Handout #2
FORT WAYNE MEDICAL EDUCATION FAMILY MEDICINE RESIDENCY CASE REVIEW WORKSHEET

Pause: Consider Outcome/Severity and Hindsight Bias and Anchoring Heuristic Effects.

**PEER REVIEW SCORE**

*If a Standard of Care score of 2.5, 3, or 4 is contemplated, it is highly recommended that the reviewer first discuss the case with the provider.*

<table>
<thead>
<tr>
<th>EVENT LEVEL</th>
<th>STANDARD OF CARE SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Event represents no problem; unpredictable or idiosyncratic; or no adverse effect</td>
<td>1 - Practice within contemporary standards; unpredictable; idiosyncratic; medically known complication.</td>
</tr>
<tr>
<td>2 - Event with, or potential for, mild adverse effect.</td>
<td>2 - More than one acceptable decision/therapy; judgment acceptable.</td>
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<tr>
<td>3 - Event with, or potential for, moderate adverse effect.</td>
<td>2.5 - Though standard of care was met, there could have been prevention or improved treatment.</td>
</tr>
<tr>
<td>4 - Event with, or potential for, severe adverse effect</td>
<td>3 - Departure (mild) from contemporary standards of care.</td>
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<tr>
<td>4 - Departure (moderate to severe) from contemporary standards of care.</td>
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</tbody>
</table>
PEER REVIEW: PRIVILEGED / CONFIDENTIAL
FORT WAYNE MEDICAL EDUCATION FAMILY MEDICINE RESIDENCY CASE REVIEW WORKSHEET

Documentation
Adequate? Yes ☐ No ☐ If No, answer the following:

Yes ☐ No ☐ N/A ☐ Substantiates clinical course and treatment?

Yes ☐ No ☐ ☐ Communicates thought processes and decision making of practitioner?

Yes ☐ No ☐ ☐ Timely to communicate with other caregivers?

Yes ☐ No ☐ ☐ Was complication or untoward event documented?

Yes ☐ No ☐ ☐ Legible?

FAILURES ANALYSIS TOOL (Mini Root Cause Analysis: Why X 5)
Where were the failures in this case? Individual versus system failures.

<table>
<thead>
<tr>
<th>Individual Failures</th>
<th>System Failures</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Communication</td>
<td>☐ Communication</td>
</tr>
<tr>
<td>☐ Handoffs (complete section on this)</td>
<td>☐ Handoffs (complete section on this)</td>
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<tr>
<td>☐ Hierarchical inhibition</td>
<td>☐ Hierarchical inhibition</td>
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<tr>
<td>☐ Loss of situational awareness</td>
<td>☐ Teamwork failure – (complete section on this)</td>
</tr>
<tr>
<td>☐ Failure to recognize</td>
<td>☐ Interruptions/distractions</td>
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<tr>
<td>☐ Failure to rescue</td>
<td>☐ Loss of institutional memory</td>
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<tr>
<td>☐ Diagnostic Failure (complete this section)</td>
<td>☐ Flow of information</td>
</tr>
<tr>
<td>☐ Provider lacked foundational knowledge</td>
<td>☐ Inadequate knowledge of established policies/procedures</td>
</tr>
<tr>
<td>☐ Evidence-base violation</td>
<td>☐ Equipment issue</td>
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<tr>
<td>☐ Cognitive Medical Error/Bias/Heuristic (complete section on this)</td>
<td>☐ Non-reliance of memory, lack of</td>
</tr>
<tr>
<td>☐ Inadequate attention to detail</td>
<td>☐ Standardization, lack of</td>
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<tr>
<td>☐ Lack of critical thinking</td>
<td>☐ Simplification, lack of</td>
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<tr>
<td>☐ Unprofessional behavior</td>
<td>☐ Parallel processing, lack of</td>
</tr>
<tr>
<td>☐ Failure to carry out order</td>
<td>☐ Redundancy, lack of</td>
</tr>
<tr>
<td>☐ Provider/Physician responsiveness/timeliness</td>
<td>☐ Forcing functions/ constraints, lack of</td>
</tr>
<tr>
<td>☐ Multi-tasking</td>
<td>☐ Multi-tasking</td>
</tr>
<tr>
<td>☐ Workaround/normative deviation</td>
<td>☐ Workaround/normative deviation</td>
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<tr>
<td>☐ Pattern matching/ look-a-likes, sound-a-likes</td>
<td>☐ Pattern matching/ look-a-likes, sound-a-likes</td>
</tr>
<tr>
<td>☐ Obtaining appropriate faculty supervision</td>
<td>☐ Inadequate or lack of faculty supervision</td>
</tr>
<tr>
<td>☐ Human factors: Fit for Duty, fatigue, alertness, lack of sleep, anxiety/stress, overwork, XS Duty Hours, illness, medication, depression, distraction</td>
<td>☐ Human factors: Fit for Duty, fatigue, alertness, lack of sleep, anxiety/stress, overwork, XS Duty Hours, distraction.</td>
</tr>
<tr>
<td>☐ Noncompliance with policy</td>
<td>☐ Noncompliance with policy</td>
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</tbody>
</table>
**ACGME / AOA Competencies (6+1 Domains)**

