

TeamSTEPPS

A Team Approach for Safety

Presentation to Quality Committee

Alaska State Hospital and Nursing Home Association

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Overview

- ▶ National Perspectives on Safety in Healthcare
- ▶ TeamSTEPPS as a Framework
- ▶ Alaska's Past Initiative
- ▶ TeamSTEPPS Basics
- ▶ Consideration for Future Alaska Initiative

National Perspective

- ▶ Institute of Medicine (IOM) Report
 - ▶ To Err is Human
- ▶ The Joint Commission
 - ▶ National Patient Safety Goals
 - ▶ Communication
 - ▶ Transitions in Care



2015 Hospital National Patient Safety Goals	
<p>The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.</p>	
Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.
NPSG.01.03.01	
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare these medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Safety as THE Priority

What Keeps You Awake at Night?

- ▶ How Could a Patient Be Harmed While in Your Care?
- ▶ What About Your Staff?
- ▶ Do You Believe Your Culture Supports Reporting?
- ▶ Do You Know What You Don't Know?

TeamSTEPPS Background

Team Strategies and Tools to Enhance Performance and Patient Safety

- ▶ TeamSTEPPS is a teamwork system designed for health care professionals to improve communication and teamwork skills. It is a source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of your health care system. The system is scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles. TeamSTEPPS was developed by Department of Defense's Patient Safety Program in collaboration with AHRQ.

TeamSTEPPS in Alaska

- ▶ Initial Consideration in 2012/13
 - ▶ Five Staff Members (each) From Three Facilities
 - ▶ Staff Primarily Focused in Quality, Safety, Nursing Areas
- ▶ Anecdotal Challenges
 - ▶ Proponency at Executive Level was Limited
 - ▶ Limited Facility-Wide Support
 - ▶ High Staff Turnover
 - ▶ Trainers and Across Facilities



Research/EBP on TeamSTEPPS

- ▶ Large Multi-Hospital System
 - ▶ Baylor Hospital System
 - ▶ The Joint Commission Journal on Quality and Patient Safety, 2012
- ▶ Long-term Care Facility
 - ▶ Communication w/ Providers...Quality of Information
 - ▶ Geriatric Nursing, 2013
- ▶ DoD/Military Health System
 - ▶ USAF - 77 Facilities...Inpatient & Outpatient

Research/EBP on TeamSTEPPS (cont.)

- ▶ What Makes Sense For You? For Us?
 - ▶ Rural Hospitals
 - ▶ “Context and Facilitation”
 - ▶ Health Care Management Review, 2016
 - ▶ Community Hospitals
 - ▶ “Active Learning...OJT...Practice & Feedback”
 - ▶ International Journal of Health Care Quality Assurance, 2015
- ▶ Take-Aways
 - ▶ More Than One Approach Works
 - ▶ Sustained Success Depends on Organizational Support (Up/Down/Across)

TeamSTEPPS in Alaska

- ▶ Why Now?
 - ▶ Increased Collaboration Across ASHNHA Partners
 - ▶ Multi-Disciplinary Energy and Commitment to HRO Concepts
 - ▶ Chassin & Loeb, TJC, 2013
 - ▶ Leadership Commitment, Culture of Safety, Robust Process Improvement
- ▶ TeamSTEPPS provides higher quality, safer patient care by:
 - ▶ Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.
 - ▶ Increasing team awareness and clarifying team roles and responsibilities.
 - ▶ Resolving conflicts and improving information sharing.
 - ▶ Eliminating barriers to quality and safety

TeamSTEPPS Basics

- ▶ Framework & Team Competency Outcomes
 - ▶ Performance
 - ▶ How We Perform -- "Do"
 - ▶ Adaptability, Accuracy, Productivity, Efficiency, Safety
 - ▶ Knowledge
 - ▶ What We Know & How We "Think"
 - ▶ Shared Mental Model
 - ▶ Attitudes
 - ▶ How We "Feel"
 - ▶ Mutual Trust, Team Orientation



TeamSTEPPS Basics

- ▶ Modular Approach
 - ▶ Team Structure
 - ▶ Communication
 - ▶ Leadership
 - ▶ Situation Monitoring
 - ▶ Mutual Support

- ▶ Build on One Another, but Can be Independent



TeamSTEPPS Tools

- ▶ Briefs
 - ▶ Set the Stage
 - ▶ Just That...Brief...Not a Meeting
- ▶ Huddles
 - ▶ Quick...Change in Plans or Updates
- ▶ Debriefs
 - ▶ Prep for Tomorrow
 - ▶ Post-Event
- ▶ How Does This Apply to Me & My Facility?

