

Kommunikation - behöver vi det i framtiden?

- eller hur vi kan förbättra kvaliteten på interprofessionell kommunikation?
- eller samarbetsträning, en framgångsfaktor för intensivvården?

- **Cecilia Escher** överläkare, simulatorinstruktör
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Karolinska Universitetssjukhuset,
Huddinge

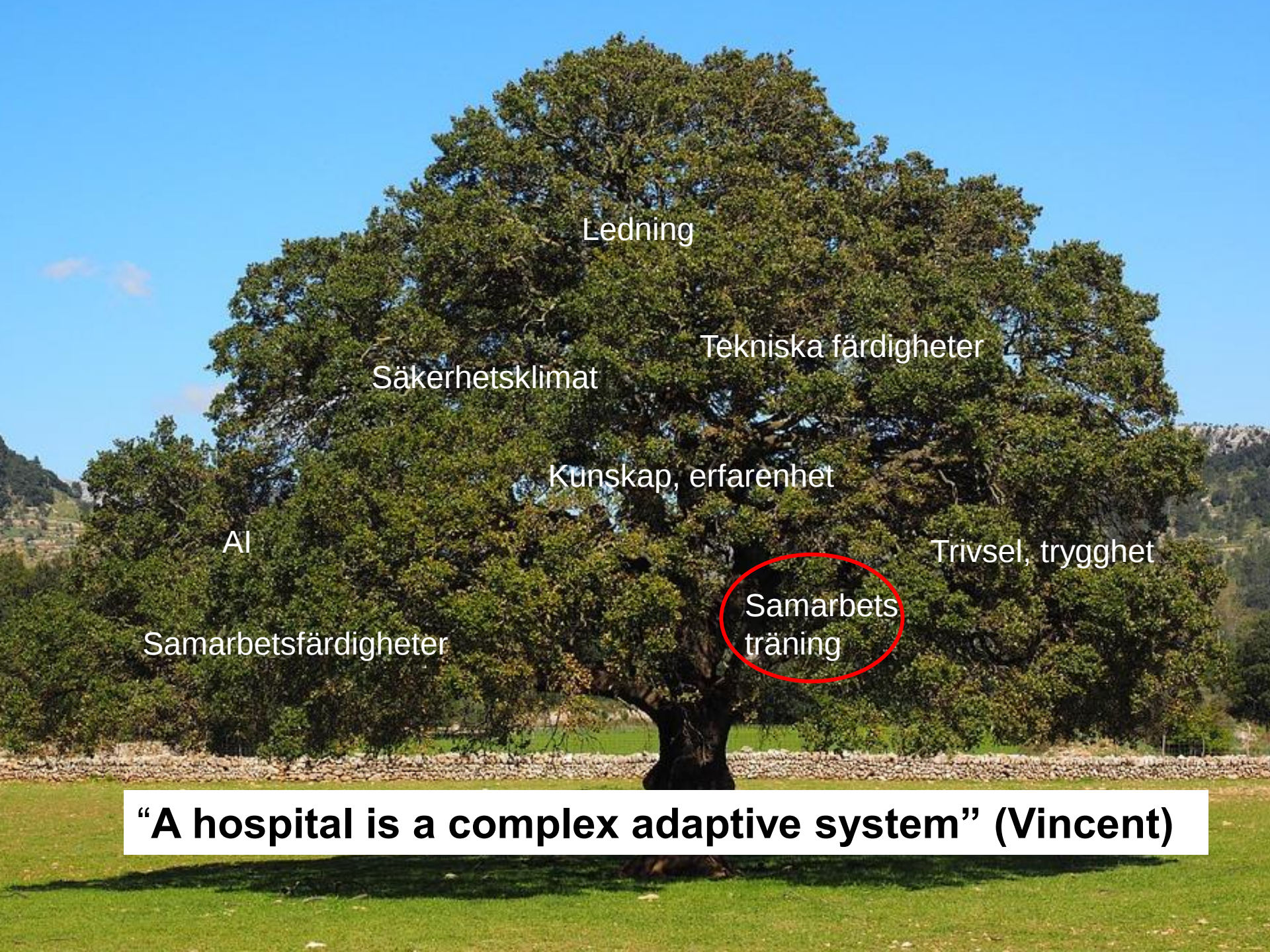




Disposition

- Evidens för samarbetsträning – vad vet vi?
- Praktiska aspekter, utmaningar, möjligheter.
Erfarenheter från IVA Huddinge





