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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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.**

Amy C. Edmundson, PhD

Table 2 Units ranked by quantitative data (detected error rates) and juxtaposed with independent qualitative ranking from table 1

	Memorial 1	University 1	University 3	Memorial 2	Memorial 5	University 2	Memorial 4	Memorial 3
Detected error rates*	23.68	17.23	13.19	11.02	10.31	9.37	8.6	2.34
Interviewer's overall rating on openness	High	High	Med/High	Med/High	Med/Low	Low	Medium	Very Low

*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.

Edmondsun, A. Qual Saf Health Care, 13, ii3-ii9 (2004)
doi: 10.1136/qshc.2003.009597

Psychological safety & Error in the Healthcare Context

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

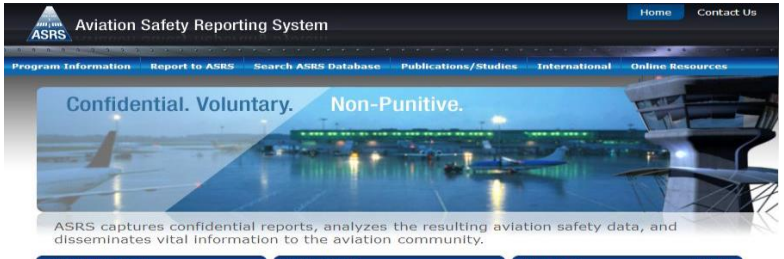
- **Culture**
- **Highly local**

Amy C. Edmundson, PhD

Outline

- Psychological safety & Error
- Communications and Culture
- **What promotes positive culture and open communication?**

