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Reducing Risks Through Effective Communication: AHRQ's TeamSTEPPS®

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Objectives

At the conclusion of this program, you should be able to:

- Identify the role of communication in healthcare litigation.
- List three essential elements for making TeamSTEPPS effective.
- Evaluate your organization's likelihood of effectively implementing TeamSTEPPS.

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Registration polling results

Registration polling results will be shared during the live webinar.

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Today's program

Today's speaker is Christine M. Hoskin, RN, MS, CPHRM, Senior Patient Safety & Risk, MedPro Group (Christine.Hoskin@medpro.com)

Christine provides comprehensive risk management services to healthcare systems, hospitals, clinics, and doctors in Colorado, Nebraska, Oklahoma, Iowa, and Kansas.

Christine has been involved in risk and quality management throughout her career, providing oversight of clinical education, epidemiology, safety, accreditation, risk management, quality improvement, and nursing. She has experience in a range of care settings — including both inpatient and outpatient facilities, primary care, specialty care, dental care, and rehabilitation — and with various patient populations.

These opportunities have enabled Christine to develop a strong understanding of the challenges and opportunities facing healthcare providers and organizations.

Christine is a registered nurse. She earned her bachelor of science and master of science degrees from Nebraska Methodist College of Nursing and Allied Health. Additionally, Christine is a member of the American Society for Healthcare Risk Management and holds a certificate in healthcare risk management and completed the TeamSTEPPS master trainer curriculum.

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Today's program

Today's speaker is MaryAnn Digman, RN, MSHA, Senior Patient Safety & Risk Consultant, MedPro Group (Maryann.Digman@medpro.com)

MaryAnn brings a wealth of education and more than 25 years of progressive clinical and operational healthcare leadership experience to her responsibilities at MedPro Group.

Her previous roles in large integrated systems, academic medical centers, community hospitals, and rural healthcare facilities in public, not-for-profit, and investor-owned systems — and her experience as a COO/CEO — are invaluable to her clients as they develop effective business strategies.

MaryAnn earned her RN degree from St. Mary's School of Nursing in Rochester, Minnesota. She completed her bachelor of science degree in health education from the University of New Mexico and her master of science degree in healthcare administration from the University of St. Francis in Joliet, Illinois.

MaryAnn is a member of the American College of Healthcare Executives (ACHE), and she has served on the Board of Directors of the Voluntary Hospitals of America (VHA) Southwest, the New Mexico Hospital Association, and numerous community agencies.

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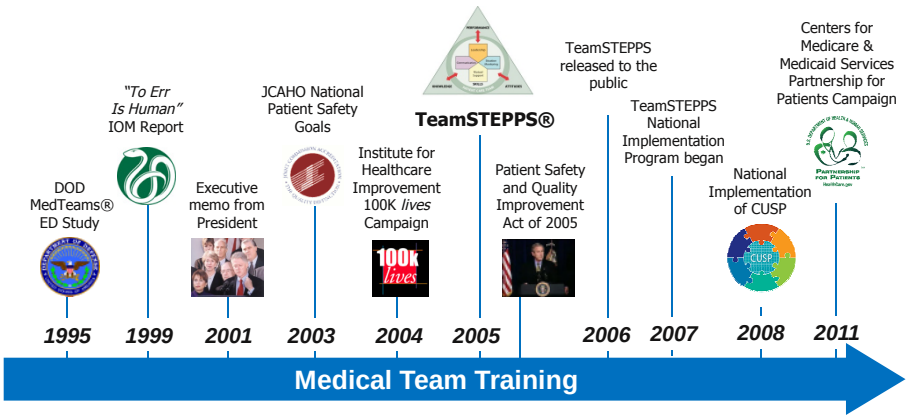
Patient safety movement



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Why are we still talking about patient safety?

Oregon brain surgery patient dies after being given wrong drug

Loretta Macpherson, 65, died unexpectedly during a hospital visit when she was paralyzing agent instead of anti-seizure medication. The fatal error is being inves

BY LEE MCRAN / NEW YORK DAILY NEWS / Tuesday, December 9, 2014, 10:10 AM

Patient on anticoagulants dies of post-op bleeding

$350,000 settlement

By: Mass. Lawyers Weekly Staff April 16, 2015

The patient went to his treating physician, the defendant, for a complaint of low back pain, bilateral lower extremity pain and fatigue on Oct. 25, 2007. The patient had been treating with

Dallas County

Dallas toddler dies after heparin overdose at Nebraska hospital

Associated Press

DENTIST CHARGED WITH HOMICIDE AFTER PATIENT DIES IN THE CHAIR WHILE HAVING 20 TEETH PULLED

February 20, 2015 by Terri Osborne

ISMP

Acute Care

ISMP Medication Safety Alert!