Ledning

Tekniska färdigheter

Säkerhetsklimat

Kunskap, erfarenhet

AI

Trivsel, trygghet

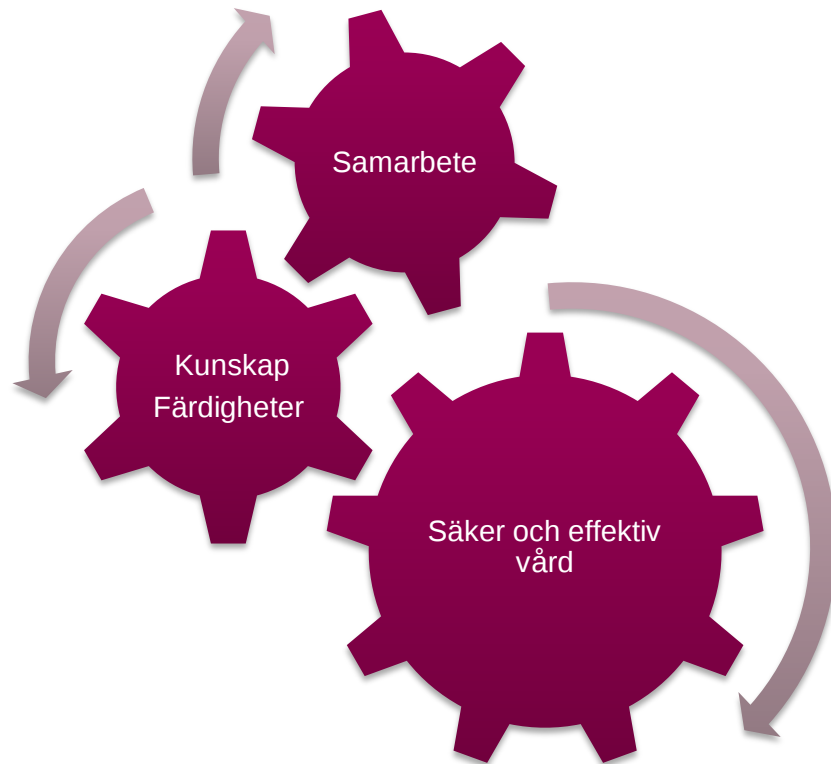
Samarbetsfärdigheter

Samarbets
träning

“A hospital is a complex adaptive system” (Vincent)



Säker intensivvård även vid oväntade händelser



Evidens

Det finns forskning som påvisar samband mellan bra samarbete och goda resultat för patienter

Det finns även samband mellan dålig kommunikation / samarbete och patientskador

Träning kan förbättra: upplevd kvalitet på samarbete, patientsäkerhetsindikatorer, stress...

IVA projektet Huddinge - Lisbet Meurling

Ref: Huang DT et al. Intensive care unit safety culture and outcomes: a US multicenter study. International Journal for Quality in Health Care. 2010;22:151-61.

Singer S, Lin S, Falwell A, Gaba D, Baker L. Relationship of Safety Climate and Safety Performance in Hospitals. Health Services Research. 2009;44:399-421

Meurling L, et al. BMJ Qual Saf 2013;22:485–494.

Sandahl et al. Int. J. Of Health Care Quality Ass.2013;26;174-188

Samarbetsträning som forskningsprojekt

Downloaded from <http://qualitysafety.bmj.com/> on March 22, 2017 - Published by group.bmj.com

ORIGINAL RESEARCH



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Systematic simulation-based team training in a Swedish intensive care unit: a diverse response among critical care professions

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ABSTRACT

Background Teamwork—that is, collaboration and communication—is an important factor for safe healthcare, but professions perceive the quality of teamwork differently.

Objective To examine the relationship between simulation-based team training (SBTT) and different professions' self-efficacy, experienced quality of collaboration and communication, perceptions of teamwork and safety, together with staff turnover.

