

TeamSTEPPS
Strategies and Tools to Enhance Performance and Patient Safety

TeamSTEPPS Master Trainers
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 PATIENT SAFETY
 TRICARE

TeamSTEPPS Introduction

Objectives

- Describe the TeamSTEPPS initiative
- Describe the impact of errors and why they occur
- Discuss key components of the Team STEPPS framework to optimize team performance across the healthcare delivery system
- Review outcomes of the TeamSTEPPS framework in multiple practice settings

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TeamSTEPPS Introduction

Sue Sheridan Video

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TeamSTEPPS Introduction

Video Discussion

- How are patients harmed as a result of medical errors?
- How can we prevent medical errors?
- What are the solutions?

*...Improved teamwork and communications...
 Ultimately, a culture of safety*

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TeamSTEPPS Introduction

Practice Reflections

Have you ever witnessed something in your practice setting that you thought was a safety issue and that you believed you were unable to address?

If you had the ability to change practice, how would you have changed the situation to address the issue?

What issues do you have in your department/facility that make delivering safe care more difficult?

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TeamSTEPPS Introduction

TeamSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety

“Initiative based on evidence derived from team performance...leveraging more than 25 years of research in military, aviation, nuclear power, business and industry...to acquire team competencies”

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TeamSTEPPS Introduction

Patient Safety Movement

Timeline of Patient Safety Movement:

- 1995: DoD MedTeams ED Study
- 1999: "To Err is Human" IOM Report
- 2001: Executive Memo from President
- 2003: JCAHO National Patient Safety Goals
- 2004: Institute for Healthcare Improvement 100K lives Campaign
- 2005: TeamSTEPPS, Patient Safety and Quality Improvement Act of 2005
- 2006: (End of timeline)

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TeamSTEPPS Introduction

Background and Significance

- Institute of Medicine Reports:
 - To Err is Human: Building a Safer Health System
 - Crossing the Quality Chasm: A New Health System for the 21st Century
 - Keeping Patients Safe: Transforming the Work Environment of Nurses
 - Alerted public and legislators to patient safety
 - Six quality and safety aims
 - Nurses should create a culture of safety
 - Fatigue and staffing affect patient safety

■ IOM 1999, 2001, 2003

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TeamSTEPPS Introduction

Institute of Medicine Report

Impact of Error:

- 44,000–98,000 annual deaths occur as a result of errors
- Medical errors are the leading cause, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS, or car accidents
- 7% of hospital patients experience a serious medication error

Federal Action:

By 5 years;

- ↓ medical errors by 50%,
- ↓ nosocomial infections by 90% and

Eliminate "never-events" (such as wrong-site surgery)


Cost associated with medical errors is \$8–29 billion annually.

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TeamSTEPPS Introduction

Background: US Army Aviation

- Army aviation crew coordination failures in mid-80s contributed to 147 aviation fatalities and cost more than \$290 million
- The vast majority involved highly experienced aviators
- Failures were attributed largely to crew communication, workload management, and task prioritization

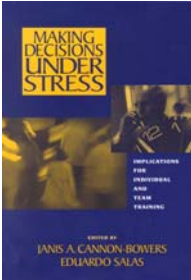


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TeamSTEPPS Introduction

US Navy Breakthroughs: Tactical Decision making Under Stress (TADMUS)

- Cross-Training
- Stress Exposure Training
- Team Coordination Training (CRM)
- Scenario-Based Training and Simulation
- Team Leader Training
- Team Dimensional Training
- Team Assessment



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USA TODAY 6/18/2005

Medical Errors Still Claiming Many Lives

By Elizabeth Weise, USA TODAY

As many as 98,000 Americans still die each year because of medical errors despite an unprecedented focus on patient safety over the last five years, according to a study released today. Significant improvements have been made in some hospitals since the Institute of Medicine released a landmark report in 2000 that revealed many thousands of Americans die each year because of medical mistakes.

But nationwide, the pace of change is painstakingly slow, and the death rate has not changed much, according to the study in *The Journal of the American Medical Association*.

The researchers blame the complexity of health care systems, a lack of leadership, the reluctance of doctors to admit errors and an insurance reimbursement system that rewards errors — hospitals can bill for additional services needed when patients are injured by mistakes — but often will not pay for practices that reduce those errors.

