Introduction

Hospitals move to provide support for clinicians after a bad patient outcome.

“Really our role is to provide peer support, to help people who need the support, who are going through a bad event, understand that their experience is normal, provide a listening ear so that they feel emotionally supported during this bad event, and optimally can continue with their professional duties.”

And…a malpractice defense attorney and a cancer surgeon debate the pros and cons of using video in the operating room to improve performance.

These stories… and more, on "Resource", a news program with the latest issues in patient safety and health care risk management. Now available online, at RMF.HARVARD.EDU. "Resource" is produced six times a year by CRICO/RMF in the Harvard medical system. Information about receiving automatic podcasts and risk management CME is at the end of this program.
Helping Clinicians Cope after Adverse Events

Hospitals are increasingly aware of the harm done to health care providers who are exposed to the trauma of serious adverse events and the normal course of pain and suffering they may see routinely. Research indicates that doctors and nurses experience the same physical and emotional reactions as other professionals who witness these human traumas. Sleeplessness, rumination, intrusive thoughts, changes in appetite, difficulty with relationships, absenteeism, and substance abuse are among the symptoms.

None of that is good for future patient care. A recent study by a research team at the University of Missouri School of Medicine in Columbia showed a predictable course for clinicians after an event.

“We almost saw it as a responsibility to figure out more about what’s going on with these clinicians.”

Susan Scott is Patient Safety Coordinator for the University of Missouri health system. She led a qualitative study of 31 so-called “second victims,” doctors and nurses who were involved in a serious adverse event or terrible clinical outcome. The study found a common trajectory.

“We identified six specific stages that involve the recovery process for second victims and we called it our trajectory of recovery. The first stage is chaos and accident response, second intrusive reflections, third is restoring persona integrity followed by enduring the investigation phase, five is obtaining emotional first aid, and six is unique, it’s called moving on, but the second victim can take one of three paths. They could drop out, they could survive or they could thrive.”

Scott and her colleagues developed a program that addressed these needs, and operationalized clinician support. The program is called “For You.” Dr. Kristin Hahn-Cover is a University of Missouri internist and the medical director for the office that oversees patient safety, risk management, and quality control, including the “For You” caregiver support program.

“The program that we established was a peer support network. We initially trained peer supporters from areas that we thought were vulnerable to having bad patient events. So areas with high acuity, pediatric areas, for example, because we know that people who take care of children, babies and have bad things happen to those children and babies, whether related to a medical error or not, are more likely to suffer personally from those events.”
The peer supporters are trained to look for risky situations, and outward signs that an individual clinician may need support. These may include responding to a high-profile event, or a fatality involving a clinician who had a long-term relationship with the patient, or a personal association, which can be as simple as sharing a first name. Dr. Hahn-Cover says the intervention can be as simple as having a cup of coffee with the provider. But if longer-term professional counseling is indicated, the chaplaincy, Employee Assistance Program, or psychiatric services are oriented to the program and can be activated on a fast-track basis. During off-hours, a pager is used for a centralized peer support resource.

“Really our role is to provide peer support, to help people who need the support, who are going through a bad event, understand that their experience is normal, provide a listening ear so that they feel emotionally supported during this bad event, and optimally can continue with their professional duties. Our primary goal is to have people be able to continue doing the hard jobs in healthcare that they do with a sense of satisfaction and not too much personal emotional toll. Our goal is to facilitate that, so sometimes the contact happens by phone. Sometimes it happens face to face. Sometimes it happens on the spot. Sometimes it happens the next day, just depending on the needs of the person who calls.”

Dr. Hahn-Cover shares some recent examples.

“We had one person who contacted the team because he was going through a peer review inquiry that was really devastating to him, so we have had some calls for help that we didn’t expect. I think the other thing that’s been interesting to me is certainly in getting physicians to participate in the team, to be peer supporters. Out of the 47 clinicians, we only have six doctors, and we certainly have many more doctors than that in our system. So we have not had robust response in terms of physicians wanting to be peer supporters. That being said, responses that I’ve made, one to an anesthesiologist, one to an intensivist, one to a surgeon, all who would be reluctant to talk about the psychosocial needs, were incredibly grateful to have someone contact them just to say, ‘I’m concerned about you as a person and how you’re responding to this. I’m available to support you as you need it.’”