Methods All staff (n=151; physicians, nurses and nurse assistants) in an intensive care unit (ICU) at a university hospital were systematically trained over 2 years. Data on individual self-efficacy were measured using the self-

and inter-correlations for the SAQ factors showed lower values than benchmarking data.

Conclusions All team members benefited from the SBTT in an authentic composed team, but this was expressed differently for the respective professions.

INTRODUCTION

Improving patient safety is a challenge for healthcare. Teamwork has been recognised as an important factor for patient safety, and staff perception of teamwork is related to the quality and safety of care.^{1–3} Healthcare professions have discrepant attitudes about teamwork: physicians seem more pleased than nurses with nurse-physician collaboration. Teamwork is a complex



3 delad intervention 2007-2009

- Seminarier
- Heldag med interprofessionell simulatorbaserad träning på IVA.
- Träningsmål: samarbete, kommunikation och medicinskt omhändertagande
- Uppföljande seminarium





Vi ser olika på kommunikation !

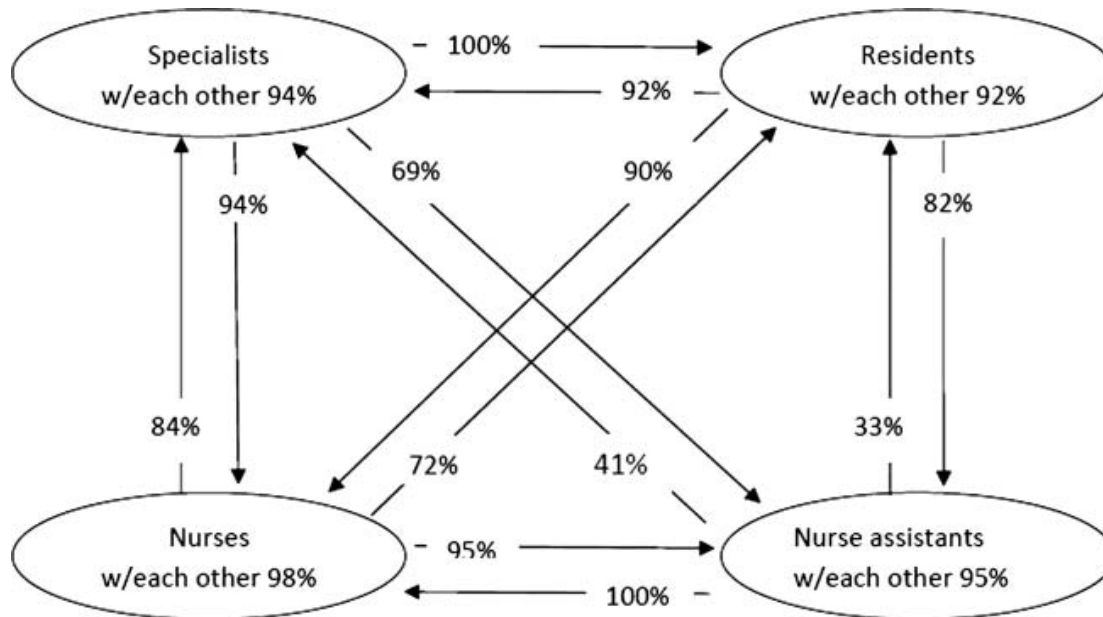


Figure 2 Percentage of each profession reporting 'high' or 'very high' level of collaboration/communication with other members of the intensive care team before simulation-based team training.

Samarbetsträning kan förändra...