"The medical community now knows what it needs to do to deal with the problem. It just has to overcome the barriers to doing it," says study co-author Lillian Leape of Harvard's School of Public Health.

The Institute, a public policy organization, pushed key health care organizations to focus on patient safety, the new report says. As a result, reductions as much as 93% have been made in certain kinds of error-related illnesses and deaths.

Computerized prescriptions, adding a pharmacist to medical teams and team training in the delivery of babies are among the improvements medical centers are making, the study finds.

But "we have to turn the heat up on the hospitals," Leape says.

For example, 5% to 8% of intensive-care patients on ventilators develop pneumonia, the study says. But by strictly following a simple protocol of bed elevation, drugs and periodic breathing breaks, those outbreaks can be reduced to almost zero. "A little hospital in DeSoto, Miss., called Baptist Memorial did it, so it doesn't take a big academic medical center," Leape says.

Hospitals that eliminate infections should receive bonuses, Leape says. "If insurance companies paid 20% more for patients in [intensive-care units] where there were no infections, they'd cut costs substantially.

"We really need to rethink how we pay for health care. What we do now is pay for services, but what we should do is pay for care and outcomes."

...little progress towards the goal
Leape and Berwick, JAMA May 2005

Improvements

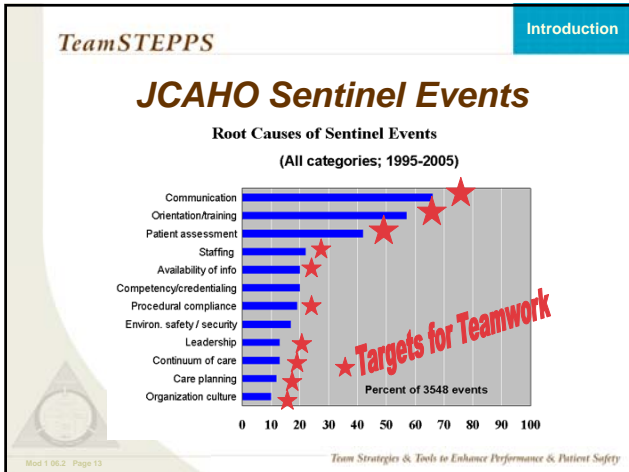
Hospitals have taken steps to reduce medical errors and injuries.

Examples:

- Computerized prescriptions: 81% decrease in errors.
- Including pharmacist in medical team: 75% decrease in preventable drug reactions.
- Team training in delivery of babies: 50% decrease in harmful outcomes — such as brain damage — in premature deliveries.

Source: *Journal of the American Medical Association*

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TeamSTEPPS Introduction

US Air Force CRM History

- Mid to Late 80s AF bombers and heavy aircraft started CRM training
- 1992 Air Combat Command developed Aircrew Attention Management /CRM Training
- By 1998, CRM deployed uniformly across the AF
- Steady decline in human factors based mishaps since CRM training deployed
- AF Medical Service adapted training, rolled out in 2000

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TeamSTEPPS Introduction

Teamwork Encompasses CRM

DoD has led the way in team research and innovations

- Non-Healthcare
 - Combat Information Centers
 - Joint Forces Operations
 - Emergency Management Communities
 - Army Special Forces
 - Tank, Submarine, and Air Crews
- Healthcare
 - ED, OR, L&D, ICU, Dental
 - Whole Hospital
 - Combat Casualty Care

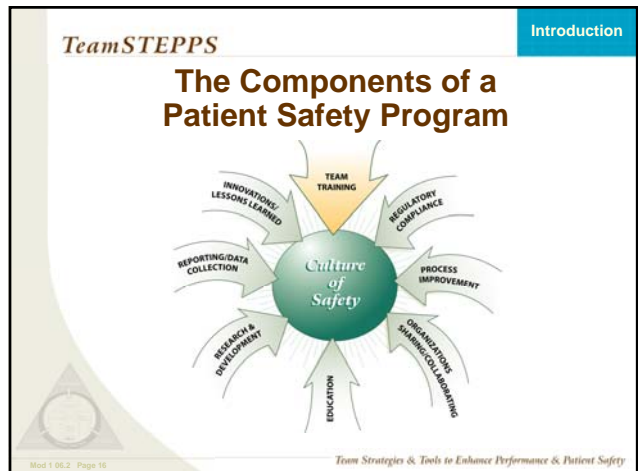
Team Training

CRM

"Learning and Safety Culture"

...striving to be a high reliability healthcare system...