Susan Scott says that her research has found that if there is no intervention or support, the results can be ultimately debilitating for clinicians.

“What we found was that many times the clinicians suffer in silence for a prolonged period of time and they self-isolate. They will come to work. They will show up, but they’re just not the same person that they were. Many are contemplating career-altering opportunities and, in fact, these people that are really suffering intensely describe any of this event as a career-jolting event and...
how it shook their profession to the core. And many times they will just take extended leaves, extended vacation time, might call in sick, but they’re trying to sort out in their mind by themselves what they need to do as the next step. And many times it could be career limiting and altering, and they might even drop the profession altogether.”

Scott says that these problems can affect patient care.

“In this experience they’re frequently distracted and more focused on historical, what happened in the past, and not on the future moment. So anytime you have a distracted clinician, you could put future patients at risk by not giving them your full attention and by looking at the details for everything because they are almost haunted by the past and they spend a lot of time thinking about the past patient. And so as a result, potentially future patients could be harmed if they didn’t have a respite to try to pull that all together.”

According to Scott, the literature is sparse on this topic, and many hospitals simply don’t have enough awareness of the problem or access to well-established solutions. When she speaks on this issue at meetings, fewer than 20 percent of audiences have heard the term “second victim.” However, Scott believes most hospitals are going to have to provide this kind of support eventually. She says the key is to have administrative support, and a process that doesn’t wait for a clinician to reach out:

“Some of the ‘must-haves’ include needs to be available 24/7. It needs to be in the peer format, I believe, someone who is familiar with being a nurse or being a trauma surgeon or being in the operating room. It needs to be someone within their own professional ranks that can support them. They need to have some policies around how to support staff. So there might be some time away from the unit that just needs to happen so that they can regroup and kind of get back on the horse again and get back into the field of battle. They are going to need to have some time, and time is so short in healthcare. We’re always going to the next patient or doing the next procedure, and so sometimes the wheels of the progress has to stop, and attention needs to be paid to the staff member, to that clinician, and give them what they need instantaneously.”

Scott says many providers have culture-reinforced resistance to getting emotional help, but it is easier to overcome this when clinical leaders share their personal experiences. Scott says that an experience early in her career with the death of a young trauma victim stays with her many years later. She says a lack of support back then, and a prevailing attitude that this shouldn’t affect her made her question her fitness for the profession.

Dr. Hahn-Cover has her own experiences:
“I’ve been in my profession for 10 years, and I can count seven experiences that still live with me, some more than others, the more recent more than the older ones, but all of them, I can call up specific details. I can tell you where I was when I learned about the problem. I can tell you where I was when I talked with my husband or with my boss about the event. They are very vivid, and I think even still, even though I have some distance on each of them, even still lead me to wonder am I good enough to be in this job? And that’s a very typical feeling, typical response. I think the other thing that I have certainly experienced and I have heard—when I have made interventions to other physicians they have said to me—I think we all have the feeling that we see what happened, understand what happened and move on. But it really can take quite some time. For one of the most potent experiences in my career thus far, it probably took me three to four months before this scenario wasn’t on my mind during any quiet moment that my mind had.”

Dr. Hahn-Cover mentions that concerns about confidentiality and liability are reduced by the training of peer supporters. They do not talk about clinical details of the case with an affected provider, but they focus on how the provider is coping with the impact on them.

If a case involves a potential error, the event is still investigated. But she believes the hospital has a duty to support clinicians through that process as well.
Closed Case Abstract:  
Removal of Infant’s Healthy Kidney

The following case abstract is based on closed malpractice claims in the Harvard medical system. Some details have been changed to protect identities.

A five-month-old girl was referred to the emergency department for evaluation of intermittent fevers and lethargy. The infant was admitted for fever workup with laboratory studies suggestive of a urinary tract infection and possible pyelonephritis. The urine culture grew out E. coli and the infant was started on intravenous Ampicillin and Gentamycin. A renal ultrasound to rule out hydronephrosis was ordered. During the night, the child spiked a temperature of 102 and was given Tylenol with good effect.

