Effective Communication is The Key to Highly Reliable Rad Onc Teams

Session: Effective Communications for Leading Diverse Clinical Teams
AAPM 2020: Wed July 15th 4:30-5:30 pm EDT

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Seattle, WA
Disclosures

- None
Outline

• Psychological safety & Error
• Communications and Culture
• What promotes positive culture and open communication?
Psychological safety & Error in the Healthcare Context

• Research on error in healthcare teams in 1990’s.
• Her hypothesis: negative relationship between teamwork and error.
• Instead .... they found the opposite.
Table 2  Units ranked by quantitative data (detected error rates) and juxtaposed with independent qualitative ranking from table 1

<table>
<thead>
<tr>
<th>Memorial 1</th>
<th>University 1</th>
<th>University 3</th>
<th>Memorial 2</th>
<th>Memorial 5</th>
<th>University 2</th>
<th>Memorial 4</th>
<th>Memorial 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detected error rates*&lt;br&gt;High</td>
<td>23.68</td>
<td>13.19</td>
<td>11.02</td>
<td>10.31</td>
<td>9.37</td>
<td>8.6</td>
<td>2.34</td>
</tr>
<tr>
<td>Interviewer’s overall rating on openness&lt;br&gt;High</td>
<td>17.23</td>
<td>Med/High</td>
<td>Med/High</td>
<td>Med/Low</td>
<td>Low</td>
<td>Medium</td>
<td>Very Low</td>
</tr>
</tbody>
</table>

*Detected error rates are: preventable adverse drug events + potential adverse drug events; mean 11.97 interceptions per 1000 patient days; SD 6.33. Interceptions: mean 3.30 interceptions per 1000 patient days; SD 2.03. Non-preventable ADEs: mean 7.03 interceptions per 1000 patient days; SD 4.75.
Psychological safety & Error in the Healthcare Context

“Good teams don’t make more mistakes they just report more.”

➢ Culture
➢ Highly local

Amy C. Edmundson, PhD
Outline

• Psychological safety & Error
• Communications and Culture
• **What promotes positive culture and open communication?**
Incident Learning

Aviation

Nuclear power

Manufacturing

Healthcare
Reports per month

Months elapsed

In this unit, we discuss ways to prevent errors from happening again.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66%</td>
<td>81%*</td>
<td>86%*</td>
</tr>
</tbody>
</table>

* * p< 0.01

After we make changes to improve patient safety we evaluate their effectiveness.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46%</td>
<td>66%*</td>
<td>64%*</td>
</tr>
</tbody>
</table>

I have confidence that my error/near miss reports get used to improve our system.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53%</td>
<td>74%*</td>
<td>76%*</td>
</tr>
</tbody>
</table>

Basic Original Report

Durable Improvement in Patient Safety Culture Over 5 Years With Use of High-volume Incident Learning System

Pehr E. Hartvigson MD a,b, *, Aaron S. Kusano MD, SM c, Matthew J. Nyflot PhD a, Loucille Jordan RT(T) a, Tru-Khang Dinh MD a, Patricia A. Sponseller CMD a, Ashlee Schindler RT(T) a, Gabrielle M. Kane MBBS, EdD a, Eric C. Ford PhD a

aDepartment of Radiation Oncology, University of Washington School of Medicine, Seattle, Washington; bDepartment of Radiation Medicine, Oregon Health and Science University, Portland, Oregon; and cAnchorage & Valley Radiation Therapy Center, Anchorage, Alaska
Open communication and punitive concerns

p <0.001
Conclusions

• Key to achieving high-reliability: psychological safety
• One mechanism to promote this
• Leadership. Transactive memory.