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TeamSTEPPS Introduction

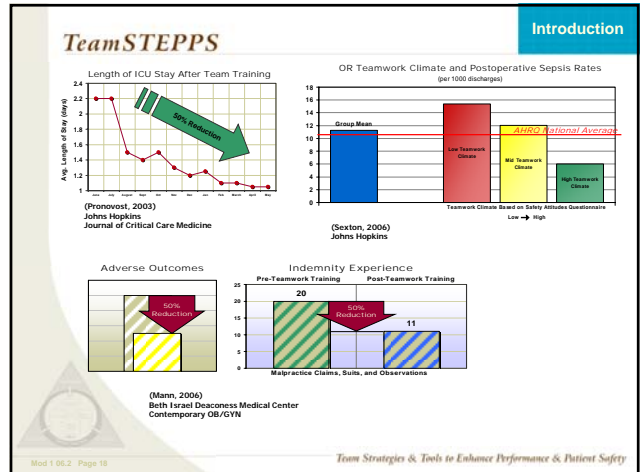
Teamwork Is All Around Us

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TeamSTEPPS Introduction

Teamwork Is All Around Us

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TeamSTEPPS Introduction

Why Do Errors Occur—Some Obstacles

- Workload fluctuations
- Excessive professional courtesies
- Interruptions
- Halo effect
- Fatigue
- Passenger syndrome
- Multi-tasking
- Hidden agenda
- Failure to follow up
- Complacency
- Poor handoffs
- High-risk phase
- Ineffective communication
- Strength of an idea
- Not following protocol
- Task (target) fixation

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TeamSTEPPS Introduction

What Comprises Team Performance?

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TeamSTEPPS Introduction

Outcomes of Team Competencies

- **Knowledge**
 - Shared Mental Model
- **Attitudes**
 - Mutual Trust
 - Team Orientation
- **Performance**
 - Adaptability
 - Accuracy
 - Productivity
 - Efficiency
 - Safety

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TeamSTEPPS Introduction

Teamwork Actions

- Recognize opportunities to improve patient safety
- Assess your current organizational culture and existing Patient Safety Program components
- Identify teamwork improvement action plan by analyzing data and survey results
- Design and implement initiative to improve team-related competencies among your staff
- Integrate TeamSTEPPS into daily practice.

"High-performance teams create a safety net for your healthcare organization as you promote a culture of safety."

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TeamSTEPPS Introduction

Eight Steps of Change

John Kotter

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Roadmap to a Culture of Safety

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TeamSTEPPS Introduction

TeamSTEPPS Essentials

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TeamSTEPPS Introduction

Key Principles

| |
|---|
| <p>Team Structure Delineates fundamentals such as team size, membership, leadership, composition, identification and distribution</p> |
| <p>Leadership Ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and that team members have the necessary resources</p> |
| <p>Situation Monitoring Process of actively scanning and assessing situational elements to gain information, understanding, or minimize awareness to support functioning of the team</p> |
| <p>Mutual Support Ability to anticipate and support other team members' needs through accurate knowledge about their responsibilities and workload</p> |
| <p>Communication Process by which information is clearly and accurately exchanged among team members</p> |

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TeamSTEPPS Introduction

Effective Team Leaders

- Organize the team
- Articulate clear goals
- Make decisions through collective input of members
- Empower members to speak up and challenge, when appropriate
- Actively promote and facilitate good teamwork
- Skillful at conflict resolution

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TeamSTEPPS Introduction

Team Events

- Briefs – planning
- Huddles – problem solving
- Debriefs – process improvement

Leaders are responsible to assemble the team and facilitate team events

But remember...