At 9:00 the next morning, the renal ultrasound revealed a 2x2 cm mass in the upper pole of her right kidney. According to the radiologist, the location and appearance of the lesion—as well as the age of the patient—made it suspicious for a Wilm's tumor. A progress note written by a pediatric resident listed the primary diagnosis as “UTI/pyelonephritis and renal mass.” The attending pediatrician reviewed the abdominal CT scan with the radiologist and confirmed the finding of a right renal mass, and no clear adenopathy (a chest CT scan was negative). The differential diagnosis at that point was Wilm's tumor.

After a pediatric surgical consult, the parents were told their daughter might have cancer and she needed surgery for either a heminephrectomy or complete nephrectomy.

On the morning of the third day, the patient was taken to the operating room. According to the operative report, the surgeon palpated the right kidney and noted only a subtle enlargement near the upper pole; he found the same result after mobilization. The kidney was removed and sent off for a frozen section.

According to the final pathology report, the right kidney had acute and chronic pyelonephritis. The kidney lesion is commonly associated with reflux infection of E. coli which was cultured in the urine of this patient. There was no evidence of malignancy.

Although relieved that their daughter did not have kidney cancer, the parents were upset that she lost a kidney, seemingly unnecessarily. They sued the attending pediatrician, the radiologist, and the pediatric surgeon, and after unfavorable expert reviews, the case was settled in the high range.

To discuss the risk management and patient safety aspects of this case, Resource speaks with Dr. William Berry. Dr. Berry is a surgical consultant for CRICO/RMF, Harvard’s medical malpractice and patient safety company.
Q: Bill, thank you for joining us.

A: It’s great to be here today.

Q: When we look at the trajectory of the case, where did this problem originate? Where did it first start to go awry?

A: Well, when the baby was admitted to the hospital, she was placed on antibiotics. All that care was completely appropriate. Before the baby was to go home, the pediatricians wanted to be certain that there wasn’t some kind of anatomic problem that the baby had that would explain why at five months she got a urinary tract infection. So they appropriately ordered an ultrasound which was abnormal and followed by a CT scan, and it was after they got the results of the CT scan that things start to veer off course.

Q: At that point, Wilms tumor is added to the differential.

A: That’s correct. As soon as Wilms tumor or the possibility of Wilms tumor is mentioned by the radiologist on the CT scan, the care of the baby kind of shifts away from an emphasis on the urinary tract infection and towards the consideration that the baby might have cancer.

Q: And why was that so problematic?

A: Narrowing the diagnostic focus too much and then missing a possible but maybe not highly probable diagnosis—we see that commonly in both medical and surgical claims here. In this case, it’s interesting because when the child comes in, the differential diagnosis is purely about infection, and the main diagnosis that’s written in the record says pyelonephritis/urinary tract infection. Cancer is never mentioned in the initial considerations. It’s not until after the radiologist puts “possible Wilm's tumor” that now the mass that they identified in the kidney now becomes a tumor and by implication cancer, and the consideration for infection just disappears totally. So what they’ve done is moved from a list of possible diagnoses of one—infec tion—to another list of possible diagnoses of one basically that it’s some kind of tumor.

Q: This narrow diagnostic focus that’s too narrow doesn’t just happen in surgery. It’s throughout medicine as we see our malpractice claims. What are some top line key methods to prevent that from happening?

A: It really is all about keeping your mind open to other possibilities and forcing yourself into the exercise of actually creating a diagnostic list. It is very easy to
drop to the thing that you think it is and really not think about other things. I mean, narrow diagnostic focus really is about considering other things that something could be. Again, the problem is that you see a patient and then you jump to a conclusion, justify it or not, and then that diagnosis then trumps everything else and actually probably keeps you from thinking about the other things that it could possibly be. When you are taught how to do differential diagnoses, you’re taught to think of the thing that it probably is but then to consciously do an exercise to try and think of every other possible thing that this could be, something masquerading as something else.

