Huddles and Debriefs

Tools for Teams to Plan Forward and Reflect Back

Adriana Morales, Tawanna Leland, DeShawn Harris, and Travis Bishop

BACKGROUND

A variety of approaches have been used to improve teamwork and communication in healthcare (Salas & Rosen, 2013). Positive team behaviors by healthcare professionals are associated with lower rates of adverse events and mortality, improved patient satisfaction and staff retention (Mazzocco et. al., 2009; Hansen et. al., 2010; Haynes et. el., 2011). Briefings, checklists, handover tools and models to manage conflict are all tactics that improve teaming (Battles et. al., 2013). Two tactics that are getting increasing attention are huddle and debriefs (Paull et. al., 2010). Team huddles and triggered debriefings have been associated with improved outcomes (Goldenhar et. al., 2013).

OUR GOAL

Develop a structured, facilitated, stand-up huddle to support team-level mindful organizing: ***Preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise and resilience.***

Planning Forward - PREP HUDDLES

Prepare

- ✓ **Gather needed data for review and make a clear statement of purpose to level-set and prepare the team**

Review and anticipate

- ✓ **Expect challenges. Build individual resilience and team shared meaning-making with an eliciting/evoking style.**

Enact

- ✓ **Close the loop and mobilize resources to support team-based care.**

Promote resilience

- ✓ **Close with a reflection on outcomes to build group capabilities.**

Reflecting Back- TRIGGERED DEBRIEFS

Structured debriefs should follow important trigger events. For example, placement disruptions could trigger a team debriefing.

Ask three simple questions

1. **What went well?**
2. **What could have been better?**
3. **What will we do differently next time?**

Debriefs are a leader facilitated discussion that accomplish two important goals:

1. **Team unity and psychological safety**
2. **Learning and improvement**

Facilitator Checklist:

- ✓ Communication clear?
- ✓ Roles and responsibilities understood?
- ✓ Situation awareness maintained?
- ✓ Workload distribution equitable?
- ✓ Task assistance requested or offered?
- ✓ Were errors made or avoided?
- ✓ Availability of resources?

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Safety Culture Check-Ups

Tools to Develop and Sustain Team Culture

Tiffany Goodpasture

BACKGROUND

Assessment of an organization's **SAFETY CULTURE** supports communication and guides resilience building. The survey strategy we recommend does several things: 1) creates a language to drive culture change, 2) raises staff awareness about safety and resilience, 3) identifies opportunities for improvement, and 4) allows you to track change over time (Vogus et. al., 2016).

Team Culture Conversations
1. Gather Your Team
a. Make it as safe and welcoming as possible. Your goal is create an atmosphere that promotes conversation.
2. Share the data
a. Give your team a few minutes to look over it
a. Define each measure and explain its importance in teams
a. Let them know which scale will be the focus of today's discussion

Use the following prompts to guide your discussion
1. How do these descriptions compare to your experience?
2. What does _____ mean to you?
3. How would it look on our team if our score on _____ was 100%?
4. What is one thing we can change?

TOOLS FOR TEAMS

Team leaders are trained to use Check-up Tools and their team's data to facilitate conversations.

THE MIRACLE QUESTION

Asking teams "what would be different" stimulates rich authentic conversations.