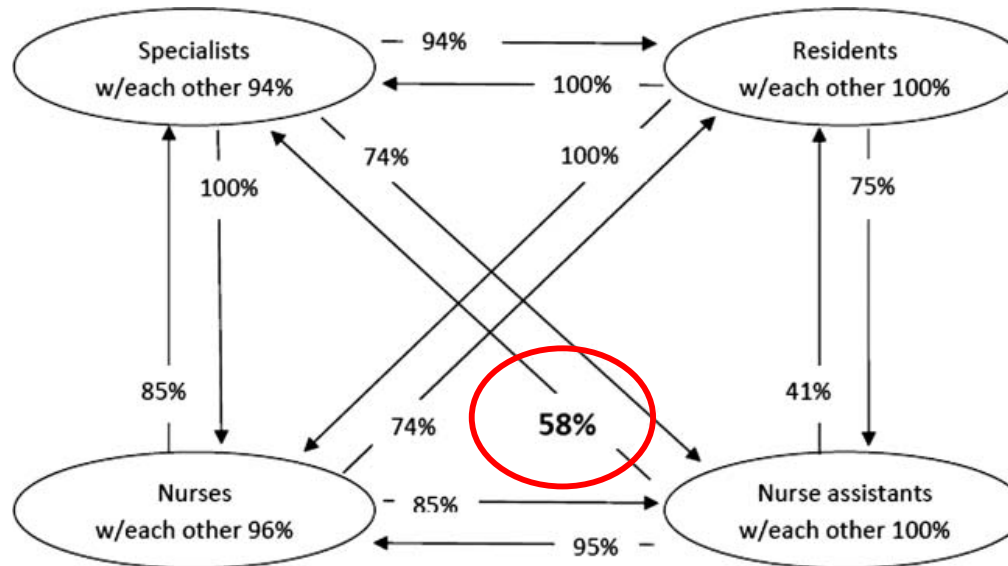
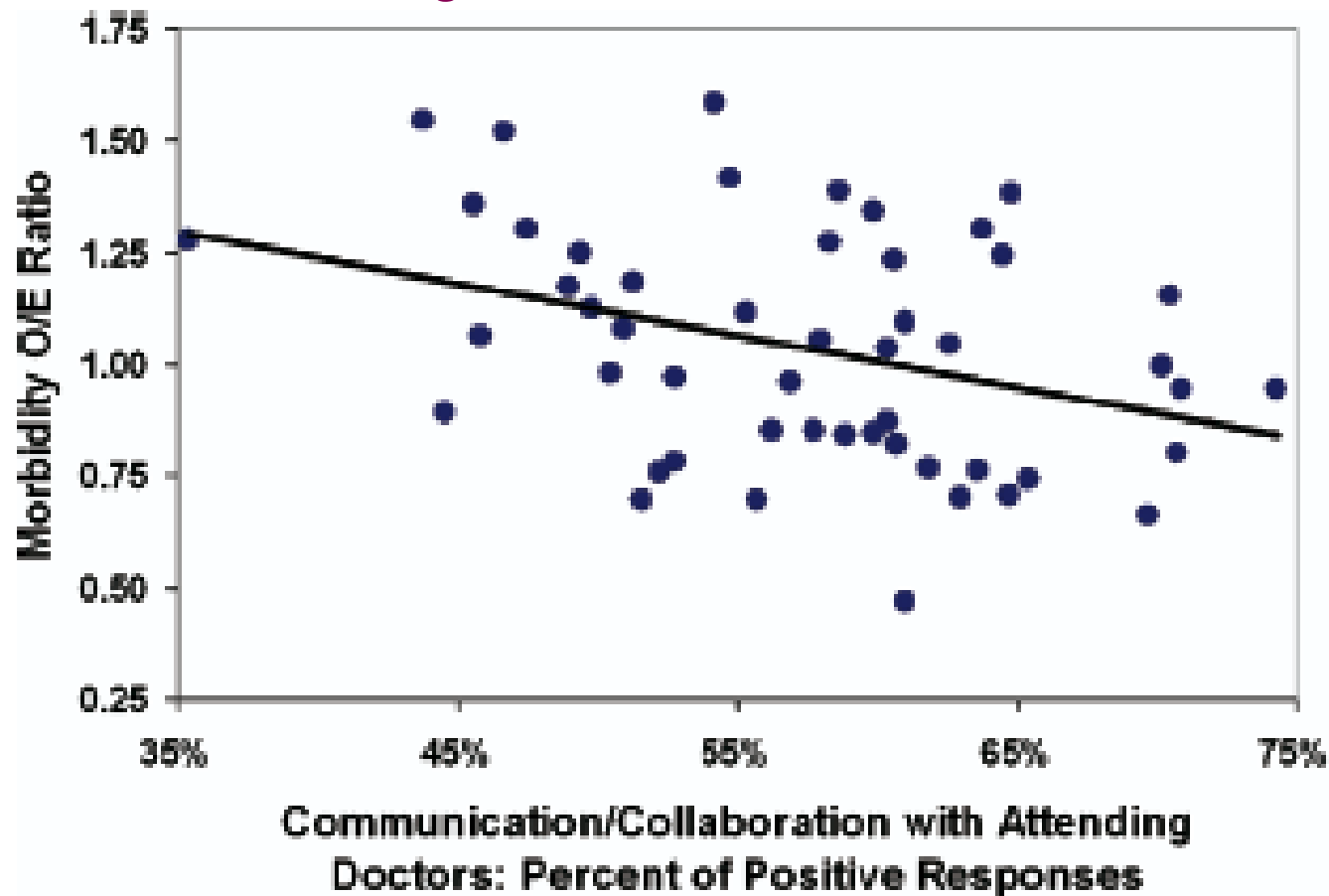