Q: Once the baby was in the operating room, was there another opportunity to find that diagnostic error?

A: Absolutely. The surgeon actually remarks in the operation report about how when feeling the kidney that the whole kidney feels the same and that he really can’t identify a mass in the kidney. And he actually describes doing two things, examining the kidney before he separated it from the surrounding tissue and then examining the kidney again, and both times he was unable to find a mass. And then it appears that he just went ahead and performed the kind of the ultimate biopsy and removed the entire kidney. I think there probably were some alternatives for him.

Q: Are there any of the techniques or the tools that we’ve started to see developed around surgical communication, around debriefs, any of those kinds of techniques that could have worked in this situation?

A: One of the things that might be and some of the things that we know about team training would be to create an environment in the operating room where the other people who are standing there and hearing the surgeon talk to himself could suggest maybe a different course of action. Clearly, the anesthesiologist and the nursing staff aren’t capable on their own of giving an opinion about whether something is a cancer or not, but in the right environment, they might say something like ‘well, should you call in Dr. X, you know, maybe he should look in the field with you if you have some doubts.’ Now in most of the operating rooms in the United States that’s something that is very counter-cultural. But it is also something that I think a lot of places are working on to be able to create a level of trust amongst the people who do surgery to have that kind of frank communication whether he should continue with the surgery basically, that the best way to deal with that is to bring somebody else into the operating room and look in the field with you or even scrub into the case and feel the kidney.

Q: The baby’s parents decided to bring a lawsuit. They were told that their baby had cancer prior to the surgery.
A: So when you’re operating because there is a tumor present and you don’t know for sure what the tumor is, a very important part of the preparation of the patient then is to share that information with them because there’s always a chance that it might not be a tumor at all. Patients then reflect back on the operation and if they go into it thinking that it’s a cancer for sure, when they come out and it’s not a cancer, then they are going to think they had an operation for no reason. Where if they’re prepared in a different way that it may be a cancer, but it may not be a cancer, when you come out and can tell them that it’s not a tumor, they share your joy that they didn’t have a cancer rather than looking back at the surgery like I never should have had this in the first place.

Q: Can the consent process which sounds a lot like the differential process actually help prevent a narrow diagnostic focus?

A: It potentially could because in thinking about all the possible outcomes of a procedure that you’re about to perform, it kind of forces you to think about all the different things that could be causing what you’re about to operate on so that the two ideas are aligned in a way. I don’t think right now in the current state of medicine that that probably happens very often because once the decision is made to do surgery, if anything, the diagnostic focus most of the time cranks down even more, but it is certainly a possibility. I think avoiding the narrow diagnostic focus is either about forcing yourself to think all the way through something or, you know, having some thing like getting consent be a trigger for you to think about things, outcomes of the procedure or causes of the reason why you’re gonna operate that will bring to mind things that you haven’t considered fully.

Q: Thank you, Dr. William Barry, Surgical Consultant for CRICO RMF. For resource, I’m Tom Augello.
Should Video Cameras be in Operating Rooms?

This legal report features the second in a series of excerpts from a presentation by a physician and a medical malpractice defense attorney. They spoke at a Harvard-sponsored patient safety conference in the summer of 2009, about the benefits and risks of improving surgeries by putting cameras in operating rooms.

First, the audience of clinicians and patient safety leaders heard from Dr. Caprice Greenberg, a surgeon at Dana Farber Cancer Institute and Brigham & Women’s Hospital in Boston. Dr. Greenberg advocated for wider use of video to study performance and safety in the operating room.

Following Dr. Greenberg would be Boston defense attorney Ellen Epstein Cohen, of Adler, Cohen, Harvey, Wakeman, Guekguezian, who described the legal risks associated with video use.

Dr. Greenberg began by pointing out that more than half of all adverse events in healthcare are surgical in nature, and that 75 percent of those events related to surgery occur in the operating room.