Crew Resource Management (CRM)




**KEEP
CALM
AND
DEBRIEF**

TeamSTEPPS Tools

- ▶ CUS
 - ▶ Concerned - Uncomfortable - Safety Issue
- ▶ Two-Challenge
 - ▶ Supports Team Approach, Advocacy, Assertiveness
- ▶ Check-Back
 - ▶ Validation Process
- ▶ IMSAFE
 - ▶ Illness - Meds - Stress - Alcohol/Drugs - Fatigue - Eating/Elimination



TeamSTEPPS Tools

▶ SBAR

- ▶ Situation - Background - Assessment - Recommendation/Request

▶ IPASStheBATON

- ▶ I - Intro
- ▶ PASS - Patient - Assessment - Situation - Safety Concerns
- ▶ BATON - Background - Actions - Timing - Ownership - Next



SBAR

救急車を呼ぶ際も SBARを使ってください！

Situation - Background - Assessment - Recommendation

- S** 状況 ~何が起きているのか~
例) 119番ですか？日前で、人が倒れました。
- B** 背景/経過 ~状況の理解に必要な情報は~
例) 呼びかけても返事がありませんでした。
- A** 判断/考え ~あなたはどう考えているのか~
例) 心停止と考えると、心臓マッサージをしています。
- R** 提案/依頼 ~相手にどうしてほしいのか~
例) すぐに来てください。場所は○駅です。

※ Rは"Request"でも可

"I PASS THE BATON"

A mnemonic for Handoffs and Healthcare Transitions

I Introduction	Introduce yourself and your role(s) (include name)
P Patient	Name, identifiers, age, sex, location
A Assessment	Presenting chief complaint, vital signs and symptoms and diagnosis
S Situation	Current status/circumstances, including code status, level of consciousness, recent changes, response to treatment
S SAFETY Concerns	Critical lab values/reports, acute economic factors, allergies, alerts (falls, isolation, etc.)
B Background	Contraindications, previous episodes, current medications, family history
A Actions	What actions were taken or are required AND provide brief rationale
T Timing	Level of urgency and explicit timing, prioritization of actions
O Ownership	Who is responsible (nurse/doctor/other) including patient/family responsibilities
N Next	What will happen next? Anticipated changes? What is the AHA/C Contingency plan?

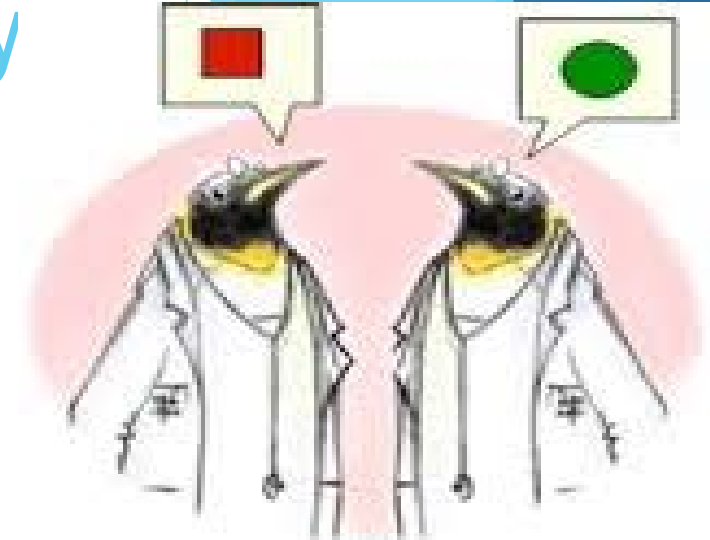
Responsibility, Accountability, Authority

AAA
AHA
CDC

2010 Patient Safety Program
211 Lombard Street, Suite 210
Falls Church, Virginia 22041
(703) 461-5444

Deliberate Team Approaches for Safety

- ▶ Shared Mental Model
 - ▶ Are We On the Same Page?
- ▶ Cross-Monitoring
 - ▶ Am I Seeing Something You Don't?
 - ▶ "I Got Your Back" vs "Gotcha!"
- ▶ Task Assistance
 - ▶ Where Can I Help?
 - ▶ An Expectation That Assistance is Sought and Offered