Figure 3 Percentage of each profession reporting 'high' or 'very high' level of collaboration/communication with other members of the intensive care team. Compared to data before simulation-based team training (figure 2) the only difference was registered for nurse assistants who reported a better collaboration/communication with specialists (58% vs 41%, $p=0.04$).



Kvalitet på kommunikation mellan läkare och sjuksköterskor och överlevnad efter kirurgi





Analys av projektet genom kvalitativa intervjuer

IJHCQA
26,2

174

Received 20 January 2012
Revised 13 March 2012
19 March 2012
Accepted 22 March 2012

23 March 2017 (PT)

Simulation team training for improved teamwork in an intensive care unit

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Abstract

Conclusions

It appears that in situ simulator-based MTT has many advantages, but this approach will not contribute to lasting change, unless senior management ensures that physicians can be actively involved. Improved communication and inter-professional collaboration can result in a demand for regular meetings for debriefing and feedback. If management supports such a development, it will most likely contribute to a cultural change that will facilitate learning, teamwork, and leadership. The policy for



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Health Services Research



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DOI: 10.1111/1475-6773.12592
PATIENT SAFETY & MEDICAL LIABILITY

Exempel på en STOR intervention..

Integrated Approach to Reduce Perinatal
Adverse Events: Standardized Processes,
Interdisciplinary Teamwork Training,
and Performance Feedback

William Riley, James W. Begun, Les Meredith, Kristi K. Miller,
Kathy Connolly, Rebecca Price, Janet H. Muri, Mac McCullough,
and Stanley Davis

