

# A PRACTICAL APPROACH TO OBSERVATION OF THE EMERGENCY CARE SETTING

**Authors:** Susan M. Hohenhaus, MA, RN, FAEN, Stephen Powell, MS, and Robert Haskins, BS

**Section Editor:** Susan McDaniel Hohenhaus, MA, RN, FAEN

*"More is missed by not looking than by not knowing."*

-Dr. Thomas McCrae

The most astute clinicians would have to admit to occasionally being caught unaware by looking without seeing. We are trained to collect and analyze data, but we often make clinical decisions based on past experiences and shared anecdotes from our colleagues, as well as learned scholars and teachers. We also know that to care for a sick patient, we must conduct an observational assessment of what is happening, as well as what is not happening, to that patient. The same applies when attempting to diagnose, treat and heal a "sick" healthcare system.

Health care teamwork training, which contains modified elements of crew resource management (CRM) and the science of teamwork, is being suggested as a method for improving teamwork between disciplines that could lead to a reduction in medical error.<sup>1</sup> Airline pilots are evaluated for teamwork competencies by trained observers during actual flight conditions as well as in simulation. In our experience, learned from both aviation and healthcare, survey self-reporting and didactic training with traditional methods of evaluation (ie, written testing) are limited in ability to identify threats to safety thoroughly, especially when services are delivered by teams rather than individuals. To detect changes in behavior, direct observation of the healthcare team in the "living laboratory" of the clinical setting has been confirmed as an additional methodology that helps to identify and analyze these threats and op-

portunities for improvement as well as the existing safety culture.<sup>2</sup> Observations before structured teamwork training initiatives can identify specific teamwork opportunities to customize training content; observations after training measure team behavioral change. Observations do not consist of simply standing in a room and watching the clinical milieu. Observational methodology must be taught, nurtured, and encouraged, as well as held to the highest standards, as in any other scientific discipline.

## Our Observation "Basics"

The purpose of observation in the clinical setting is to gather useful data that leads to recommendations for system improvement. But who should actually conduct the observations? In our experience, an observer team consisting of a clinician (nurse, physician, and technician) and a human factors expert is a powerful team, especially when using a standardized observational assessment tool. The teamwork assessment observational tool (Table) can be used to identify threats to patient safety during hand-offs, resuscitations, or other critical events in the ED, both critical and routine, and includes observations for related team behaviors and events such as change of shift.<sup>3</sup>

Our observations occur during varied dates, days of the week, and times of day, including nights, weekends, and holidays. Health care is not a predictable business and requires observation during peak and low productivity times. In our experience, it is in these "off" hours that front line staff members are more comfortable disclosing issues of discomfort and anxiety that they experience.

The greatest challenge in conducting direct observation in the healthcare setting is that it must be accomplished during the active practice of patient care. Observers should establish "up front" with staff that they do not wish to interfere with clinical care. We are also very clear in explaining that we never collect identifying information, nor are we "evaluating" any one individual. An introduction of the observer made by a local member of the team has been the best method for our observer integration within a unit and team environment. The observer should be a skilled communicator and have the ability to quickly establish trust. No one should be observed without express permission,

The opinions expressed are those of the respondents and should not be construed as the official position of the institution, ENA, or the Journal.

Susan M. Hohenhaus is President, Hohenhaus & Associates, Inc, Wellsboro, Pa.

Stephen M. Powell, Healthcare Team Training, LLC, Peachtree City, Ga.

Robert N. Haskins, Healthcare Team Training, LLC, Peachtree City, Ga.

For correspondence, write: Susan M. Hohenhaus, MA, RN, FAEN, President, Hohenhaus & Associates, Inc, 6 Willard Terrace, Wellsboro, PA 16901; E-mail: [shohenha@ptd.net](mailto:shohenha@ptd.net).

J Emerg Nurs 2008;34:142-4.