Dr. G. For this reason, we know that it is important to understand what happens in the OR in order to improve patient safety and performance. Traditionally in patient safety research, we’ve tried to do that by recreating what happens. We’ve tried to recreate it through the use of medical malpractice claims. We have tried to recreate it through root cause analyses, and we tried to recreate it through self-reporting systems rather than studying it in real time. If we look at what other domains have done, they’ve used video to prospectively capture performance for evaluation and improvement. Just as this technique can impact performance in competitive sports, so too can surgical technique affect surgical outcomes. Skills and team performance can be optimized by giving feedback through video images of intraoperative care. Like football teams watch game tapes on Monday, an OR team could see how they functioned as a team, and this can lead to an appreciation of how seemingly inconsequential events and activities in the OR impact performance and influence outcomes. So research is taken to the point of care. You have a complete record of what’s happening. The other way to perform research at the point of care is to have observers go on and perform field observations. And there you’re based on what the observers are actually able to record, whereas the video really is a complete record of everything that happens. You can do your analysis once outcome is realized. You’re able to go back and review older cases as new patterns arise in the data, and finally, it allows for a larger number of observers. And it also allows for the involvement of experts
when something needs to be clarified, both surgical experts as well as experts in
fields like human factors.

Dr. Greenberg also mention limitations, including costs, workflow interruptions, and
culture.

…So this is expensive, the hardware is expensive, the personnel is expensive, and
I am going to talk in a minute about how culture is changing, but I think a lot of
our institutions are actually investing this type of hardware. So having video
cameras in the OR is becoming more and more common, so a lot of what you’ll
need to do this actually exists and that can cut down on some of the expense. It
can be viewed as intrusive, and I think you have to keep that in mind when you
design your methodologies. As I was talking about, trying to find alternatives to
putting a lapel mic on everybody so that really you minimize the impact on work
flow. It can be limiting in the range of setting, so you can’t do this in an operating
room where the video equipment isn’t available or you have to go in and install it,
which can again influence the intrusiveness of the study. The analysis is very time
consuming, which adds to the expense, so estimates vary from four hours to 12
hours per hour of video for transcribing and analyzing. And then there are issues
relating to discoverability, confidentiality and privacy and cultural barriers.

So as far as some of the medical/legal considerations, which I’m sure will be
touched on, there’s really two sets of subjects when you do this type of research.
So there’s the OR personnel and there’s the patient. So you have to think about
the logistics of how you’re gonna consent the OR personnel. Because this is so
time consuming, these studies usually have a very low number of cases that are
enrolled, and does it make sense to consent hundreds of people when you’re
probably only going to be involving about 10 cases? But if you try to get
informed consent on the morning of the surgery, that’s gonna cause a large
impediment in people’s work flow. And then the consenting of the patients. Our
standard consent at Partners now includes a clause saying that your surgery may
be videotaped, and this would be used for educational purposes or for presentation
at national meetings. Now the question is, does that cover research or do you want
to do a separate consent for patients because I think a lot of people would argue
that this type of research goes beyond what is expected as part of the clinical
course. We came up with this idea of retention policy as opposed to destroying
the videotapes because it puts in a little bit more of a positive light, but the
question is, how long do you need to retain the videos? I think ultimately, one of
the goals at least in my mind should be to have a video bank, something that
parallels a tissue bank for the clinicians in the room where we have videotapes
that our prospectively recorded, and they are stored in parallel with a database that
has patient and surgery characteristics so that you can go back and do research in quality, safety, and even education.

So just to summarize my position on this, video has the potential to greatly advance surgical safety research by allowing real time analysis of system, individual and team performance in the OR. Most of the fear about this type of research is hypothetical, and I’ve talked to a lot of people around the country who are doing this in coming to that conclusion. And in my mind the benefits outweigh the risks. Thank you.

Attorney Cohen provided some words of legal caution. In her role as a medical malpractice defense attorney, Attorney Cohen has extensive experience defending some of the top physicians and hospitals in Massachusetts. Although she did not advise against videotaping surgical procedures for performance improvement and patient safety, Cohen offered several considerations for hospitals to think about.