TO CHEW, OR NOT TO CHEW? PATIENT DIES AFTER CHEWING MEDICATION

Toddler bled to death in hospital on a weekend due to 'catastrophic' lack of communication between doctors

- Two-year-old Tharun Umashankar died from bleeding of the stomach lining

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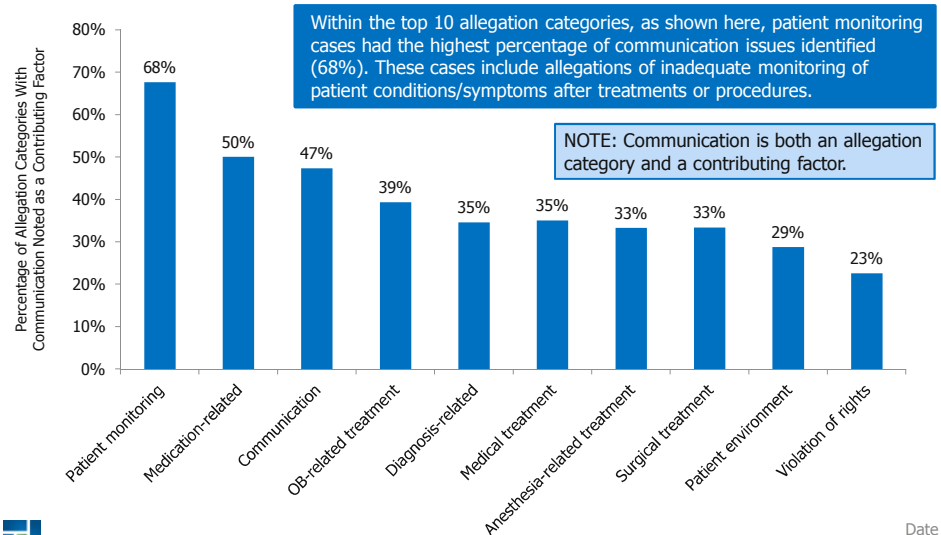
Communication as a risk factor by allegation category

36% of all MedPro claims closed between 2005 and 2014 involve communication as a contributing factor. Of these, 59% were associated with outpatient settings, and 41% were associated with inpatient settings.

Within the top 10 allegation categories, as shown here, patient monitoring cases had the highest percentage of communication issues identified (68%). These cases include allegations of inadequate monitoring of patient conditions/symptoms after treatments or procedures.

NOTE: Communication is both an allegation category and a contributing factor.



Source: MedPro Group closed claims, 2005-2014

Date

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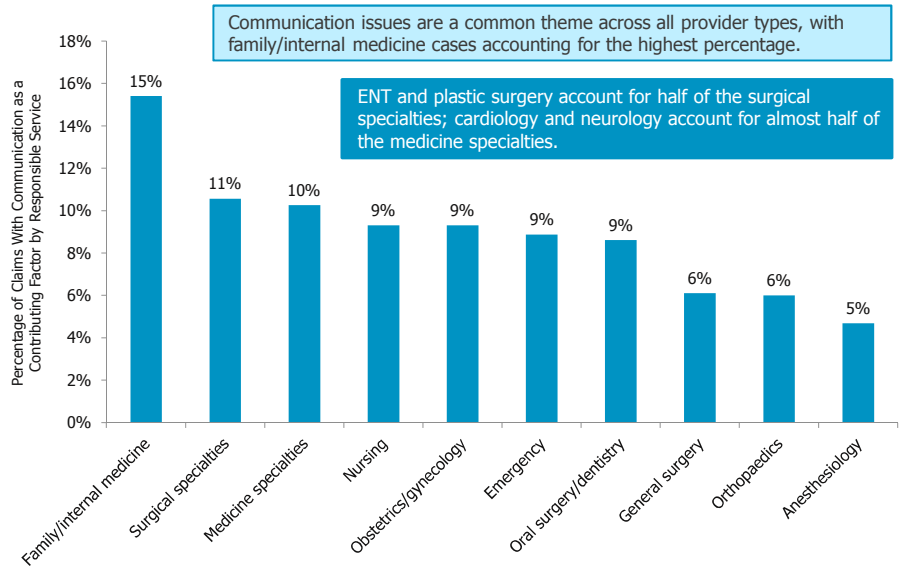
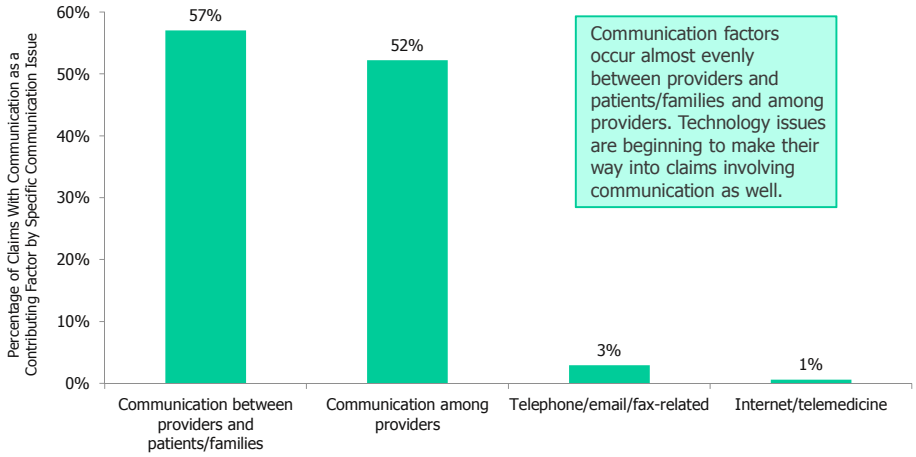
Communication as a risk factor by responsible service