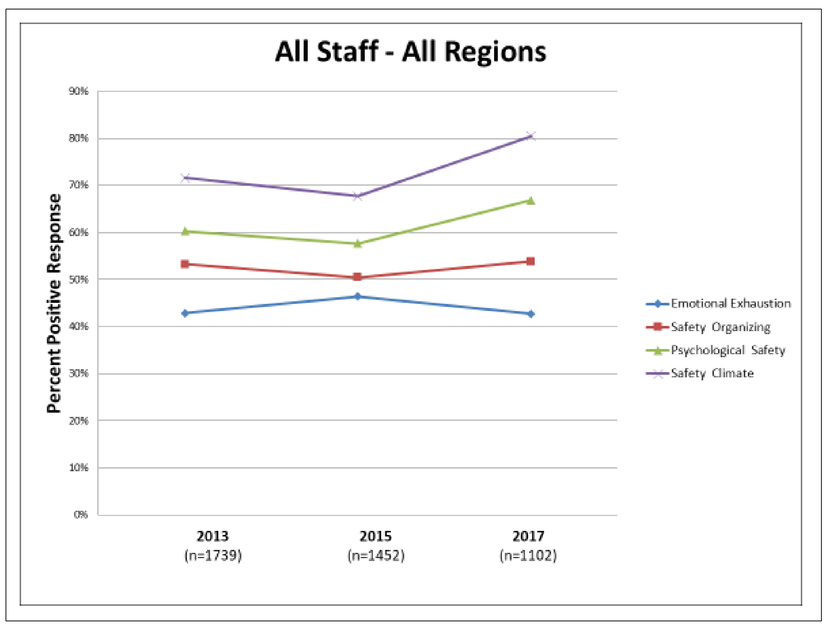
SCALES

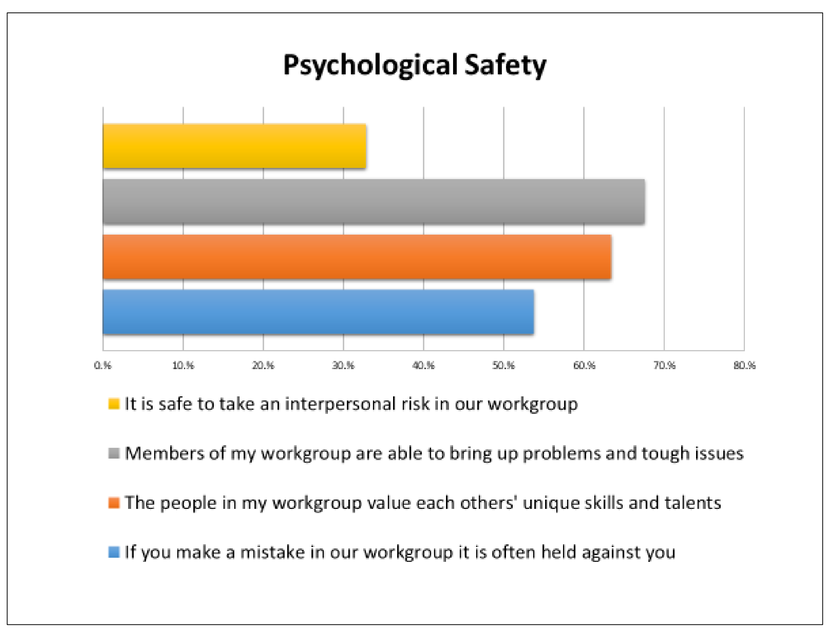
Safety Organizing: The described preconditions that support rapid detection and correction of errors and unexpected events.

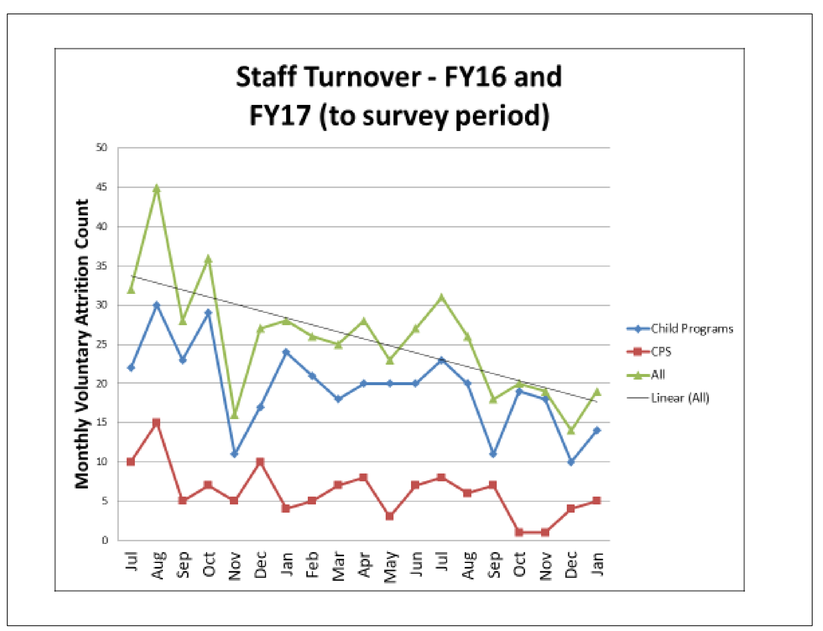
Psychological safety: The shared belief that team members are accepted, respected, and safe to take interpersonal risks.