<table>
<thead>
<tr>
<th></th>
<th>OK</th>
<th>N/A</th>
<th>Breach</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Professionalism</td>
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<tr>
<td>Interpersonal &amp;</td>
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<tr>
<td>Communication Skills</td>
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<tr>
<td>Medical Knowledge</td>
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<tr>
<td>Patient Care</td>
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<tr>
<td>Practice-Based</td>
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<tr>
<td>Learning/Improvement</td>
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<tr>
<td>System-Based Practice</td>
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<td>OMT/OPP</td>
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**IOM (Institute of Medicine) Aims / IHI (Institute for Healthcare Improvement)**

*(Check all that apply where patient care provided did not meet the following)*

- **Safe**: Avoid injuries or harm intended to help patient, no needless death, no nosocomial infections, no errors, 100% reliable.
- **Effective**: Care is evidence-based when such exists; avoid overuse of ineffective care and underuse of effective care
- **Patient-centered**: Honor the patient and respect their choice; patient choice/goals obtained/known; patient engaged in decision-making, communication, family oriented/involved, no patient feeling of helplessness, no needless pain, comfort, respect, dignity, privacy, personal attention.
- **Timely**: Reduce waiting for patients and their caregivers
- **Efficient**: Reduce waste; cost efficient
  - Defects – mistakes, errors, rework
  - Overproduction – doing more than is required
  - Waiting – queuing (waiting in line to be served), idle time
  - Not using staff talent – not using problem solving skills of people
  - Transportation – all patient, staff, and material movement
  - Inventory/Inspection – all stock and corresponding control systems
  - Motion – unnecessary reaching, bending, searching
  - Extra processing – unnecessary activities, over-complicated
  - Cost conscience/ efficient
- **Equitable**: Close racial and ethnic gaps in health status, common humanity, cultural competence/medical certified interpreter, health literacy
ACGME Recognized Core Skill Sets

(Check all that apply if breach occurred in the provision of patient care)

☐ Leadership – (If checked, fill out leadership section of TeamSTEPPS Four Skills below)

☐ Teamwork – (If checked, fill out TeamSTEPPS section below)

- Team performance, adaptability, mutual trust, mutual support, shared mental model (members on same page), team orientation, communications, handoffs, situation monitoring, cross-monitoring/watch each other’s back, maintain situational awareness, psychological safety/freedom to speak up/professionally find one’s voice, coordination of care; like sports - expert team of individuals rather than group of expert individuals.

☐ Use of Information Technology

☐ Appropriate Transitions in Care - Handoffs, patient transfer to different units in hospital, to NH, office, home, assisted living, etc. – including coordination of care.

Patient/Family Engagement

☐ NA

WHO Patients for Patient Safety

(Check all applicable)

Breach  OK  Unknown  NA

☐ ☐ ☐ ☐  ☐ Patient/family knowledgeable about diagnosis and therapeutic plan
☐ ☐ ☐ ☐  ☐ Patient/family encouraged/asking for clarification if don’t understand
☐ ☐ ☐ ☐  ☐ Respect patient/family voice

☐ NA

TeamSTEPPS and Patients/Families

(Check all applicable)

Breach  OK  Unknown  NA

☐ ☐ ☐ ☐  ☐ Individual/team listened to patient/family
☐ ☐ ☐ ☐  ☐ Asked patient how involved s/he preferred to be in their own care.
☐ ☐ ☐ ☐  ☐ Spoke in lay terms with patient/family understanding of communication
☐ ☐ ☐ ☐  ☐ Gave patient and family access to relevant information.
☐ ☐ ☐ ☐  ☐ Asked patient and their family for feedback and to be proactive participants in patient care/shared decision-making, guided/empowered on how to self-manage illness, patient and family as partners in care plans.
☐ ☐ ☐ ☐  ☐ Medical interpreter given permission to CUS and “stop-the-line”
☐ ☐ ☐ ☐  ☐ Use of check-backs for confirmation with medical interpreter
Responsibility/Accountability/Blameworthiness

Decision Tree for Determining Culpability of Unsafe Acts

(Circle end result)

Think Three: Hold and measure the three sources of accountability: Individual, Team performance (peers), Leadership

Were the actions as intended?