EC: I’m back. So if a picture is worth a thousand words. A videotape to a plaintiff’s lawyer, priceless. So this is something that’s been going on in litigation as an issue, been coming up as an issue for as long as I’ve been a lawyer. And the increasing technology and ability to videotape, whether laparoscopically or from external cameras, either head cameras or room cameras, makes this even more enticing and exciting to the other side of the bar, to the plaintiff lawyers. And so the one thing I can say about this is if you’re using it for research and to improve patient safety, you have to remember that we’ve always had this very difficult balance between transparency, you know, everything’s up front, we own up to our mistakes, we tell the patients everything, we report facts and problems to our patients vs. peer review, which has been embedded in all of you from day one. And there is a cloak of secrecy and it’s statutorily protected about peer review, so there’s this dynamic, this tension between the way doctors have always been taught to study and improve, to talk about things behind closed doors and to make notes and minutes and reports that we know no one can see and the courts actually protect this. We’ve done a good job legally of making peer review sacrosanct for the most part versus this transparent idea of everyone can see everything I’m doing, what I’m wearing, how I’m speaking, how I’m holding my instruments, how long this is actually taking me, and so on. And so there is a tension that you can’t ignore between those two concepts.

There is also another tension that I think is critically important to recognize and somehow address, and that is the tension between promoting increased communication in the operating room setting between different caregivers, anesthesia, surgery, nursing. We as defense lawyers, we want you talking. You as providers want each other talking throughout the procedure. You want open and ongoing communication, and no matter how many times you tell people this is for
research and we’re not evaluating you, I think it’s very difficult to avoid the chilling effect that having multiple cameras at multiple different angles that you know people are going to be studying especially if there’s any intention of using this for credentialing that that chilling effect may have an adverse patient care impact in that you’re gonna decrease communication among providers, you’re going to have a very quiet OR and that’s exactly the opposite of what you want. So I would ask you to keep in mind that sort of opposite effect from what you’re looking for.

Ownership of the videotape, ownership is huge when it comes to the legal question. You know, if someone goes and has their mammograms done and then they need their mammograms, they show up in Radiology, they say they’re my films, and I want them and technically they are. Medical record may be the hospital’s record, but the patient owns that information, and the patient owns those films. And you have to make abundantly clear in any consent form that has to be gone over with the patient, not the moment before surgery, A. this is for research only, it has to be in writing, and B. that this is the property of the hospital or the study that’s funding it or whoever is going to own it and C. you need the consent of the patient both to take it, to share it with others; it needs to be clear what that’s going to be used for. And at the very end of the day you want to be clear about how this is going to be maintained. I love that you’re calling it a retention policy and not a destruction policy, someone has been listening, but at the same time, it means it’s not gonna be here after a certain period of time and the consent form needs to make that clear as well. Because once you tell someone we are videotaping and they say ‘okay,’ And then they have a bad outcome, the first thing they want is the videotape. The first thing their lawyer wants is the videotape, and if the videotape no longer exists and it isn’t clear what it was being done for and why it no longer exists, all of a sudden you have either a huge suggestion of cover-up or you have from a legal perspective what we call a spoliation of evidence issue. A videotape is going to be the best evidence of what happened in that operating room and so if that gets…is not retained or destroyed, there is a suggestion that there was something about that videotape that was harmful to the people who were in it. So you have to be very careful to spell those things out.

So I guess I would throw out there even though this is for patient safety improvement, improvement of performance, if you’re unfortunate to film a poor outcome, a complication, something significant and serious which, of course, you want to study, do you have a different obligation to maintain that or to notify before you destroy that? From a legal perspective, that might be a very important thing to consider. Thank you.
The Nitty Gritty of OB Team Training

The patient safety movement has focused attention throughout health care on team principles for at least 10 years. Research into team training has introduced such concepts as flattened hierarchies, communication protocols, and briefings to organized interventions across the country. It’s a different approach than the traditional way medicine has been practiced in Labor & Delivery units for decades.

What are these facilities learning as they go forward with a team-based model of OB care?

A group of obstetrical providers met in Boston recently to review their experiences implementing team training at their institutions. The event was sponsored by RMF Strategies, which promotes team delivery models and expertise developed in the Harvard system through a training program called Team Performance Plus.