Safety Climate: Perceived organizational attributes related to safety which may be induced by policies and practices.

Burnout: Exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration.







Spaced Education and Safety Notices

Expediting Frontline Professionals' Collective Learning from Child Deaths

David Lomascolo, Tiffany Goodpasture, and James Brinkley

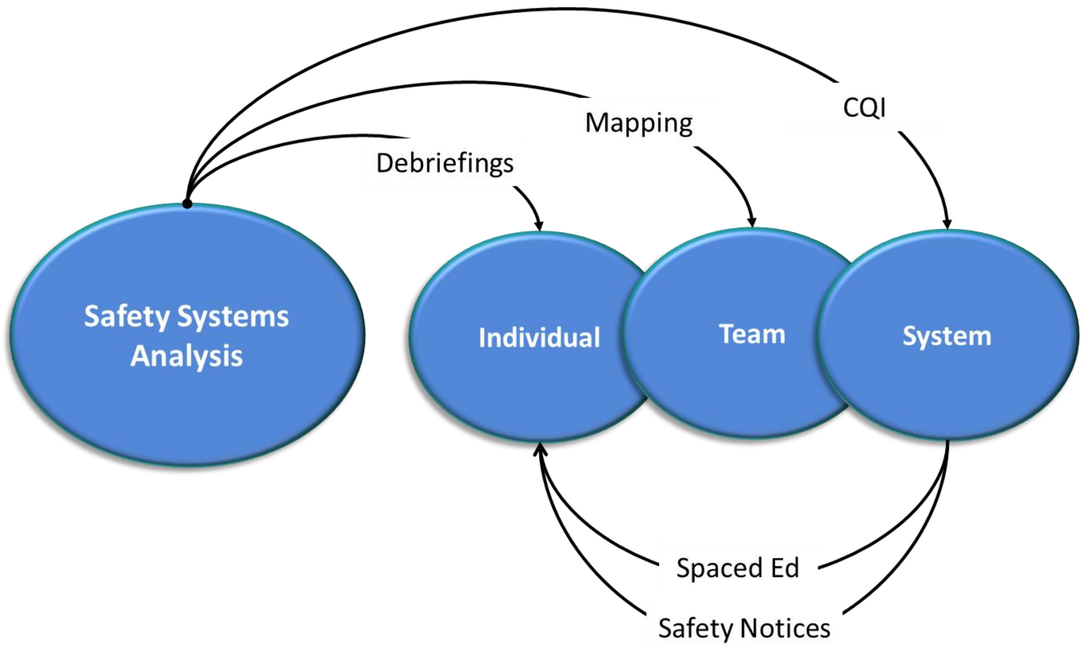
THE PURPOSE

In contrast to traditional classroom-based trainings, **spaced education** is structured as a series of concise, complex reasoning questions designed to quickly inform participants on learning objectives with questions "spaced" from several hours to several days apart and take only a few minutes to complete. **Safety Notices** are one-page documents that address common knowledge deficits discovered in critical incident review. They are disseminated formally via the attachment to applicable Departmental policies and by adding their content to existing frontline and supervisory-level trainings.

