PROVIDING INFORMAL FEEDBACK: AN INTERACTIVE WORKSHOP

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Patient Safety Academy

Objectives

• At the end of the presentation you should be able to explain the concepts and importance of providing informal feedback as well as perform the activity
Raise Your Hands

• Who here is a member of a team?
• Who is on your team?
• What is feedback?
• Have you given or received informal feedback?

Informal Feedback

* Informal - having a relaxed, friendly, or unofficial style, manner, or nature

* Feedback - helpful information or criticism that is given to someone to say what can be done to improve a performance, product, etc

• Team training
• Business
• Education (including physician training)
TJC Root Cause Sentinel Event Data

70% of Sentinel Events involve communication issues

<table>
<thead>
<tr>
<th></th>
<th>2013 (N=887)</th>
<th>2014 (N=764)</th>
<th>2015 (N=936)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Factors</td>
<td>635</td>
<td>547</td>
<td>Human Factors 999</td>
</tr>
<tr>
<td>Communication</td>
<td>563</td>
<td>Leadership 517</td>
<td>Leadership 849</td>
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<tr>
<td>Leadership</td>
<td>547</td>
<td>Communication 489</td>
<td>Communication 744</td>
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<tr>
<td>Assessment</td>
<td>505</td>
<td>Assessment 392</td>
<td>Assessment 545</td>
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<tr>
<td>Information Management</td>
<td>155</td>
<td>Physical Environment 115</td>
<td>Physical Environment 202</td>
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<td>Physical Environment</td>
<td>138</td>
<td>Information Management 72</td>
<td>Health information technology-related 125</td>
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<tr>
<td>Care Planning</td>
<td>103</td>
<td>Care Planning 72</td>
<td>Care Planning 75</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>97</td>
<td>Health Information Technology-related 59</td>
<td>Operative Care 62</td>
</tr>
<tr>
<td>Medication Use</td>
<td>77</td>
<td>Operative Care 58</td>
<td>Medication Use 60</td>
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<tr>
<td>Operative Care</td>
<td>76</td>
<td>Continuum of Care 57</td>
<td>Information Management 52</td>
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</tbody>
</table>

Maine Sentinel Event Data

2014 Sentinel Event Data for Maine
Communication Failures

32% of Nursing cases involve one or more communication error.

CRICO Benchmarking Report*

Harm to Healthcare Workers

Impact of Disrespectful Behavior on Patient Safety

- 70% Linked behaviors to medical error and poor quality of care
- 65% Linked behaviors to an adverse event
- 50% Reported that patient safety was compromised
- 25% Linked behaviors to patient mortality

- 34% of nurses meet the criteria for severe exhaustion or burnout
- Surgeon burnout linked to medical error

OSHA and ISMP Survey*
Diagnostic Error

• For the last several years there have been more outpatient claims than inpatient and ED claims combined
• The vast majority of these claims are around diagnostic failure (missed/delayed)

The Diagnostic Process

• 58% of cases involve assessment failures
  – Voids in physician’s evaluation of the patient’s history, presentation, differential diagnosis, and test ordering
• 29% testing failures
  – Breakdowns in clinical systems for test result management, interpretation, and communication of results
• 46% follow-up failures
  – Breakdowns in communication among caregivers and failure to involve specialty consultation
Communication and Team Training

Communication and human factors are the top root causes of patient harm, and team training addresses both of these issues

• Team-training can positively impact healthcare team processes and patient outcomes
• Toolkits are available to support intervention development and implementation
• Bundled team-training interventions and implementation strategies that embed effective teamwork as a foundation for other improvement efforts may offer greatest impact on patient outcomes
  *BMJ Quality and Safety February 5, 2014: “Team-training in healthcare: a narrative synthesis of the literature”

• Team-training improved communication, task coordination and perceptions of efficiency, quality, safety and interactions among team members as well as patient perception of care coordination
  *BMJ Quality and Safety 2013: *High performance teamwork training and systems redesign in outpatient oncology*