Substance or medication use?

Knowingly violates procedure, rule, policy, duty?

Risk Behavior 4

Pass Standard of Care Test? (Peer Review Level 1, 2, or ? 2.5)

History of unsafe acts?

Were there consequences as intended?

Provider has medical condition?

Were policies/- procedures available, workable, intelligible and correct?

Deficiencies in training, or inexperience, or wrongly granted privileges?

were policies/- procedures available, workable, intelligible and correct?

Possible risk behavior 4

System-induced violation

Possible negligent error/conduct 5

System-induced error

Blameless error but corrective training, counseling needed, sometimes removal

Blameless error

Sabotage, malevolent damage, suicide, etc.

Substance abuse without medical reason

Substance abuse; or side effect with medical reason

Possible reckless conduct 1

Or work-a-round 2/ normative deviation 3

Diminishing culpability

CULPABLE

Discipline

GRAY AREA

Coach

BLAMELESS

Console

Adapted and used by permission of the publisher: Reason J, Managing the Risks of Organizational Accidents. Ashgate Publishing; 1997; Fig 9.4 pg 209 Modified by Fort Wayne Medical Education Program

1 Reckless conduct: Gross negligence; conscious disregard of a visible substantial and unjustifiable risk.

2 Work-a-round: Skip step(s) or short-cut in a policy or procedure.

3 Normative deviation: Work-a-round or deviation from policy/procedure that becomes the “norm” when no untoward effect has occurred over time.

4 Risk behavior: e.g., clowning around, excessive fatigue due to working double shift, using equipment known to be sub-standard/inappropriate.

5 Negligent conduct: Failure to exercise expected care. Should have been aware of substantial and unjustifiable risk.

Human Error: Should have done other than what they did (inadvertent, mistake, slip, lapse)

Intentional rule violation: Knowingly violated a rule or procedure.
<table>
<thead>
<tr>
<th>Hierarchy of Actions*</th>
<th>Strong</th>
<th>Intermediate</th>
<th>Weak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Architectural/physical plant changes</td>
<td>☐</td>
<td>☐ Increase staffing/decrease workload</td>
<td>☐ Double checks</td>
</tr>
<tr>
<td>New device with usability testing</td>
<td>☐</td>
<td>☐ Software enhancement or modification</td>
<td>☐ Warnings and labels</td>
</tr>
<tr>
<td>Engineering control or interlock</td>
<td>☐</td>
<td>☐ Eliminate or reduce distractions</td>
<td>☐ New procedures, memorandum, or policies</td>
</tr>
<tr>
<td>Simplify the process &amp; remove unnecessary steps</td>
<td>☐</td>
<td>☐ Checklist or cognitive aids</td>
<td>☐ Training</td>
</tr>
<tr>
<td>Standardize equipment, process or care maps</td>
<td>☐</td>
<td>☐ Eliminate look &amp; sound-a-likes</td>
<td>☐ Additional study or analysis</td>
</tr>
<tr>
<td>Tangible involvement &amp; action by leadership in support of patient safety</td>
<td>☐</td>
<td>☐ Read back</td>
<td>☐ Didactics/Grand Rounds</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐ Enhanced documentation &amp; Communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐ Redundancy</td>
<td></td>
</tr>
</tbody>
</table>

* VA-National Center for Patient Safety/IHA-Indiana Patient Safety Organization

**Education** (To Hospital CME Department and/or Residency Didactics Committee with identified Professional Practice Gaps (PPG) to be addressed.)