Safety Notice Topics:

- Avoiding Fentanyl Exposure
- Distinguishing Between Subutex and Suboxone
- Simple Strategies for Interviewing Children
- Using Pharmacy Records in Substance Abuse Assessment
- Access to "911" in Areas with no known Cellular Reception
- Understanding Newborn Drug Screens

Spreading Learning from Critical Incidents

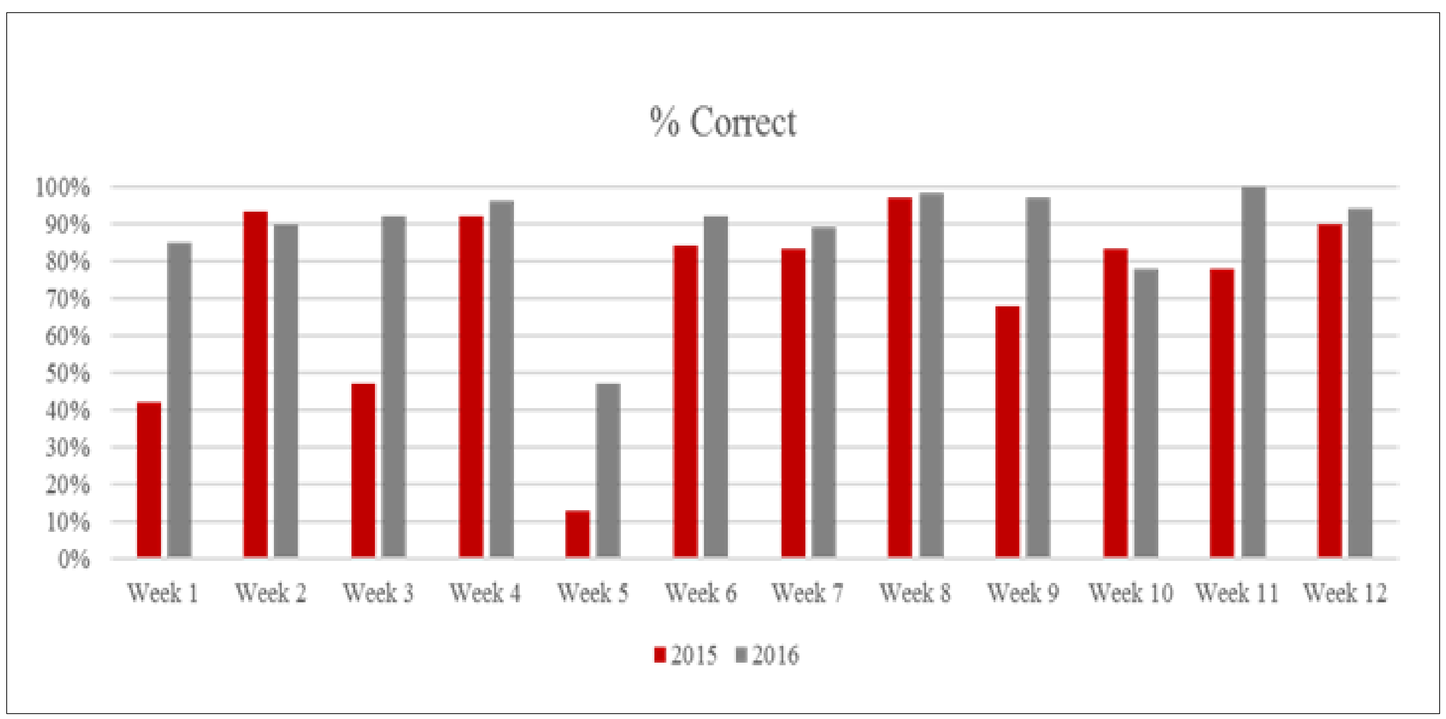


WHY SPACED EDUCATION?

- Studies show "binge" learning isn't very retainable.
- Spaced Ed activates the brain to learn differently
- "spacing effect:" stimulates ongoing learning and retention
- "testing effect:" long-term retention is drastically improved in comparison to reading alone
- Spaced education curriculums can increase knowledge as much as 50% with memory retention for up to two years (Lambert, 2009).