Anyone can request a brief, huddle, or debrief

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TeamSTEPPS Introduction

Briefs

Planning

- Form the team
- Designate team roles and responsibilities
- Establish climate and goals
- Engage team in short and long-term planning





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TeamSTEPPS Introduction

Planning Essentials for Teams


- Leader usually initiates the planning process
- Team members are included in the planning process
- Team members have a common understanding of the problem and their roles




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TeamSTEPPS Introduction

Briefing Checklist



| TOPIC | |
|--|-------------------------------------|
| Who is on core team? | <input checked="" type="checkbox"/> |
| All members understand and agree upon goals? | <input checked="" type="checkbox"/> |
| Roles and responsibilities understood? | <input checked="" type="checkbox"/> |
| Plan of care? | <input checked="" type="checkbox"/> |
| Staff availability? | <input checked="" type="checkbox"/> |
| Workload? | <input checked="" type="checkbox"/> |
| Available resources? | <input checked="" type="checkbox"/> |



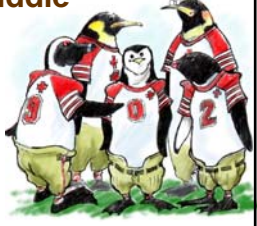


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TeamSTEPPS Introduction

Huddle

Problem solving

- Hold ad hoc, "touch-base" meetings to regain situation awareness
- Discuss critical issues and emerging events
- Anticipate outcomes and likely contingencies
- Assign resources
- Express concerns

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TeamSTEPPS Introduction

Debrief


Process Improvement

- Brief, informal information exchange and feedback sessions
- Occur after an event or shift
- Designed to improve teamwork skills
- Designed to improve outcomes
 - An accurate reconstruction of key events
 - Analysis of why the event occurred
 - What should be done differently next time

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TeamSTEPPS Introduction

Debrief Checklist



| TOPIC | |
|---|-------------------------------------|
| Communication clear? | <input checked="" type="checkbox"/> |
| Roles and responsibilities understood? | <input checked="" type="checkbox"/> |
| Situation awareness maintained? | <input checked="" type="checkbox"/> |
| Workload distribution? | <input checked="" type="checkbox"/> |
| Did we ask for or offer assistance? | <input checked="" type="checkbox"/> |
| Were errors made or avoided? | <input checked="" type="checkbox"/> |
| What went well, what should change, what can improve? | <input checked="" type="checkbox"/> |

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TeamSTEPPS Introduction

Debrief




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TeamSTEPPS Introduction

Importance of Communication

Communication failure has been identified as the leading root cause of sentinel events over the past 10 years (Joint Commission)

Communication failure is a primary contributing factor in almost 80% of more than 6000 root cause analyses of adverse events and close calls (VA Center for Patient Safety)

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TeamSTEPPS Introduction


Paradigm Shift to Team System Approach

| From (INDIVIDUAL) | To (TEAM) |
|--------------------------------|---------------------------------------|
| Single focus (clinical skills) | Dual focus (clinical and team skills) |
| Individual performance | Team performance |
| Under-informed decision-making | Informed decision-making |
| Loose concept of teamwork | Clear understanding of teamwork |
| Unbalanced workload | Managed workload |
| Having information | Sharing information |
| Self-advocacy | Mutual support |
| Self-improvement | Team improvement |
| Individual efficiency | Team efficiency |

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TeamSTEPPS Introduction

Situation Monitoring



"Attention to detail is one of the most important details ..."

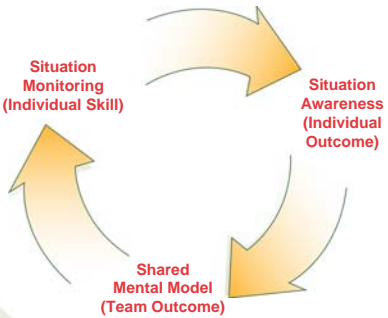
–Author Unknown

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TeamSTEPPS Introduction

A Continuous Process



Situation Monitoring (Individual Skill)

Situation Awareness (Individual Outcome)

Shared Mental Model (Team Outcome)

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TeamSTEPPS Introduction

Cross Monitoring is...

Process of monitoring the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors




- Mechanism to help maintain accurate situation awareness
- Way of “watching each other’s back”
- Ability of team members to monitor each other’s task execution and give feedback during task execution

Mutual performance monitoring has been shown to be an important team competency. (McIntyre and Salas 1995)

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TeamSTEPPS Introduction

Cross Monitoring

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TeamSTEPPS Introduction

STEP

Components of Situation Monitoring:

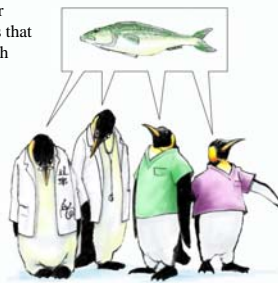


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TeamSTEPPS Introduction

A Shared Mental Model is...

