente in Colorado Springs, Colorado. Dr. Frankel is director of patient safety at Partners HealthCare in Boston. Ms. Simmonds is a director at the Institute for Healthcare Improvement in Boston and works as well for the Massachusetts Coalition for the Prevention of Medical Errors.

The Pathways for Patient Safety *team would like to thank the following individuals whose c ontributions of time and energy were crucial to the development of the Pathways modules:*

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About HRET

Founded in 1944, the Health Research and Educational Trust is a private, not-for-profit organization involved in research, education and demonstration programs addressing health management and policy issues. HRET, an American Hospital Association affiliate, collaborates with health care, government, academic, business and community organizations across the United States to conduct research and disseminate findings that shape the future of health care. Visit HRET's web site at www.hret.org.

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About ISMP

The Institute for Safe Medication Practices is a nonprofit organization recognized worldwide as the premier education resource for understanding and preventing medication errors. ISMP represents more than 30 years of experience in helping keep patients safe, and continues to lead efforts to improve the medication use process. Working with health care practitioners and institutions, regulatory and accrediting agencies, consumers, professional organizations, the pharmaceutical industry, and others, ISMP also provides timely, accurate medication safety information to the healthcare community, policy makers, and the general public. For more information on ISMP, or to read more about its other self-assessment tools for hospitals and community pharmacies, visit the Institute's web site at www.ismp.org.

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About MGMA

MGMA is the premier membership association for professional administrators and leaders of medical group practices. Since 1926, MGMA has delivered networking, professional education and resources, and political advocacy for medical practice management. Today, MGMA's 21,500 members lead 13,500 organizations nationwide in which some 270,000 physicians provide as much as 40 percent of the health care services delivered in the United States. MGMA's mission is to continually improve the performance of medical group practice professionals and the organizations they represent. MGMA promotes the group practice model as the optimal framework for health care delivery, assisting group practices in providing efficient, safe, patient-focused and affordable care. MGMA is headquartered in Englewood, Colo., and maintains a government affairs office in Washington, D.C.