INITIAL FINDINGS

Studies of the Spaced Education in CY15 and CY16 showed 72% of the CY 2015 participants answered the questions correctly for all 12 weeks and 88% of the CY 2016 participants answered all questions correctly. For each year, weekly progress results indicated steady learning outcomes for child welfare workers within the topic domain of teamwork and coordination. Participant feedback revealed learners generally felt the spaced education model was helpful (2015: 87%, 2016: 78%) in keeping them up to date with proper procedures and situational awareness techniques while on the job.



Safety Organizing Strategy: SBAR

Tools for Structuring Safety-critical Communications

DeShawn Harris and Melandie Akins-Simerly

OUR GOAL

Implement a structured communication tool to support team-level mindful organizing during safety-critical case communications, such as case transfers, supervision, court reviews, and professional /legal case consultation. SBAR provides professionals with a simple tool to organize information and standardize their communicate.

During safety-critical communications, remember **SBAR**:

Situation
- ➢ What is currently happening?

Background
- ➢ What historical context is relevant to share

Assessment
- ➢ What risks do you see? What risks do others see?

Recommendation
- ➢ What would you do, and what is the next decision you believe needs to be made?

When receiving SBAR communication:

- Avoid mental distractions (e.g., cell phones, email)
- Listen intently
- Ask clarifying questions
- ***Reflect back*** *always* (and use SBAR when you do)

In all communications, remember the **"4Cs."** Communication should be **Clear, Concise, Complete,** and **Congruent**.

Story of Success #1: *Southwest Region Uses SBAR in Court*

A Breakthrough Series Collaborative team began using SBAR as a introduction/summary page for their court-ordered home studies. The local juvenile court judge had previously expressed concern the reports were too long and too much to review. Case Managers were frustrated their reports were being minimally read and worried their recommendations were not being fully considered. After using SBAR, the team reported the judge noticed the change, liked the new format, and started taking the team's recommendations more seriously, since all the most critical information was concisely contained on the front page. The judge then referred to the rest of the home study documents only as needed. The team said the change was simple and easy, and the outcomes were very positive! They hope to spread this practice to other teams throughout their region.

Story of Success #2: *Shelby Region's Investigators Use SBAR in Supervision*

A Breakthrough Series Collaborative team began using SBAR as a structure for communicating about cases during supervision. Supervisors and Investigators were both supplied with laminated SBAR cards to remind them of the structure. Investigators and supervisors report enjoying the structure and feeling like it keeps them efficient and focused on safety and making decisions about next steps in casework.

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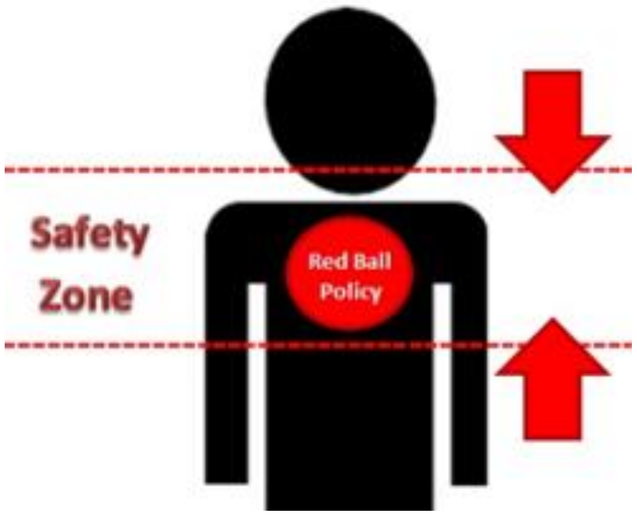
Reducing Team Stress

Creating Distraction-Free Zones and Regulating Team Stress

Charles Arms and Jaclyn Anderson

BACKGROUND

Employee turnover can range from 30% to 85% in the child welfare industry (Ellett & Millar, 2001; Jordan Institute for Families, 1999; Thomas, 1998). Burnout alone may explain more than 30% of turnover (Drake & Yadama, 1996). Poor supports and supervisory relationships may explain turnover as well (Barak, 2001; Dickinson & Perry, 2002; Rycraft, 1994). Colleagues managing stress poorly and treating one another badly may be a primary factor affecting burnout (Genovese, 2013).