☐ Residency Didactics
☐ Hospital Grand Rounds
☐ Other: ______________

**System Change Recommendation(s)**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Individual Practitioner Recommendation(s):**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Rationale for event level / error / SOC scores:

________________________________________________________________________

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Follow-up: ______________________________________________________________________

Signature of Resident Peer Reviewer ______________________ Date: __________

Routing:

☐ To Hospital Quality Improvement Department.
☐ De-identified pertinent information to GMEC for its oversight function
Diagnostic Failure / Cognitive Medical Errors
Heuristics/Bias/Cognitive Blindness/Inattention
Common Reasons for Misdiagnosis or Delayed Diagnosis

Source of unconscious influence on decision-making

- **Anchoring Heuristic/Premature Closure**: Relied too heavily on initial diagnostic impression despite subsequent information to the contrary. Staying locked on to a diagnosis made early on despite dis-confirming evidence. Tendency to stop consideration of diagnostic possibilities once a diagnosis has been settled on – often before it is has been fully verified or workup complete. Failure to consider alternative diagnoses. One of most influential cognitive errors and common reason for missed diagnosis.
  - Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation. Pretend initial diagnosis is wrong, think of another, does info line up more consistently?
  - Distinguish between a working diagnosis and a definitive diagnosis
  - Always consider new and inconsistent information
  - Keep open mind about diagnostic possibilities (Generate a new differential diagnosis (Diff 3x3))

- **Availability Heuristic**: Jumping to a diagnosis which comes quickly to mind because it is common, serious, or recently encountered. Diagnosis of current patient biased by experience with past cases. Influenced too much by a similar case…esp. if an associated visceral response. Judge diagnosis as being more likely if readily comes to mind or if frequently occurring. Thus, a recent experience with a diagnosis may inflate the likelihood of its being diagnosed. Conversely if a diagnosis has not been seen for a long time (non-availability), it may be underdiagnosed.
  - Question the supporting information
  - Consider the influence of recent or more vivid/visceral encounters
  - Remain mindful of the true prevalence
  - Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation
  - Diff 3X3

- **Blind Obedience/Expert Bias**: Influenced too much by the consultant; false negative or positive labs or tests.
  - Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation
  - Generate a new differential diagnosis (Diff 3x3)

- **Overconfidence Bias**: Believing one knows more than one actually does or a test or procedure is more accurate or effective than it actually is.
  - Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation
  - Generate a new differential diagnosis (Diff 3x3)

- **Framing Effects**: Diagnosis influenced by the way the story is framed or told…lead listener down the same path of errant thinking (increased risk during handoffs), who told the story, and where the patient is seen (increased risk on specialty service floors). Decision-making unduly biased by subtle cues and collateral info. (A heroin-addicted patient with abdominal pain was treated for opiate withdrawal, but proved to have a bowel perforation). 
  - Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation.
  - Diff 3X3

- **Diagnosis Momentum**: Diagnosis being carried forward from previous encounters without evaluation of its accuracy or how well it fits with the current patient presentation. Once a diagnosis is attached to a patient it tends to stick as the patient migrates through the health system and other possibilities are not as likely to be explored. The initial diagnosis may have been provided by patient, nurse, EMS, nursing home, covering physician, emergency physician, or other and carried through without adequate information being collected or as an initial speculation. What might have started as a possibility gathers increasing momentum until it becomes definite.Subset to this is Triage Cueing: during triage labels get applied and patients get sorted to locations which ultimately influence downstream providers, leading to the maxim: “Geography is destiny.”
  - Be aware of this when assuming care of a patient from another provider
  - Review existing data and ask if congruent with diagnosis
  - Generate a new differential diagnosis (Diff 3x3)
Outcome Bias: Tendency to pick diagnosis which lead to a good prognosis rather than one associated with a bad outcome. This may result in a serious diagnosis being minimized.
- Be mindful of selecting diagnosis with better prognosis
- Consider the true prevalence
- Generate a differential diagnosis (Diff 3x3)
- Collect more/sufficient data before making a diagnosis
- Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation

Fundamental Attribution Error: Tendency to be judgmental/blame patients for their illness rather than examine the circumstances that might be responsible. (Especially heightened bias if a visceral response is aroused in practitioner)
- Be aware of this prejudice and human factor
- Remember that medical conditions can mimic psychiatric illness
- Imagine a relative or friend in this situation
- Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation
- Generate a differential diagnosis (Diff 3x3)

Representativeness Restraint: Reliance on prototypical manifestations of disease (If it looks like a duck, walks like a duck, and quacks like a duck, then…..) Results in atypical variants of disease being missed.
- Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation
- Consider atypical variants (Diff 3X3)

Commission and Omission Bias:
- Commission: tendency toward action rather than inaction, due to obligation toward beneficence.
- Omission: tendency toward inaction based on principle of non-maleficence (first do no harm).

