Transitions in Care and Authority Gradients

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Purpose

- Transfer of clinical information
- Transfer of responsibility and authority
- Overall situational awareness of clinical setting (volume, resources, staffing etc.)
- Forum for review of decision making?
- Error prevention
Turnover Content

Expectations for future

Information

Authority*

Responsibility

Contingency plans

Attitudes towards changes in plan

Confidence in current understanding

Recent history of attempts at process control
Factors Influencing Transition:
- Hospital Factors
- ED Factors
- Credibility
- Competency
- Perceptions/Roles
- Limited co-presence

Co-Orientiation

Co-Construction
- Shared Sensemaking
- Interaction

Factors Influencing Transition:
- Limited co-presence

??Match??
- Yes
- No

Negotiation

Sign-over proceeds on this patient

On to next patient

Resignation
(sign-over stopped for this patient)
Transitions: Present Weaknesses

- Limited investigations in Medicine to create minimum standard literature in other industry
- No education for residents
- Not customized to setting or function
  - patient acuity
  - medical specialty
  - short term coverage or patient transfer
- Individual not team activity
- Encounter is variable in terms of:
  - Content
  - Format
  - Structure
  - Personnel
  - Tools used
Potential Threats to High Quality Transitions

- Traditional Patient Presentation
  - Diagnosis oriented
  - Lacks process issues (pending tests or tasks)
  - Transactional not interactive (one way data transfer)
- Interruptions
  - Incomplete or inaccurate data
- Patients labeled
  - Cognitive bias may limit work up
  - High risk groups
    - Psychiatric, substance abuse, frequent fliers
Focus on Enhancement

Patterson (2004), INTERNATIONAL JOURNAL OF QUALITY IN HEALTHCARE. VOL.16, NO 2 p125-132

- Focus on enhancement rather than control of the process
- 21 strategies for improving effectiveness (across all sites, differing domains)
Suggested Strategies for Improvement

• Face to face verbal update w/ interactive questioning
• Topics initiated by incoming as well as outgoing
• Additional update from practitioners other than the one being replaced (nurses, etc)
• Limited interruptions during update
• Limit initiation of operator actions during update
• Include out-going team’s stance toward changes to plans and contingency plans
• Readback to ensure that information was accurately received
Strategies for Improvement (cont.)

• Out-going writes summary before handoff
  – IT support?
• Incoming assesses current status
• Update information in the same order every time
• Incoming activities
  – scans historical data before update
  – reviews automatically captured changes to sensor-derived data before update
• Intermittent monitoring of system status while “on-call”
• Out-going has knowledge of previous shift activities
Strategies for Improvement (cont.)

- Incoming receives paperwork that includes handwritten annotations
- Incoming receives primary access to the up-to-date information
- Unambiguous transfer of responsibility
- Make it clear to others at a glance which personnel are responsible for which duties at a particular time
- Overhear others updates
- Outgoing oversees incomings work following update
- Dealt the transfer of responsibility when concerned about status/stability of process
Authority Gradients
Authority Gradients

• Long recognized in aviation and aerospace
  – 40% junior officers report failure to relay doubts
  – Factor in Challenger disaster

• Introduced to medicine in IOM report
  – “To Err is Human”

• Little in medical literature
Authority Gradient in Medicine

• Medicine steep hierarchy
  – Promotes safety
  – Contributes to error

• Authority gradient
  – Different seniority of team members
  – Higher seniority wield influence

• Conflicts
  – Impede free flow of information
  – Decrease team performance

• High profile cases in medicine
Medical Education

- Focus on knowledge acquisition
- Neglect interpersonal skills
- Lack Patient Safety Curriculum
  - Teamwork training
  - Conflict Resolution
    - Structure
    - Formal communication skills
Clinician Attitudes About Teamwork

- **Operating Room** (Sexton JB et al. BMJ. 320(7237):745-9, 2000 Mar 18.)
  - Only 55% of consultant surgeons rejected steep hierarchies
  - Minority of Anesthesia and Nursing reported high levels of teamwork
  - Discrepant attitudes between physician and nurses about teamwork
  - 73% physicians “High” or “Very High”
  - 33% nurses “High” or “Very High”
Conflict in Roles

- Resident Physician
  - Personal accountability to patient
  - Fear of error
  - Focus on limited patient
- Attending Physician
  - Management of overall system
  - Assuage fear
  - Prioritize effort
Conflict Between Specialties

• Daily occurrence
• Not usually resolved constructively
  – Compromise
  – Avoidance
  – Accommodation
  – Dominance
• Put patient at center not your ego
• Structure for resolving conflict
Conflict Resolution: DESC$^2$ SCRIPT

D - Describe the specific situation or behavior providing concrete data.

E - Express your concerns about the action.

S - Suggest other alternatives and seek agreement.

C - Consequences should be stated in terms of impact on performance goals.

C - Consensus should be obtained with a focus on patient outcome.

Reproduced with permission (DRC). Emergency Team Coordination Course- Student Guide.
Practical Solutions: How to Challenge?

• New Lexicon
  – Increasing threat
    • “How might I recognize this complication”
    • “I’m worried”
    • “Something is wrong”

• Cultural Change
  – Value all team members
  – Expectation to speak up
  – Formal structure for challenge
Organizational Solutions

• Military and Aviation
  – Safety can take precedence over rank
  – Formal Teamwork Training

• Business
  – Emotional Intelligence

• Medicine
  – Change in medical education
  – Organizational/Hospital system change
  – Cultural Change