OUR GOAL

Use the metaphor of the “Red Ball” to help teams externalize, identify, and regulate stress responses. Give teams freedom to conduct small tests of change and find systematic ways to reduce stress and create “distraction free zones” in casework.

The “**Red Ball**”… a metaphor for **emotions** and the **stress response**

If we think about our emotional state as a red ball, the goal is to keep it centered. Somewhere between “the head and the heart”—where feelings are energized, psychologically safe, thoughtful, and responsive. This is called the “**safety zone**.”

When the ball is too high, we may feel intense worry, respond in angry/agitated ways, sleep poorly, and make decisions too quickly. **When the ball is too low**, we may be tired, disinterested, and delay in making decisions or being responsive to others. Sometimes people **throw their ball at others** by raising their voice or speaking negatively of a colleague, and people can also **hold their ball too tightly** and become guarded– not sharing their feelings with others.

Individuals can contribute to a team’s **mindful organizing** by regulating their “red ball” and helping their teammates do the same. By acknowledging the constant presence of the “red ball,” we identify our emotional responses and can help keep ourselves and one another in the “safety zone.”

Story of Success:

Reducing Team Stress by Managing the Flow of Case Assignments

A Breakthrough Series Collaborative (BSC) team in the Smoky Mountain Region chose to reduce team stress by giving every team member one day off rotation from case assignments where an immediate response would be required. Team members worked together to chose their days off rotation and used these opportunities as **“distraction free zones”** to catch up on documentation and other caseworks tasks. Since beginning this practice, the team’s documentation, case closures, and assessment timeliness has demonstrated sustained improvement. Since the BSC began in January 2017, the team has not experienced any turnover.

Teams mindfully organize to reduce stress by:

- ✓ Creating distraction-free zones (e.g., quiet spaces)
- ✓ Listening to music
- ✓ Going for walks outside
- ✓ Opening windows; adding plants to office space
- ✓ Stretching (e.g., yoga)
- ✓ Structuring for increased teamwork during high-stress moments (i.e., avoid over taxing any one team member)
- ✓ Verbally acknowledging the “red ball” and responding mindfully to teammates

Critical Incident Review: Safety Systems Analysis

Becoming a Learning Organization and Promoting Safety Culture

Tiffany Goodpasture and Ramona Huggins

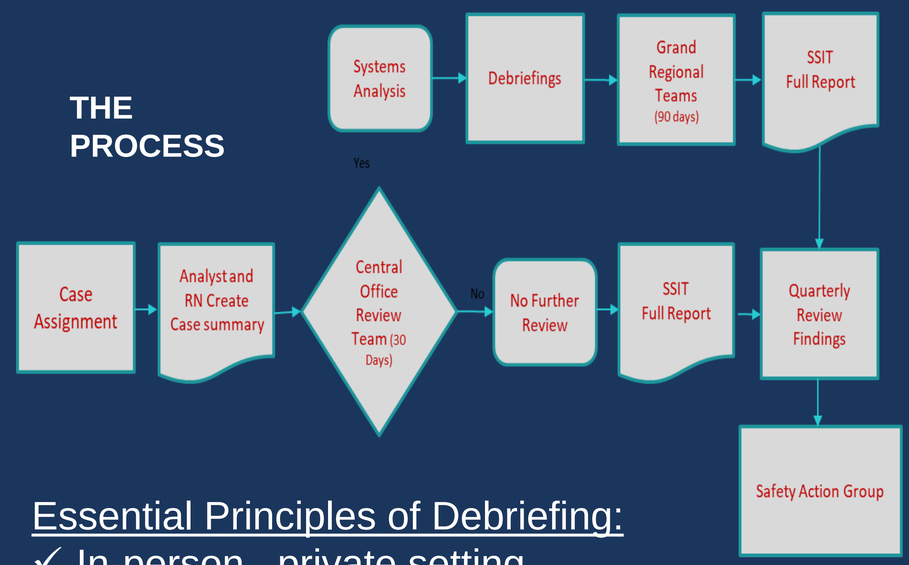
TN Department of Children's Services

Center of Excellence for Children in State Custody, Vanderbilt University Medical Center