Team Training

Team STEPPS Framework

Outcomes

• Shared mental model—anticipating and predicting each others’ needs
• Adaptability—identify opportunities for improvement and innovation for routine practices
• Team orientation—taking into account alternative solutions provided by teammates to determine what is most correct
• Mutual trust—willingness to admit mistakes and accept feedback
• Team performance—increased information sharing and goal setting
• Increased patient safety—minimizing the incidence and impact of and maximizing recovery from adverse events
Mutual Support

Ability to anticipate and support team members’ needs through accurate knowledge about their responsibilities and workload.

<table>
<thead>
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<tbody>
<tr>
<td>22. Staff assist fellow staff during high workload.</td>
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<tr>
<td>23. Staff request assistance from fellow staff when they feel overwhelmed.</td>
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<tr>
<td>24. Staff caution each other about potentially dangerous situations.</td>
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<tr>
<td>25. Feedback between staff is delivered in a way that promotes positive interactions and future change.</td>
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<tr>
<td>26. Staff advocate for patients even when their opinion conflicts with that of a senior member of the unit.</td>
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<tr>
<td>27. When staff have a concern about patient safety, they challenge others until they are sure the concern has been heard.</td>
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<tr>
<td>28. Staff resolve their conflicts, even when the conflicts have become personal.</td>
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</tbody>
</table>

Team STEPPS*

Defining The Team

- The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable. 

IHI*
Patient Safety Culture Results

Communication Openness

Staff speak up about problems, share their ideas and suggestions, and feel free to question those with more authority
Purpose of Feedback

• Foster open communication and enhance teamwork
• Strengthen your rapport with coworkers/patients
• Redirect undesirable behavior
• Motivate and inspire a higher level of performance
• Contribute to others learning and development

Harvard Business Review: Giving Effective Feedback*

Effective Feedback

• Shared Frequently and in context (timely)
• Aims to achieve a specific outcome
• Realistic in its expectations
• Respectful
• A two-way conversation
• Expressed as a point of view, rather than an absolute truth
• Directed towards improvement
• Assumes opportunity for follow-up

Harvard Business Review: Giving Effective Feedback*
Barriers To Feedback

- Worry that feedback will make recipient dislike you or strain relationship
  - Fear an awkward or volatile situation
- Recall instances in the past when feedback was not well received
- Assume the recipient cannot handle feedback
  - The person is too stuck in their ways
- HIPAA

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When To Provide Feedback

Feedback is useful:
- When good work and resourceful behavior deserves to be recognized
- When improving skills are high and likelihood of skills again is imminent
- When the person is expecting feedback
- When a problem cannot be ignored

Feedback can be detrimental:
- When you do not have all the information
- When feedback involves factors recipient cannot easily change
- When the person who needs feedback appears highly emotional
- When you do not have the time or patience to deliver it calmly
- When feedback is based on personal preference
Influencing Behavior

- Easy To Influence
- Difficult To Influence

| Job Skills | Time and Work MGT | Knowledge | Attitudes | Habits | Personality |

Harvard Business Review: Giving Effective Feedback*

Where and How to Provide Informal Feedback

- Pick a quiet spot/neutral location
- Gather all the information available about the behavior
  - What will you do if recipient objects to facts of shares additional evidence
- Create a discussion plan
  - Craft responses to anticipated reactions
- Prepare yourself to listen
  - Anticipate questions and possible responses
- What do you want to get out of the discussion?
  - Long term/short term
- Develop an action plan

Harvard Business Review: Giving Effective Feedback*
Planning a Feedback Session

Examples:

• Communication Failure
  – Patient condition
  – Documentation
• Disrespectful behavior
• Diagnostic error

Providing Feedback

• Deliver the feedback
• Self Assessment
  – What worked
  – What could be improved
Contact Information

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This presentation is not intended to replace specific legal advice from an attorney. It is an educational program expressing views and opinions using generally acceptable risk management methodology.