Alternatives to TeamSTEPPS

- ▶ What are you using now?
- ▶ Variations of Mnemonics From TeamSTEPPS
 - ▶ I-PASS
 - ▶ Pediatric Resident Hand-off Tool
 - ▶ Desire for a Same General Info .. But Quicker/Briefer
 - ▶ SBAR vs SBARQ
 - ▶ SBAR + Questions



I	Illness Severity	<ul style="list-style-type: none">• Stable, "watcher," unstable
P	Patient Summary	<ul style="list-style-type: none">• Summary statement• Events leading up to admission• Hospital course• Ongoing assessment• Plan
A	Action List	<ul style="list-style-type: none">• To do list• Time line and ownership
S	Situation Awareness and Contingency Planning	<ul style="list-style-type: none">• Know what's going on• Plan for what might happen
S	Synthesis by Receiver	<ul style="list-style-type: none">• Receiver summarizes what was heard• Asks questions• Restates key action/to do items

Outcomes/Metrics

- ▶ Decreased Patient Safety Events
 - ▶ More “Near Misses”
- ▶ Increased Reporting
 - ▶ Just Culture...More is Better...and Reality
- ▶ Safer Care
 - ▶ Including Patients in Hand-offs?
- ▶ More Efficient/Effective Practice?
 - ▶ ROI

LifeWings Project Results:

**\$470K Invested
Produced \$2M ROI.**

OR on-time starts = 100%:
A 51% improvement.

OR room turnover = 23.9 min.:
A 35% improvement.



Outcomes/Metrics

- ▶ Improved Staff Communication
 - ▶ Hand-offs Across Disciplines
 - ▶ Hand-offs Across Units
- ▶ Improved Staff Satisfaction
 - ▶ Enough Info to Make Decisions
 - ▶ Just Culture & Expectation Management
- ▶ Increased Patient Satisfaction

SBAR Communication Worksheet

The assignment to make work

Patient Name:		Patient Date of Birth: / /	
Day: / /	Time: : : AM/PM	Location:	Room Number:

Pre-call preparation Gather the following information: Patient's name, age, chief. Release to you what you plan to say. Run it by another nurse. Follow-up: Finding about pain, when and what was last pain medication? Finding about time, what was the most recent temperature? If calling about an abnormal lab, what was the result of the test last? What is the goal of your call? Remember to start by introducing yourself by name and location. Use your name as a model to gather your thoughts and prepare.

<input type="checkbox"/> Situation Briefly describe the current situation. One or two, succinct overview of pertinent issues.	_____
<input type="checkbox"/> Background Briefly review the pertinent history. What got us to this point?	_____
<input type="checkbox"/> Assessment Summarize the facts and give your best assessment. What is going on? Use your best judgment.	_____
<input type="checkbox"/> Recommendation What actions are you asking for? What do you want to happen next?	_____

Follow-up (After Hand-off) Document the call and "read back" orders to ensure accuracy. Is there a change in the plan of care? Yes No



Barriers to Adoption

- ▶ In the Research
 - ▶ Stovepipes
 - ▶ Clinical vs Non; Physicians vs Others
 - ▶ Lack of Leadership Support
 - ▶ Orientation...Messaging...Visible Proponency
 - ▶ Fragmented Implementation
 - ▶ One Discipline, One Unit, Etc
- ▶ Real/Perceived at Your Facility
 - ▶ What's *Your* Reality?
 - ▶ For Us...What Makes Today Different Than 2012/13?
 - ▶ How Do We Support Internally *and* Across Organizations

Realistic Way Forward



- ▶ Considerations for State-Wide Initiative
 - ▶ Common Language?
 - ▶ Single Framework
 - ▶ IMSAFE? SBAR? Huddles?
 - ▶ Survey at Executive (Decision-Making) Level
 - ▶ Facility “Buy-in”
 - ▶ Refer for Discipline-centric “Pilot”
 - ▶ Refer to Subordinate Committee?

Review/Questions

- ▶ National Perspectives on Safety in Healthcare
- ▶ TeamSTEPPS as a Framework
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