0099-1767/\$34.00

Copyright © 2008 by the Emergency Nurses Association.

doi: 10.1016/j.jen.2007.09.019

**TABLE**  
**Teamwork Evaluation of Non-Technical Skills (TENTS) observation tool**

Date: _____		Time: _____		Process: _____			
Location/Unit: _____		Observer: _____					
Element	Behavior	0	1	2	3	4	NA
1a	Communication	Sends and receives appropriate information					
1b		Asks questions					
1c		Uses feedback between team members					
1d		Sends and receives information to/from patient/family					
1e		Uses appropriate critical language					
1f		Uses teamwork tools					
1g		Debrief completed					
1h		Uses teamwork tools					
2a	Leadership	Establishes event leader					
2b		Verbalizes plan: states intentions, recommendations, and timeframes					
2c		Delegates as appropriate					
2d		Instructs as appropriate					
3a	Situation monitoring	Visually scans environment					
3b		Cross monitors activities; uses back-up behavior					
3c		Verbalizes adjustments in plan as changes occur					
4a	Mutual support/assertion	Secures additional resources					
4b		Supports others					
4c		Prioritizes appropriately					
4d		Uses conflict resolution					
4e		Speaks up/persuades					
5	Overall teamwork						
6	Overall leadership						

0 = expected but not observed.  
 1 = observed but poor.  
 2 = observed but marginal.  
 3 = observed and acceptable.  
 4 = observed and good.  
 NA = not applicable.  
 Any value of "1" or "0" require a narrative comment.

and clinicians should feel free to ask the observer to move out of the way, or even to leave if they are uncomfortable about any aspect of the observation.

Patients should also be made aware that an observer is present. We have not found this to be difficult, especially when the patient becomes aware that the observer is helping to identify issues that will help construct a safer health-care system. Some organizations will require patient and staff written consent to conduct observations, whereas others will not, considering the observer to be part of the patient care team. All observers should be held accountable to the strictest levels of confidentiality and remain sensitive to patient privacy.

Frequently we find at the beginning of our observations that clinicians are on their "best behavior." However, we have noted that the business of providing health care is an intense process and the "Hawthorne Effect" can be detected easily by the trained observer; in fact, some studies suggest that this phenomenon can be absent during observations in the healthcare setting.<sup>4</sup>

### Recommendations for Training Observers

*"We cannot create observers by saying "observe," but by giving them the power and the means for this observation and these means are procured through education of the senses"-Maria Montessori*

All observers in the healthcare setting should be trained in the specialty and given the tools necessary to perform their role. Novice observers should be partnered with experienced observers in the clinical area to provide real-time instruction, coaching, and effective inter-rater reliability through calibration exercises. Clinical teamwork videos from the AHRQ TeamSTEPPS<sup>TM</sup> curriculum as well as other sources are valuable training aids for developing observation skills through focused group review and subsequent discussions.<sup>5</sup>

### Conclusion

Combined with formal teamwork training, standardized observation in the emergency department is one method that may be helpful in identifying threats to safety. The emerging healthcare setting observational specialty is an important addition to other methods of data collection and analysis. Skilled teamwork observers internal to the healthcare organization must be trained and methodically deployed to audit, monitor, and sustain behavior change sought by the organization.

### REFERENCES

1. Baker DP, Day R, Salas E. Teamwork as an essential component of high-reliability organizations. *Health Serv Res* 2006;41:1576-98.
2. Morey JC, Salisbury M. Introducing teamwork training into healthcare organizations: Implementation issues and solutions. *Proceedings of the 46th Annual Meeting of the Human Factors and Ergonomics Society*; 2002 Sep 29-Oct 4; Baltimore, MD. Santa Monica, CA: Human Factors and Ergonomics Society; 2002. pp. 2069-73.
3. Thomas EJ, Sexton JB, Lasky RE, Helmreich RL, Crandell DS, Tyson J. Teamwork and quality during neonatal care in the delivery room. *J Perinatol* 2006;26:163-9.
4. Schnelle JF, Ouslander JG, Simmons SF. Direct observations of nursing home care quality: Does care change when observed? *J Am Med Dir Assoc* 2006;7:541-4.
5. Clancy CM, Tornberg DN. TeamSTEPPS: Assuring optimal teamwork in clinical settings. *Am J Med Qual* 2007;22:214-7.

**Clinical questions** from nurses are welcome, as are names and addresses of clinicians who are interested in answering questions. Submit to:

**Susan McDaniel Hohenhaus, MA, RN, FAEN**

6 Willard Terrace, Wellsboro, PA 16901

570 724-1715 • [shohenha@ptd.net](mailto:shohenha@ptd.net)