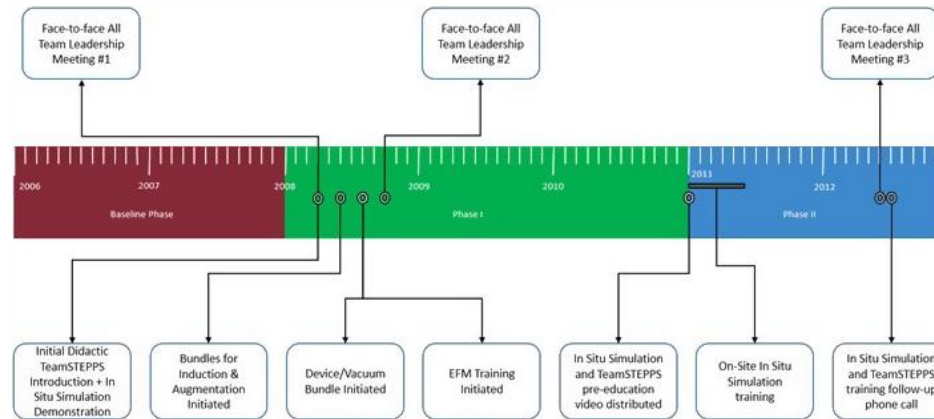
14 förlossningsenheter

50000 förlossningar/år 2 år baseline, 5 år intervention

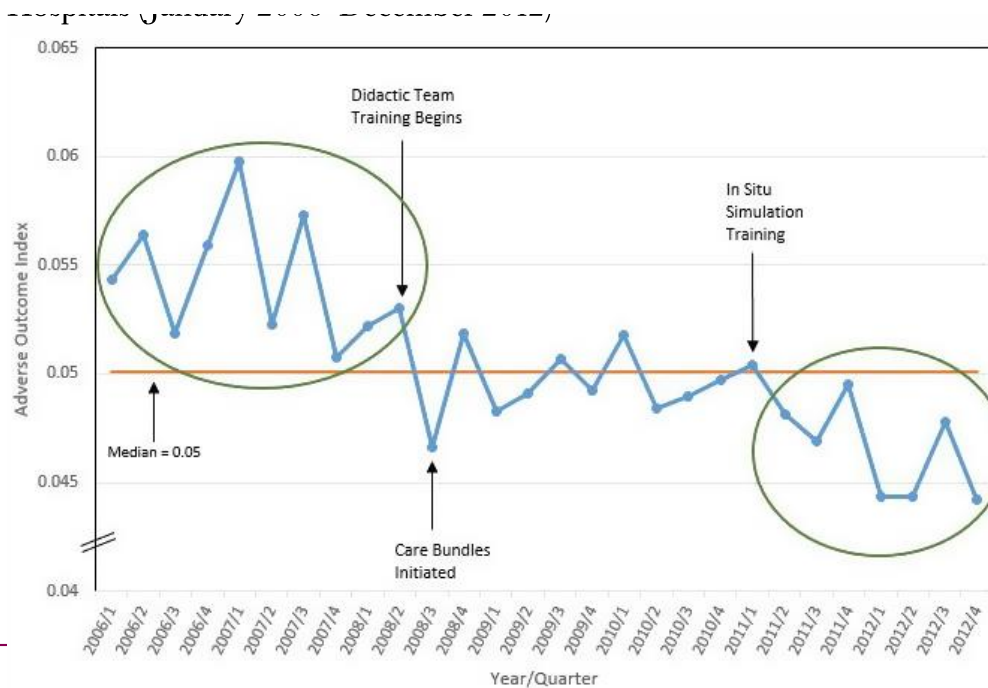
Teori: Rutiner vid sugklocka och induktion av förlossning

Träning med fokus på samarbete och kommunikation

Utfallsmått: AOI (Adverse outcome index) inkluderar t ex blodtransfusion,
uterusruptur, svår förlossningsskada



Notes. The timeline depicts the dates of meetings and intervention implementation that occurred during the 7-year project. On-site *in situ* simulation training occurred from January to June 2011.



Resultat: AOI
Minskade med 14 %
P=0.03



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Kan simulatorträning påverka personalens hälsa?



Stress hos intensivvårds sjuksköterskor

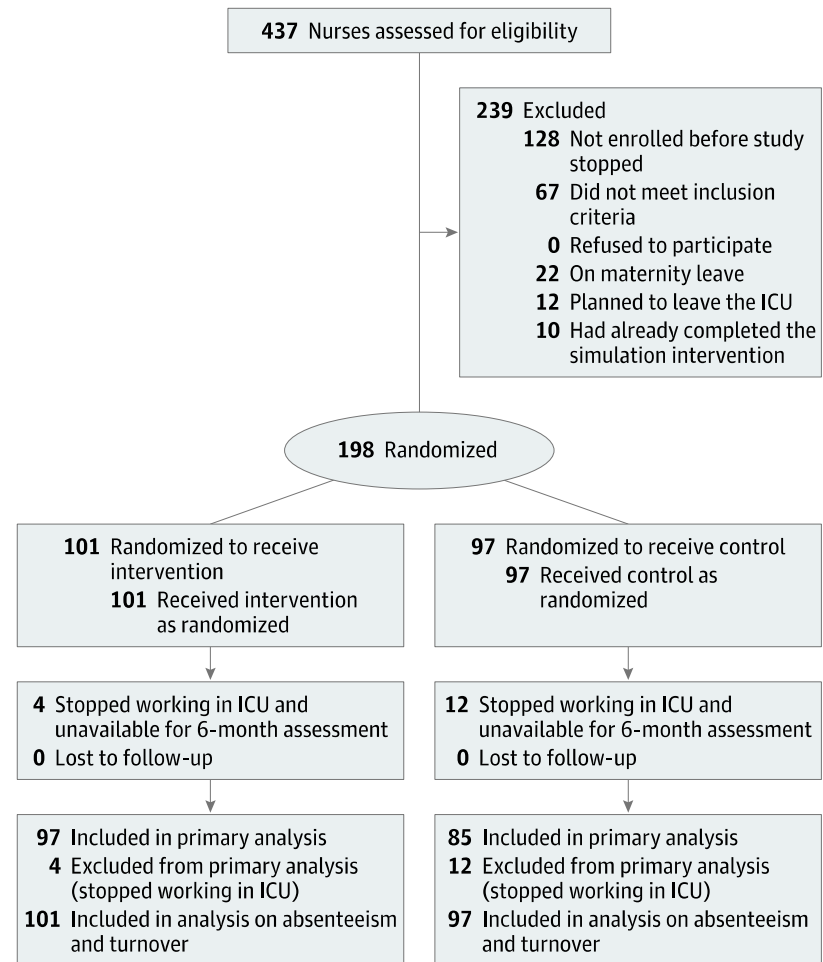
JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Effects of a Multimodal Program Including Simulation on Job Strain Among Nurses Working in Intensive Care Units A Randomized Clinical Trial