The perception of, understanding of, or knowledge about a situation or process that is shared among team members through communication.



“Teams that perform well hold shared mental models.”
(Rouse, Cannon-Bowers, and Salas 1992)

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TeamSTEPPS Introduction

How Shared Mental Models Help Teams


- Help ensure that teams know what to expect, so if necessary, can regroup to get on the “same page”
- Foster communication to ensure care is synchronized
- Ensure that everyone on the team has a picture of what it should look like
- Enable team members to predict and anticipate better
- Create commonality of effort and purpose

“Shared mental models help teams avoid errors that place patients at risk.”

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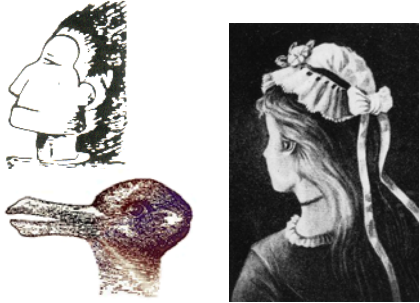
Shared Mental Model?



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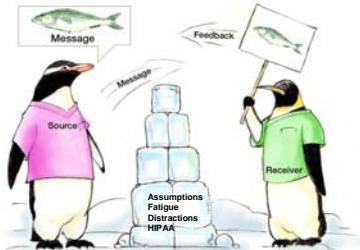
What Do You See?



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TeamSTEPPS Introduction

Communication



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TeamSTEPPS Introduction

Communication is...

The process by which information is exchanged between individuals, departments, or organizations

The lifeline of the Core Team

Effective when it permeates every aspect of an organization



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TeamSTEPPS Introduction

Standards of Effective Communication

- Complete
 - Communicate all relevant information
- Clear
 - Convey information that is plainly understood
- Brief
 - Communicate the information in a concise manner
- Timely
 - Offer and request information in an appropriate timeframe
 - Verify authenticity
 - Validate or acknowledge information

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TeamSTEPPS Introduction

Standards of Effective Communication

B

r

Clear

Timely

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TeamSTEPPS Introduction

SBAR provides...

A framework for team members to effectively communicate information to one another

Communicate the following information:

- Situation—What is going on with the patient?
- Background—What is the clinical background or context?
- Assessment—What do I think the problem is?
- Recommendation—What would I recommend?

Remember to introduce yourself...

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TeamSTEPPS Introduction

SBAR Example

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TeamSTEPPS Introduction



Call-Out is...

SEAL!

A strategy used to communicate important or critical information

- It informs all team members simultaneously during emergency situations
- It helps team members anticipate next steps

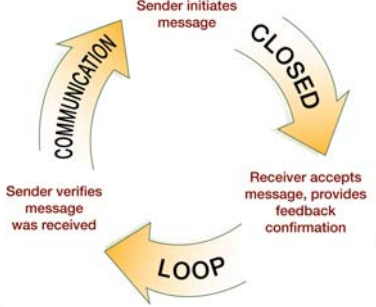
...On your unit, what information would you want called out?

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TeamSTEPPS Introduction


Check-Back is...



Sender initiates message

Receiver accepts message, provides feedback confirmation

Sender verifies message was received



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TeamSTEPPS Introduction

Handoff

The transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include an opportunity to ask questions, clarify, and confirm




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TeamSTEPPS Introduction

Handoff

- Optimized Information
- Responsibility– Accountability
- Uncertainty
- Verbal Structure
- Checklists
- IT Support
- Acknowledgement

Great opportunity for quality and safety



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TeamSTEPPS Introduction

“I PASS THE BATON”

Introduction: Introduce yourself and your role/job (include patient)

Patient: Identifiers, age, sex, location

Assessment: Present chief complaint, vital signs, symptoms, and diagnosis

Situation: Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment

Safety: Critical lab values/reports, socio-economic factors, allergies, and alerts (falls, isolation, etc.)

