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Team Breakdown: Analysis Of Two Case Studies

While businesses often require people to work in teams, the team approach often fails. In this issue we will analyse actual case studies of teams that performed poorly.

The August 2006 issue of *The Viridiant Business Newsletter* (Vol. 1, No. 3) described two cases where teams broke down. In this we will analyze those cases.

Case Study: Analysis of The Law Firm

The team consisted of the senior partner, the junior associate and the client. Never forget the client. Leaving the client out of the loop is a major cause of project failure and client dissatisfaction. Clients are sometimes left out because they hesitate to communicate due to a ticking clock. At Viridiant (www.viridiant.com), we charge one fixed fee for our work. This encourages clients to call if they have a concern or feel they have new information to provide, without worrying it will raise the cost of the project.

Whenever taking on a new project, first thing, always **identify the team**. This may seem obvious. But if you think the team consists of nine individuals, and you forget the administrative assistant who has to file documents and send them on time, you have failed to identify a member of the team who could undermine the work of everyone else.

The team in this case broke down in several areas. First, there may be a **competency** issue with the junior associate. He was convinced of argument A when the developer of the technology was confident of argument B. If the partner's agreement with argument B in Washington was heartfelt (and not an attempt to cover up an earlier mistake), this further suggests the associate did not grasp the correct way to argue the case.

There were multiple breakdowns in **communication**. The junior associate said the partner agreed with argument A, but a year later the partner supported argument B. The senior partner may not have known there was an earlier disagreement between the client and the junior associate but perhaps he should have called the client before the patent was filed to be sure all the i's were dotted. Finally, the client should have called the partner himself, since his scientific background told him the wrong argument was being filed.

It is a fact of life that any time we delegate, whether to an attorney, a subordinate, a colleague, or even to our boss, it is our responsibility to follow up. Follow up should be scheduled far enough in advance of the deadline to ensure an error can be corrected. These days, that is easy to do. We can start with e-mail. If that does not generate an appropriate response, we can follow up with a phone call. When delegating, in work teams or in our personal lives, we should always follow up to see that things are on track.

There did not seem to be clear **checks and balances** between the attorney and the associate. For if argument A really seemed poor to the senior partner, he would have known

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> *"Communication focus groups can be used to improve communication among team members."*

that a year earlier had he read the response from the patent office. It seems the associate was left on his own, and the senior partner simply signed off on the work.

Finally, the junior associate and the partner did not "get it right" for some reason. This may have been due to the short time the associate was at the firm, a lack of "practice" time.

Case Study: Analysis of The Hospital

The team consisted of doctors, nurses, a respiratory therapist, a pharmacist and a ward clerk. In general, the larger the team, the more likely miscommunication will occur. This is a team that is functioning under a certain amount of stress. A patient's life hangs in the balance and decisions need to be made rapidly. Finally, almost all the individuals described are shift workers and may never have met before the Code was called.

The first issue, **competence**, is difficult to assess from one case. However, resuscitation protocols are fairly standardized and known to multiple individuals at the scene. Furthermore, the fact that the patient's heart did respond to the first code suggests that appropriate and competent care was administered. However, another issue of competence arises, not in terms of resuscitative care, but in terms of hospital procedure. How was this patient identified? Was his name bracelet immediately compared with the chart brought to the bedside? How are patients flagged as "No Codes?" Some systems are clearer than others. Finally, after the resident said the patient was a "No Code" did anyone question his statement? Though not necessarily an issue of medical competence, there seems to be a lack of procedural competence in how patients are identified at the hospital.

It is apparent that there was a major breakdown of communication: failure to recognize whether this was the correct patient, failure of the nurse to say she did not know her patient to be a "No Code," failure in fact of all the individuals present not to request to see verification of the patient's "No Code" status before walking away from a patient who was being successfully resuscitate

Checks and balances were absent. When one individual stated the patient was a "No Code" the attempt at resuscitation was ended. No one else verified that the "No Code" status on the chart in fact described this particular patient.

Lack of **practice**. Since many healthcare workers are shift workers, some team members do not meet prior to an actual code. It would be preferable if members of the Code Team met before. In fact, it is preferable for all emergency teams to practice together. Viridiant provides training programs to optimize team performance. For more information visit www.viridiant.com

Learn from your mistakes. Always break them down to determine which of the **Four Vital Team Components** were missing or malfunctioning. This will help you prevent these mistakes in the future.

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