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Intervention:
5 dagars kurs med simulering
och teori

Figure. Flow of Intensive Care Unit (ICU) Nurses Through the Trial



RESULTS Among 198 ICU nurses who were randomized (95 aged ≤ 30 years [48%] and 115 women [58%]), 182 (92%) completed the trial for the primary outcome. The trial was stopped for efficacy at the scheduled interim analysis after enrollment of 198 participants. The prevalence of job strain at 6 months was lower in the intervention group than in the control group (13% vs 67%, respectively; between-group difference, 54% [95% CI, 40%-64%]; $P < .001$). Absenteeism during the 6-month follow-up period was 1% in the intervention group compared with 8% in the control group (between-group difference, 7% [95% CI, 1%-15%]; $P = .03$). Four nurses (4%) from the intervention group left the ICU during the 6-month follow-up period compared with 12 nurses (12%) from the control group (between-group difference, 8% [95% CI, 0%-17%]; $P = .04$).

- Lägre frånvaro, lägre “jobstress” och färre som slutade vid uppföljning 6 månader efter kursen
 - Kostnad 2000 Euro/person
-

Second Victims in Swedish Obstetrics

ÅSA WAHLBERG



We examined self-reported exposure to severe events in a survey among 1459 midwives and 706 obstetricians. A severe event was defined as severe injury or death to a mother or child or other stressful events, such as threats or violence, during delivery. Of the midwives and obstetricians who responded, 71% and 84%, respectively, had experienced one or several severe events during their career. Post-traumatic stress symptoms following the perceived worst event were measured. Fifteen percent of the midwives and obstetricians reported symptoms equivalent to partial post-traumatic stress disorder (PTSD), and 5% of the midwives and 7% of the obstetricians reported symptoms commensurable with PTSD. Increased risk was correlated with emotions of guilt, and negative experience or support from friends. Professionals with partial PTSD left delivery care significantly more often than their less traumatised colleagues.

Experiences of severe events were furthermore investigated using qualitative content



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Kan träning vara kostnadseffektiv ?

Article

What Is the Return on Investment for Implementation of a Crew Resource Management Program at an Academic Medical Center?

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American
College of
Medical
Quality

American Journal of Medical Quality

1-7

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DOI: 10.1177/1062860615608938

ajmq.sagepub.com



Table 2. Implementation Costs and Yearly Ongoing Expenses for the Crew Resource Management Program.^a

	Implementation Phase; July 2009 to July 2012	Yearly Ongoing Expenses; August 2012 to July 2013
Training	\$652 000	\$100 000
Programmatic fixed costs	\$100 000	\$148 000
Physician time away from work	\$640 000	\$480 000
Nurse (RN) time away from work	\$960 000	\$320 000
Leadership time	\$91 000	\$66 000
Total	\$2 443 000	\$1 114 000

^aProgrammatic fixed costs include 1 full-time employee (FTE) in the implementation phase and 1.25 FTE plus data analysis assistance in yearly ongoing expenses.

Table 3. Avoidable Adverse Events in the Fiscal Year (FY) Prior to CRM Implementation and 3 Years After.