A panel of two obstetricians and an obstetrical nurse related their challenges and victories along the way to incorporating team methods in their Labor & Delivery units. The first speaker was Anne Shea-Lewis, Director of Maternal Child Health nursing at St. Charles Hospital on Long Island, New York.

A: When we went to choose our teams, it was obvious that there were a couple of very, you know, the good doobie kind of nurses, the ones that have been there for years, very well respected, very strong nurses, and those were the easy ones to choose. I chose two of those right away for my team and we started doing the training. The third one was actually one of the very intimidating nurses that a lot of nurses were afraid of, and I chose her on purpose because I think we needed somebody who was going to be that if we could win her over, we could win over all of the nursing department. Choosing the physician, anesthesia was much more willing to be involved at St. Charles than the obstetricians were, which was a surprise to me, and it still is one of our challenges was trying to convince every OB that this is going to be something important. But as far as keys go, when you’re looking at your people and who you’re going to choose, don’t automatically toss aside those people in your units that are very vocal, whiners, complainers, the first people to speak up. So I think that was to me the greatest lesson was, the first lesson I guess, was who to pick and that was a big deal for us and I think that made the difference in driving it.

So we had an initial great takeoff and things were going really well with nursing only until one very fateful day. We had an obstetrician kind of say in a really kind of snarky tone, well, ‘why don’t we have a team meeting’ about a patient that had shown unexpected. She was probably going to have her third section.
She had come in laboring by ambulance and already ruptured. So you had to now disrupt everybody’s day and fit this lady in and do a section. So when this one physician said it, he just said, ‘oh why don’t we call a team meeting,’ it was like ‘okay, here we go.’ And we did the team meeting and we found out at that point that this lady was upwards of 300 pounds and so the OB tech says well I’ll make sure we have a Mobius retractor. But it was a really good thing because they had those things then ready in this very large patient, and that one doctor then thought ‘okay.’ And then a week or so later you had another doctor: ‘okay.’

So gradually we got almost all of the obstetricians on board. I think one of the presenters was talking about how it’s not going to solve all your problems. It’s not going to give you more staff. It’s not going to give you…you will still have shoulder dystocias. You will still have postpartum hemorrhage, but it’s how you respond to them that’s going to make the big difference and having everyone saying the same thing. Then obstetricians, anesthesia, nursing all says you know what would make this work if we had—and then it’s a lot easier to bring that argument to senior administration, hospital administration and get the tools that you need.

The next panelist was Mark Albini, the OB/Gyn Chair at St. Maria’s Hospital in Waterbury, Connecticut. His hospital just completed its first year of team training.

What’s very important for our unit is we don’t have residents but we do have midwives. Midwifery is integral to the delivery of our care, particularly we have a large clinic population. We have a great NICU, so we figured, you know, we have a provider instead of doctor/nurse team, provider/nurse. So we sent eight and we picked someone, we picked one of our midwives, we picked one of our pediatric physician assistants who again is integral in providing care. We picked some docs. We picked nurses. Our vice president of nursing went to one of the days of training, our quality people and our risk manager which was all key. We did our training. We came back. We trained everyone including our housekeepers.

Our biggest stumbling block was not with our obstetricians because—I would like to say it was my tremendous powers of persuasion that convinced everyone, but the truth is I had a pretty big hammer—and that was, ‘if he want your insurance through the captive—and the rates are very attractive for our providers—then you need to complete this training.’ So when I said that with a smile, all it took was once and everyone got the message. Anesthesia people were really reticent. We did have one of the younger, newer anesthesiologists who kind of came around finally, and he became kind of like our champion. What was interesting is, we went along and we had the same struggles everyone else did. Again, you’re changing the culture.
But what seemed to change one day is I had a patient who was about 32 weeks pregnant, and she had a tumor, a lung tumor, and the thoracic surgeon said he had felt he had waited too long and he was hot to get this tumor out. This was a bad ugly tumor, and we knew that this woman probably wasn’t going to survive to see her child live. So we had a team meeting, and I had my idea how we were going to manage it, but the anesthesia people came, the thoracic surgeon came. Almost all of our attendings were there, our nurses, our perinatologists, no excuse me, our neonatal staff. How we decided to manage this case was 180 degrees to how we thought to should be managed, and it was managed in the right way. After that the anesthesiologist who had taken about 5 pounds of flesh out of my backside on numerous occasions for this came to me and said ‘now I can understand what this is about.’ And to me that was the turning point. It was a great turning point.