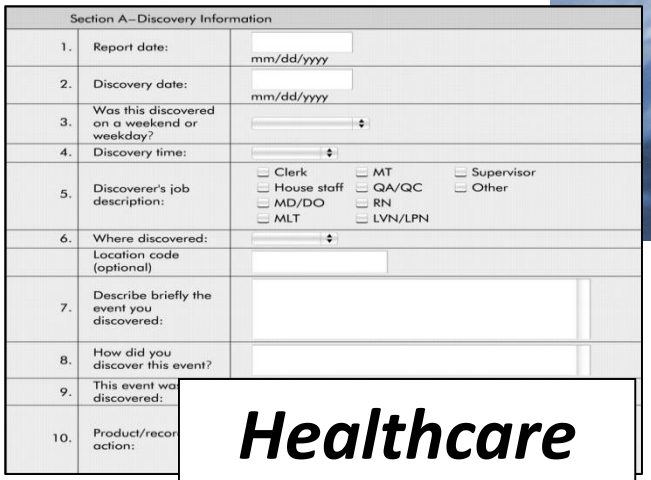
Incident Learning



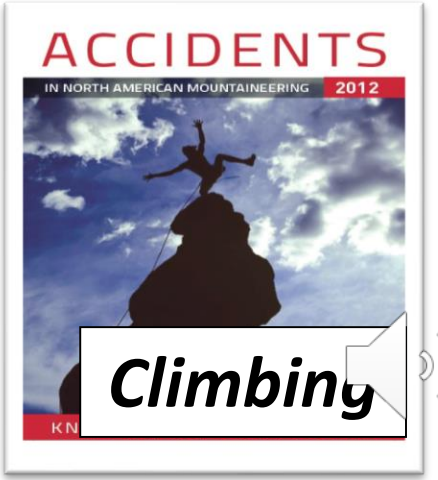
Aviation

Nuclear power

Manufacturing

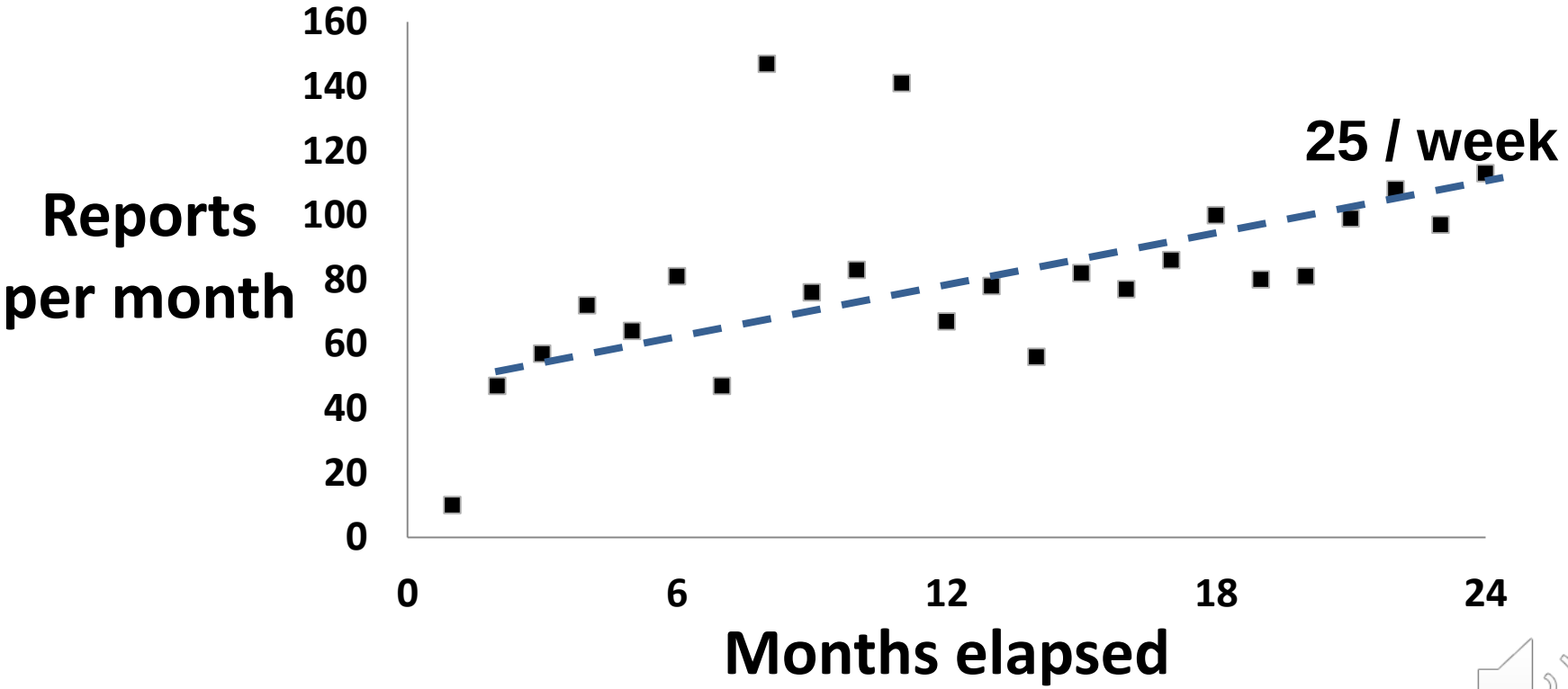


Healthcare



Climbing

Reporting Volume



Nyflot, M. et al. Prac Radiat Oncol, 5, e409-416 (2015)

Safety Culture

	2012	*2013*	*2014*
In this unit, we discuss ways to prevent errors from happening again	66%	81%*	86%*
After we make changes to improve patient safety we evaluate their effectiveness.	46%	66%*	64%*
I have confidence that my error/near miss reports get used to improve our system.	53%	74%*	76%*

* $p < 0.01$

Kusano, A.. et al. Prac Radiat Oncol, 5(3), e229-237 (2015)

Practical Radiation Oncology (2019) 9, e407-e416

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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]