THE PURPOSE

Child welfare work is inherently complex. It's important leaders seek to supportively learn (rather than assume) factors that influence frontline decision-making. Though such decisions alone are rarely direct causal factors in a child's death ; they may affect the overall trajectory of well-being for a child or family and are an influence of poor outcomes. To promote Safety Culture and foster organizational learning, we provide a psychologically safe environment for professionals to process, share ideas, and learn from child deaths , so we can best support quality case management practices and influence increasingly safe outcomes for children.

THE PROCESS



<u>Essential Principles of Debriefing:</u>

- ✓ In-person , private setting
- ✓ Voluntary
- ✓ Supportive Inquiry
- ✓ Seeks to Understand Systemic Context for Decisions
- ✓ Learning-focused
- ✓ Assessment-oriented (i.e., Safe Systems Improvement Tool)
- ✓ Offers EAP information

<u>Grand Regional Systems Analysis Teams:</u>

- ✓ Multi-disciplinary
- ✓ Attended by field professional, regional leaders, and external partners
- ✓ Focused on personal and organizational learning
- ✓ Use an **accimap (see below)** to ascertain systemic effectors of problems (i.e., findings)

Safe Systems Improvement Tool

3. TEAM DOMAIN

This section focuses on factors primarily present within teams. The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisor's unique role in supporting the professional. This domain is not exclusive to factors only present among internal teams; collaboration with relevant community partners is assessed as well.

Question to Consider for this Domain:

For the TEAM DOMAIN, use the following categories and action levels:

0 No evidence, no need for action.
1 Latent factor.
2 Action needed to mitigate risk and avoid reoccurrence.
3 Immediate or intensive action required to prevent recurrence.

Safe Systems Improvement Tool 8 | Page

Professional

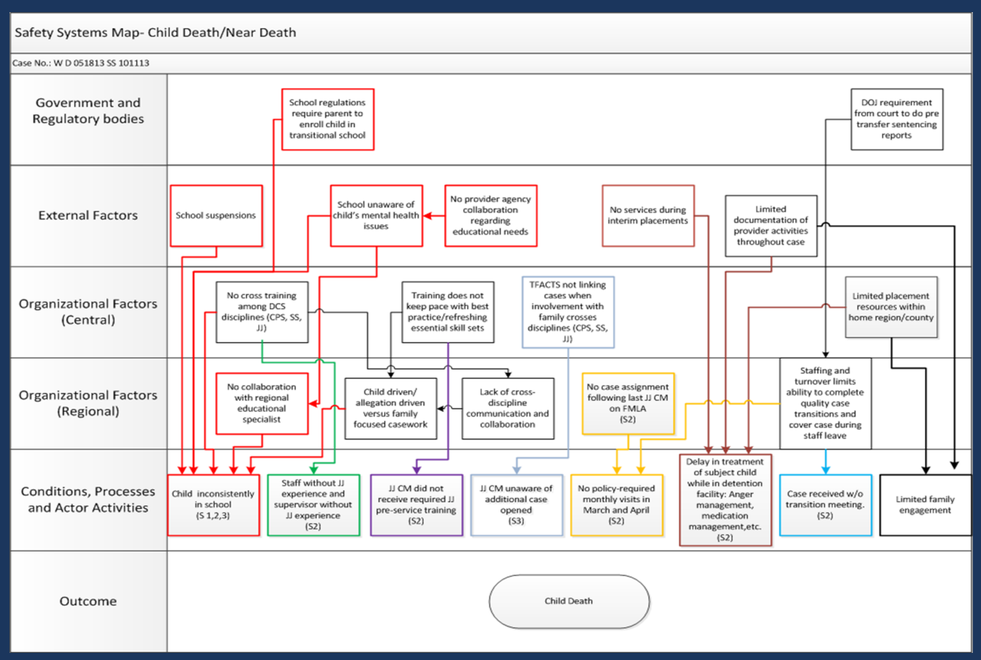
1. Cognitive Fixation
2. Stress
3. Fatigue
4. Knowledge Deficit
5. Documentation
6. Evidence