Hassle Bias: Tendency to avoid difficult actions. (Call in consultant at 2 am; pelvic exam on med/surg or hallway patient)
- Be aware of such bias and regimentally call in, or perform, what is needed for patient safety

Confirmation Bias: Tendency to look for and weight confirming evidence to support a diagnosis rather than evidence that refutes it, despite the latter often being more persuasive and definitive. Looking for clues to support the diagnosis rather than trying to work the outliers into a diagnosis.
- Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation. Pretend initial diagnosis is wrong, think of another, does info line up more consistently?
- Diff 3X3

Search Satisfying Bias: Universal tendency to call off a search once something is found. (Failure to thoroughly examine for additional gunshot wounds in a trauma patient once one is found).

Knowledge Bias: Chose a diagnosis one knows more about than the one the patient most likely has.

Visceral Bias: Allowing personal feelings towards a patient to influence diagnostic conclusions.

Contextual Factors which increase risk of cognitive error: (circle the factor) Lack of interest in patient’s case, lack of confidence, specialty service which patient admitted to, time pressure, recent transfer, insufficient or inability to get information from patient/family/outside institution, too many patients, chaotic environment, complex illness, vague history from patient, patient with bad reputation or negative connotation, patient refusing services, patient with poor prognosis, history of drug seeking or substance abuse.
- Knowledge deficit - didn’t know enough about condition/disease
- Evidence-base violation
- Diagnosis never crossed physician’s mind
- Paid too much attention to one finding
- Didn’t listen to patient enough
- Too much in a hurry
- Patient had too many problems at once / didn’t prioritize
- Didn’t reassess the situation
- Failure or delay in identifying a critical piece of history
- Failure or delay in physical exam finding
- Failure or delay in considering the diagnosis
- Failure or delay in ordering needed tests
- Failure or delay in ordering follow up tests
- Conditions of cognitive overload, sleep deficit, fatigue
Suggestions for remediation
“Cognitive Pills for Cognitive Ills”

☐ Develop insight/awareness of cognitive errors and high risk situations where more likely to occur.
   High risk patients: the young, old, and mentally ill, the hostile, abusive, and intoxicated, and those with unreliable history, atypical presentations, or negative visceral response; High risk times: patient sign-out (loss of information, misinterpretation of new incoming info), high acuity or volume, end-of-shift (personal fatigue); High risk diagnoses: Chest pain: MI, PE  Headache: SAH, meningitis, SDH  Abd pain: appendicitis, ectopic, torsion.

☐ Metacognition: Increasing awareness/self-assessment/reflection - thinking about thinking. Step back, disengage, reflect, and reconsider before taking action. Reflect on the decision-making process itself and ask oneself if cognitive bias/heuristics may have been involved, then apply specific cognitive and affective forcing strategies to avoid failure - Mamede et al, 2011; Croskerry

☐ Forced thinking – Ask: What else could it be? Is there anything that doesn’t fit? Is it possible that I have more than one problem? Have I explained all of the patient’s findings? Have I considered the worst first?

☐ Rethink the diagnosis while ignoring the most obvious finding or history of a clinical presentation – see if a new diagnosis fits the clinical scenario better. Coderre et al, 2010

☐ Forced consideration of other possibilities – Develop a differential diagnosis formation (Diff 3x3): 3 most common, 3 that can kill the patient, 3 in between/atypical variant/uncommon diagnoses.

☐ Structured series of questions one should routinely ask (and exam elements and diagnostics performed) on top diagnoses provider sees. Hurst, 2008

☐ Slowed down thinking – Moulton et al, 2007

☐ Decrease reliance on memory – improve accuracy of judgments via cognitive aids such as use of clinical practice guidelines, mnemonics, algorithms.

☐ Combined reasoning approaches – Eva et al, 2007

☐ Involve the patient

☐ Cognitive Autopsy: Soon after event, explore with provider the various cognitive biases/heuristics which may have occurred and their relative impact.

☐ Simulation training: Specific clinical scenarios to allow cognitive errors/bias/heuristics to appear and their consequences to be observed, followed by a “cognitive walkthrough” with strategies such as debiasing or forced thinking.