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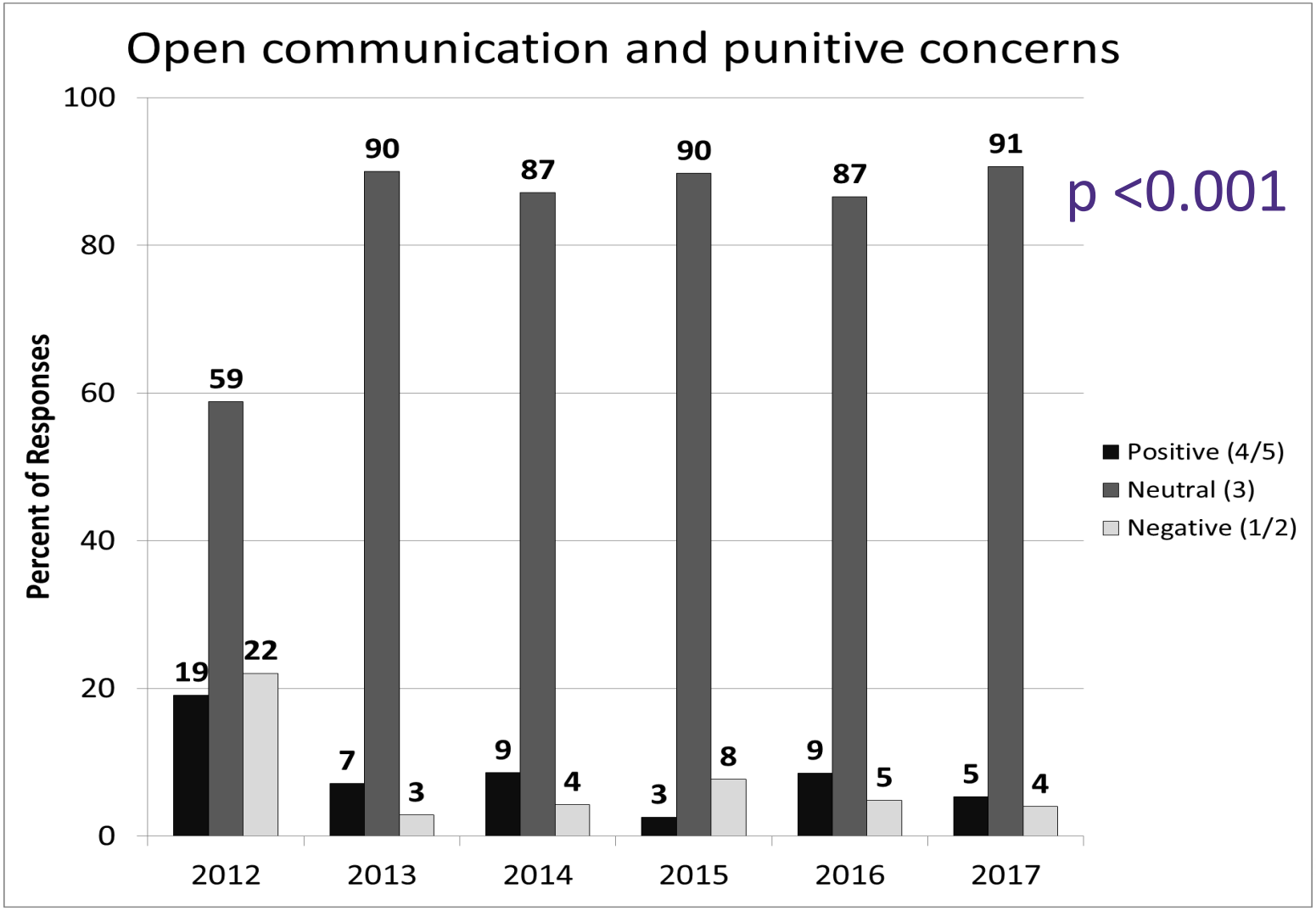
Open communication and punitive concerns
Percent of Responses
100
80
60
40
20
0
2012
2013
2014
2015
2016
2017
19
59
22
7
90
3
9
87
4
3
90
8
9
87
5
5
91
4
p <0.001
Positive (4/5)
Neutral (3)
Negative (1/2)

Conclusions

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