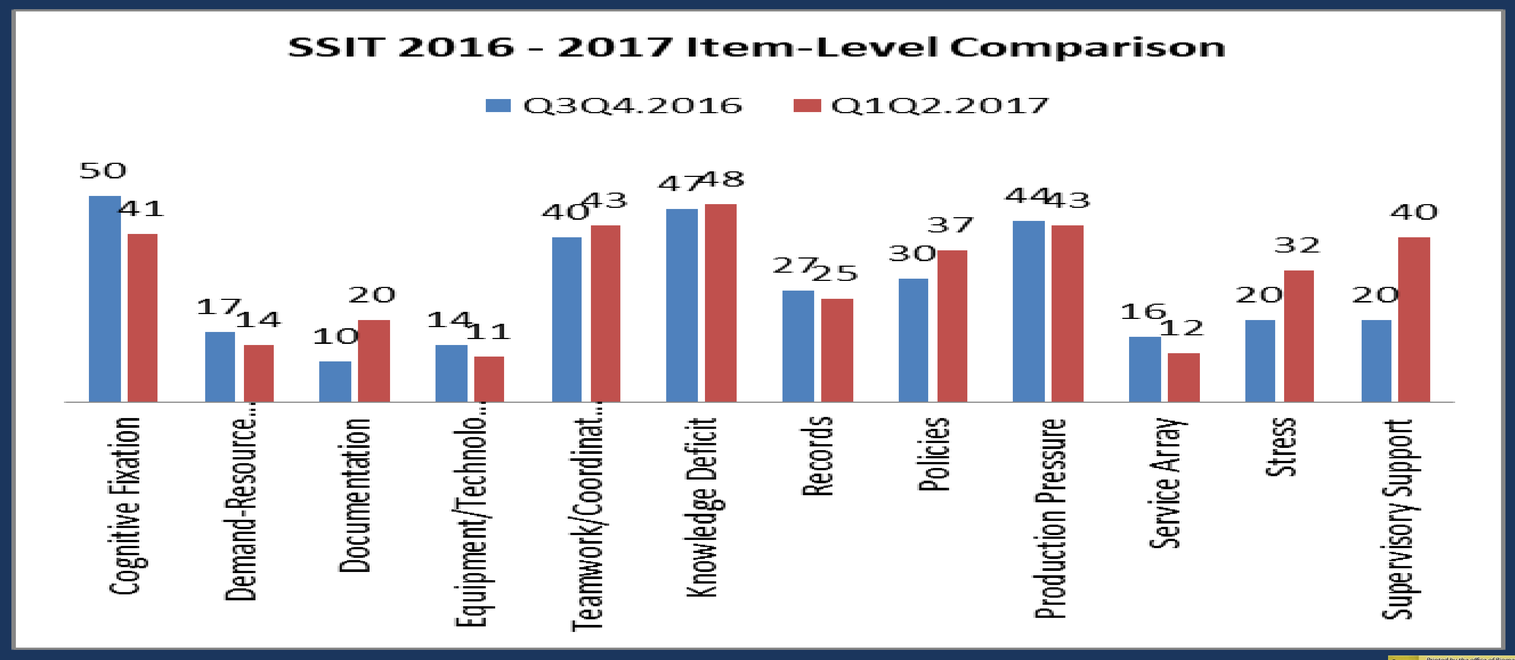
Team

1. Teamwork/Coordination
2. Supervisory Support
3. Production Pressure

Environment

1. Demand-Resource Mismatch
2. Technology/Equipment
3. Policies
4. Service Array





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