Categories of Adverse Events	Number of Avoidable Adverse Events				Actual Events; FY 2011 to FY 2013	Expected Total ^b ; FY 2011 and FY 2013	# Fewer Events
	Baseline FY 2010 ^a	FY 2011	FY 2012	FY 2013			
Severe falls	41	27	50	43	120	123	3
VAP	116	60	26	44	130	348	218
HA-DU	151	131	147	91	369	453	84
HA-SSI	154	153	105	132	390	462	72
HA-CDI	163	179	267	235	681	489	-192
ME w/ Harm	176	124	71	19	214	528	314
CLABSI	154	96	65	65	226	462	236
Total	955	770	731	629	2130	2865	735

Abbreviations: CLABSI, central line-associated bloodstream infection; CRM, crew resource management; HA-CDI, hospital-acquired *Clostridium difficile* infection; HA-DU, hospital-acquired decubitus ulcer; HA-SSI, hospital-acquired surgical site infection; ME w/ Harm, medication events with harm; VAP, ventilator-associated pneumonia.

^aBaseline is the fiscal year prior to CRM implementation (July 2009 to August 2010).

^bThe Expected Total is assuming the same yearly total as the baseline year.



Vilka evidens finns?

- Troligen bäst effekt med “bundles” dvs. interventioner där flera delar ingår t ex: teoretisk/ färdighets träning och samarbetsträning
 - Kvalitet på samarbete (läkare sjuksköterskor undersköterskor) kan påverkas och har sannolikt betydelse
 - Kostnadseffektivitet – sannolikt men vilken är den “bästa interventionen?”
 - Nytt fält där arbetsmiljö, utmattning, stress, patientsäkerhet och samarbete belyses...
-



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Var står vi nu på IVA Huddinge?



- 2007-2009 IVA HS alla deltog, 3 delar (seminarier, träning, uppföljning)
- 2010-2012 CIVA Solna (seminarier, träning)
- Huddinge 2013-2015 heldagsträning igen. Sedan dess halvdagsträning. Senast inför temporär flytt av IVA till Interim IVA våren 2018



Simulering i nya lokaler

- Farhågor: POP nya lokaler, långa avstånd, uppbyggda väggar emellan patientplatserna, hittar inte.
- 1 dag, 3 grupper, minst 6 personer/grupp, 2tim per grupp.
- Kort intro, genomgång av hot spots.
- 2st scenarion, ett överraskningsmoment, ett MIG-larm
- Hjärtstopp i den mest avlägsna rummet



Scenario nr 2

- MIG-Sökning-patient med resp & cirk svikt
- Förberedelse tid 5-10min
- Förväntad handling
- Minst 2 läkare intubationsvana vid intubation på IVA

Briefing
Rapport
Ledarskifte/ledare/följare
Repetera rapport
Rollfördelning
A-B-C-D-E undersökn
Stabilisera vitala
parametrar
Sammanfattning
Time-Out
Avslut





Time-out för säkert samarbete IVA

Ta sin roll i laget, kommunicera, skapa gemensam förståelse, ta beslut och samordna

Före ankomst av patient
Före behandling/procedur

Förberedelse

- Presentation
- Klargör tänkt plan / procedur
- Information om patienten?
- Riskbedömning / Plan B
- Kontroll av utrustning
- Rollfördelning
Behov av ytterligare resurser?
- Frågor?

Under pågående behandling/procedur

Avstämningar

- Reevaluering (ABCDE)
- Revidera planen?

Efter avslutad behandling/procedur

Avslutning

- Målet uppnått?
- Fortsatt plan
- Vad gick bra?
- Vad kan vi förbättra?

Time-out ska utföras

vid situationer där fler personer är involverade (ett team) och där det kan föreligga en risk för patienten t.ex. inför:

- Intubation, bronkoskopi, cvk/cdk-inläggning
- Ny patient
- Transporter
- Externa vårdgivare t.ex. rtg, trakeotomi, ECMO

Vi arbetar i ett team där allas iakttagelser är viktiga!

Vår upplevelse av hur träningen har påverkat vår IVA

- Struktur  och stressnivå  vid akuta situationer
- Bättre samtalsklimat, teamkänsla och trivsel.
- Mer reflektion
- Implementering av nya rutiner (time out, 2 intubatörer)
- Medvetenhet av att vi alla är felbara människor som måste hjälpas åt för att kunna leverera den bästa vården





Utmaningar och framgångsfaktorer

- Ledningens stöd
- Logistik och planering
- Instruktorer - attityd
- Långsiktighet