Having said that, it is still a struggle, you know, we still have our own individual personalities. We still have, we have to go over our skills. So we’re into our second year. We didn’t have a sentinel event where we paid out tens of millions of dollars on a baby. So for us it was harder to move our numbers because our numbers actually were actually good, not perfect, but they were good so it’s hard to move the numbers when you’re starting in a pretty good place, but even that at the end of the year we have moved our numbers.

So I’m encouraged. I think it’s transformed our unit. I think our staff is, one thing they do have is that they can now enunciate a plan. They feel that they do work together, and I believe that it has made a big impact on the care.

The final panelist was Dr. Peter Rotolo a staff obstetrician from Winchester Hospital in Massachusetts. Winchester Hospital has a relationship with Beth Israel Deaconess Medical Center for Perinatology services. Beth Israel was the facility that helped create the team training program that Dr. Rotolo implemented at Winchester.

The program rolled out initially just in the labor and delivery department, but we very rapidly then expanded it to the rest of our maternal child health unit, the postpartum and special care nursery, so that everyone was on the same page. There were difficulties certainly. I’m sure everybody has the resistance that we’ve talked about here. I remember being at one of these meetings and I tried as chair to go to each session to introduce the process so I was pretty much met with most of the folks there. You know, I remember one obstetrician who was there saying well, I don’t know why I’m here, I’m not going to do this, you know, which I think was, you know, at least could verbalize as opposed to being passive aggressive about it, but it was that type of situation.
We established our teams. I think that the program was better accepted by the physicians than I initially thought it would be, and I think part of that was the fact that we had already started some of these. I had called it ‘Safety Rounds’ before we ever had the team meetings, and we had started to have a meeting at the beginning of each shift to review what was going on in the labor floor so that everyone really did start on the same page. I think that that worked out very well.

I thought of just one example because I think one of the slides had talked about the debriefing. Dr. Pratt I think had talked about the fact that, you know, 300 C-sections, only 120 got debriefed. I think we found the same thing that, you know, you had finished the section, the system would go one way, the doctor would go the other way, and you really couldn’t do it as well as you would like to do it. So what a lot of us have started to do now is basically ask that question. When we are on skin or at closings, you know, do we need to debrief this case? Does anyone want to stop and talk about this afterwards? The majority of the time I’d say the answer is no, but at least you verbalized it right off the bat and people have decided that everything went well.

I think of one example, where I was doing a cesarean section, and we usually have a dedicated labor and delivery scrub nurse, but this particular time she wasn’t there, and our labor room nurses try to fill in as far as being the scrub nurse. This particular case turned out to be a lot more difficult than we thought it was going to be, and the woman who was helping us really did not have the skills. I think she understood it and knew it as well and was uncomfortable. So I did ask for a debrief afterwards, and I would say that probably, you know, 3-4 years before that, I would have maybe gone to Sue and said ‘you’ve got to do something about this, this is terrible. This person really didn’t know what she was doing.’ Instead, we all had that conversation, and the nurse herself said gee, I really did feel very uncomfortable in this situation, how can we improve it? Well, we decided that perhaps the best way to improve that was to have a program where the nurses who would be scrubbing would in fact scrub in with the skilled nurse to have some training, rather than just being thrown in and saying this is a Kelly, that they understood the progress of what was going on in a cesarean. I think that’s still ongoing, and I think we still have, you know, people who are still being trained, but I think it was one of the things that came out of this program that I thought was really very worthwhile. I think the first scores that we got back did certainly show an improvement. I think Sue had said at the beginning, we had done a pre-evaluation and then a post evaluation and certainly I think we can see demonstrably that there is an improvement from the program.

More information about Team Performance Plus, the training program used by these providers, is available online at www.RMFSolutions.com/tpp.