THE

Background: Co-morbidities, previous episodes, current medications, and family history



Actions: What actions were taken or are required? Provide brief rationale

Timing: Level of urgency and explicit timing and prioritization of actions

Ownership: Who is responsible (nurse/doctor/team)? Include patient/family responsibilities

Next: What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

Question, Clarify, and Confirm

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TeamSTEPPS Introduction

Mutual Support

Mutual support is the essence of teamwork

Protects team members from work overload situations that may reduce effectiveness and increase the risk of error

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TeamSTEPPS Introduction

Advocacy and Assertion

Advocate for the patient

Invoked when team members' viewpoints don't coincide with that of a decision maker

Assert a corrective action in a *firm* and *respectful* manner

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TeamSTEPPS Introduction

The Assertive Statement

- Respect and support authority
- Clearly assert concerns and suggestions
- Use an assertive statement (**nonthreatening and ensures that critical information is addressed**)
 - Make an opening
 - State the concern
 - State the problem
 - Offer a solution
 - Reach an agreement

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TeamSTEPPS Introduction

Mutual Support Tools Advocacy and Assertion

| | | |
|--|--|--|
| <p>C= I am Concerned</p> <p>U= I am Uncomfortable</p> <p>S= This is a safety concern</p> | <p>2 Challenge Rule</p> <p>Voice concern twice if response is unacceptable</p> <p>Utilize chain of command</p> | <p>D= Describe a specific situation</p> <p>E= Express how situation makes you feel</p> <p>S= Suggest other alternatives</p> <p>C= Consequences</p> |
|--|--|--|

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TeamSTEPPS Introduction

Two-Challenge Rule

Invoked when an initial assertion is ignored...

It is your *responsibility* to assertively voice your concern at least *two times* to ensure that it has been heard

The member being challenged must acknowledge

If the outcome is still not acceptable

- Take a stronger course of action
- Use supervisor or chain of command

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TeamSTEPPS Introduction

Two-Challenge Rule

“Empower any member of the team to “stop the line” if he or she senses or discovers an essential safety breach.”

This is an action never to be taken lightly, but it requires immediate cessation of the process and resolution of the safety issue.

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TeamSTEPPS Introduction

Please Use CUS Words but *only* when appropriate!

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TeamSTEPPS Introduction

Conflict Resolution DESC Script

A constructive approach for managing and resolving conflict

- D**—Describe the specific situation
- E**—Express your concerns about the action
- S**—Suggest other alternatives
- C**—Consequences should be stated

Ultimately, consensus shall be reached.

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TeamSTEPPS Introduction

DESC-It

Let's "DESC-It!"



- Have timely discussion
- Frame problem in terms of your own experience
- Use "I" statements to minimize defensiveness
- Avoid blaming statements
- Critique is not criticism
- Focus on what is right, not who is right

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TeamSTEPPS Introduction

Collaboration

Achieves a mutually satisfying solution resulting in the best outcome

All Win!: Patient Care Team (team members, the team, and the patient)

Includes commitment to a common mission

Meet goals without compromising relationships

"True collaboration is a process, not an event."

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TeamSTEPPS Introduction

Partnering with Patient and Family

- Learn to listen to patients and families
- Assess patient/family preference regarding involvement
- Ask patients and families about their concerns
- Speak in lay terms
- Ask for feedback
- Provide access to relevant information
- Encourage patients and families to proactively participate in care

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TeamSTEPPS Introduction

How to Start?

- Create a sense of urgency
- Pull together the guiding team
- Formulate a change vision and strategy
- Communicate vision for understanding and buy-in
- Send personnel to TeamSTEPPS Training Resource Centers

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TeamSTEPPS Introduction

Resources Available

TeamSTEPPS resources include:

- Three teamwork training curricula
- Course Management Guide
- Multimedia course materials
- TeamSTEPPS Implementation Guide
- Measurement tools

Web site for updated resources and information:
<http://teamstepps.ahrq.gov/>

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TeamSTEPPS Introduction

Practice Implications

- Patient safety – priority in your practice
- Change agent – Recognizing that change is dynamic and necessary
- Evidence based practice translated into daily care
- Shared Mental Model

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TeamSTEPPS Introduction

危機

When written in Chinese the word crisis is made up of two characters. One represents danger, the other represents opportunity.

John F. Kennedy

...we choose opportunity

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