☐ Deliberate practice and feedback – (Have competent good decision-making provider observe, live or videotape, the provider with patient and during decision-making period. Give feedback soon afterwards) Croskerry, 2003

Further references for Cognitive Medical Errors:
Bordage, G, 1999; Schiff, 2009; Rensink, R; Schmidt, H, 2011, Croskerry, P, 2012, AHRQ)
Safety Perspectives on Diagnostic Failure and Patient Safety; Healthcare Quarterly, 2012; 15: 50-56
Bordage, G. Why Did I Miss the Diagnosis? Some Cognitive Explanations and Educational Implications, Acad. Med. 74(s)m 1999
AHRQ Website - Diagnostic Errors  http://psnet.ahrq.gov/primer.aspx?primerID=12
Society to Improve Diagnosis in Medicine (SIDM)
TeamSTEPPS Principles
(Check all that apply either as a breach, or possible corrective action (CA) which may have prevented error)

<table>
<thead>
<tr>
<th>Breach</th>
<th>CA</th>
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<tbody>
<tr>
<td>Brief</td>
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<td>Huddle</td>
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<td>Debrief</td>
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<td>Cross Monitoring (highest benefit)</td>
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<td>Feedback</td>
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<td>Advocacy and Assertion/&quot;Stop the Line&quot;</td>
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<td>Two-Challenge Rule</td>
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<tr>
<td>CUS</td>
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<td>Collaboration</td>
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<td>Call-Out</td>
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<td>Check-Back</td>
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<td>Handoffs</td>
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<td>Quiet and controlled environment</td>
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<td>Face to face and interactive</td>
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<td>Patient status conveyed</td>
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<td>Significant exam findings</td>
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<td>Significant lab/x-ray/diagnostics</td>
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<td>Family contact information</td>
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<td>Advanced Directives/Code status</td>
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<td>Change in attending physician</td>
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<td>Recent clinical changes and anticipated changes including pending diagnostics and consults</td>
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<tr>
<td>Anticipated clinical course discussed (Predictive/Anticipatory)</td>
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<td>Alternative clinical trajectories discussed (Predictive/Anticipatory)</td>
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<tr>
<td>What could harm the patient discussed: DVT, falls, foley, central line, vent, decubitus risk</td>
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Barriers to Teamwork Identified
- No leader identified or took role
- Inconsistency in team membership
- Lack of role clarity/role ambiguity
- Lack of information sharing
- Hierarchy inhibition/psychologic safety
- Defensiveness
- Conventional thinking
- Complacency
- Varying communication styles
- Conflict
- Lack of coordination and follow-up with co-workers
- Distractions
- Fatigue
- Workload (excess or inappropriate distribution)
- Misinterpretation of cues
- Lack of mutual trust
- Lack of shared mental model – not on same page
- Lack of time
TeamStepps Four Skills

**Leadership**
- Designated or situational
- Organize the team
- Articulate clear goals
- Make decisions through collective input
- Empower members to speak up and challenge
- Resolve conflicts
- Resource management
- Prevent overload situations/balances workload
- Ensure clear understanding of available resources
- Delegation
  - Decide what to delegate
  - Decide whom to delegate
  - Communicate clear expectations
  - Request feedback
- Facilitate team events:
  - Briefs for planning - short session prior to start to discuss team formation; assign essential roles; establish expectations and climate; anticipate outcomes and likely contingencies.
  - Huddles for problem solving - ad hoc to reestablish situational awareness; assess need to change plan or reinforce existing plan.
  - Debriefs for process improvement - post event information gathering to improve team performance

**Situational Monitoring**
Process of actively scanning behaviors to assess the situation and environment. Fosters mutual respect and team accountability, provides safety net for team and patient.
- Individuals have situational awareness
- Shared mental model – whole team on same page; team maintains situational awareness.
- Cross-monitoring status of:
  - Patient
  - Team (fatigue, workload, stress)
  - Environment
  - Progress towards goal

**Mutual Support**
- Anticipate and support other team members’ needs
- Shared work distribution initially and prn redistribution
- Protect team members from work overload which may reduce effectiveness or increase risk of errors
- Culture of task assistance – expected that assistance actively sought and offered
- Effective feedback – timely, respectful, specific, directed towards improvement.
- Patient advocacy, may challenge hierarchy firmly and respectfully – CUS/Two Challenge Rule

**Communications**
- Complete, brief, clear, timely
- Handoff mnemonic
- Call-out – simultaneously communicate critical info to all team members
- Check-back – ensures closed loop communication
- SBAR – effective communication to team members esp. if hierarchy present