TeamSTEPPS

A Team Approach for Safety

Presentation to Quality Committee

Alaska State Hospital and Nursing Home Association

Dr Melissa Ring

CEO, Alaska Psychiatric Institute

Colonel Jim Reineke

Chief Nurse, 673d Medical Group/JBER

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

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 Relevance, AHRQ, 2015)

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

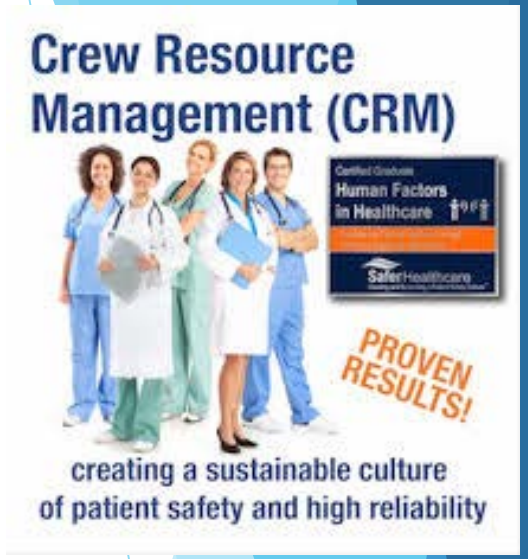
TeamSTEPPS Basics

- 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?



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

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-PASS
BETTER HANDOFFS. SAFER CARE.

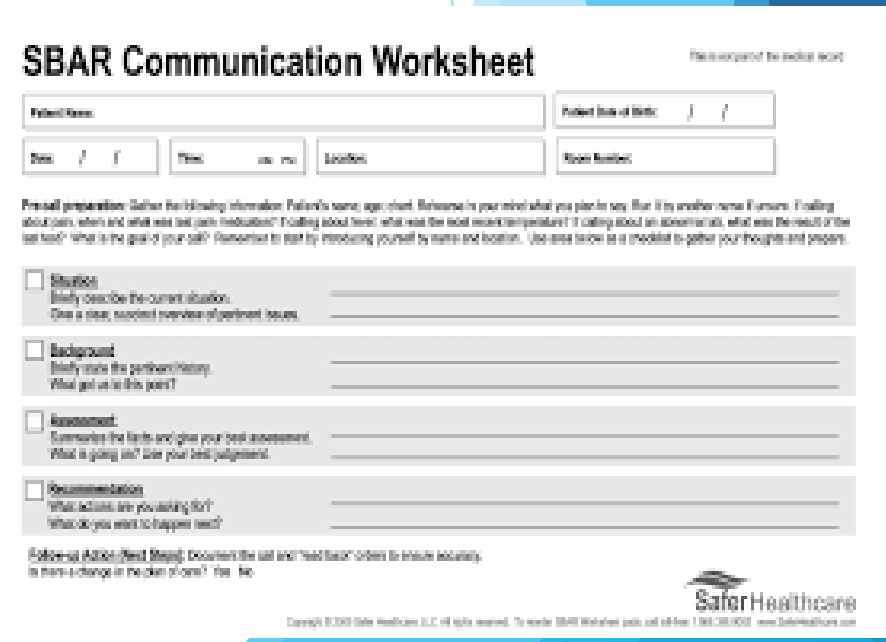
I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• 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

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

Situation
Briefly describe the current situation.
One or two sentence overview of pertinent issues.

Background
Briefly state the pertinent history.
What led us to this point?

Assessment
Summarize the facts and give your best assessment.
What is going on? Use your best judgment.

Recommendation
What actions are you asking for?
What do you want to happen next?

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

SaferHealthcare

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
- Alaska's Past Initiative
- TeamSTEPPS Basics
- Consideration for Future Alaska Initiative