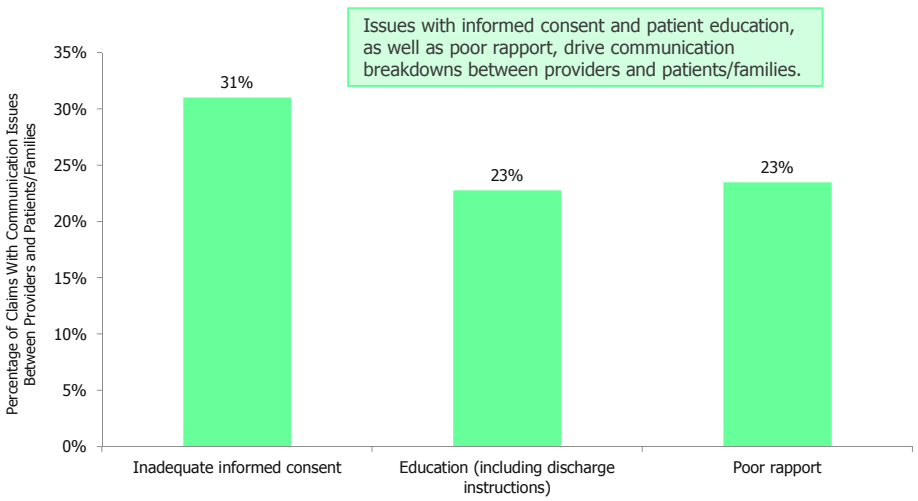
Source: MedPro Group closed claims, 2005-2014

Communication as a risk factor by specific issue



Source: MedPro Group closed claims, 2005-2014

Communication as a risk factor between providers & patients/families



Source: MedPro Group closed claims, 2005-2014

Date
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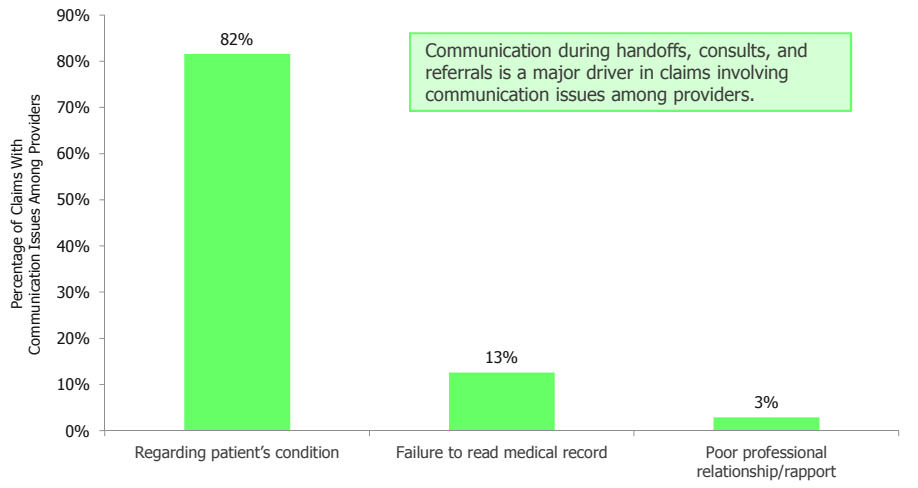
Communication as a risk factor among providers



Source: MedPro Group closed claims, 2005-2014

Date
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It's a problem — how do we fix it?

Date
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What does TeamSTEPPS stand for?

Team

S Strategies
&
T Tools
to
E Enhance
P Performance
and
P Patient
S Safety

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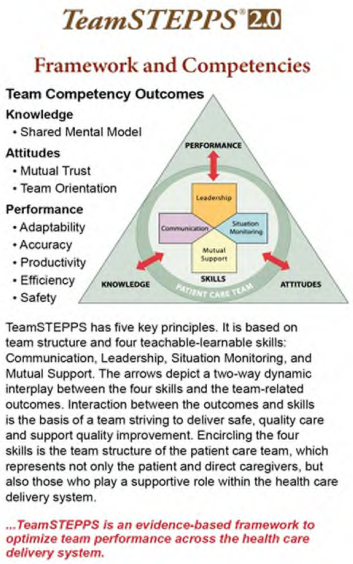
What is TeamSTEPPS?

TeamSTEPPS is an evidence-based teamwork system designed to optimize patient outcomes by improving communication and teamwork skills among healthcare professionals.

The TeamSTEPPS framework and competencies are based on knowledge, attitudes, and performance.

The program includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any healthcare system.



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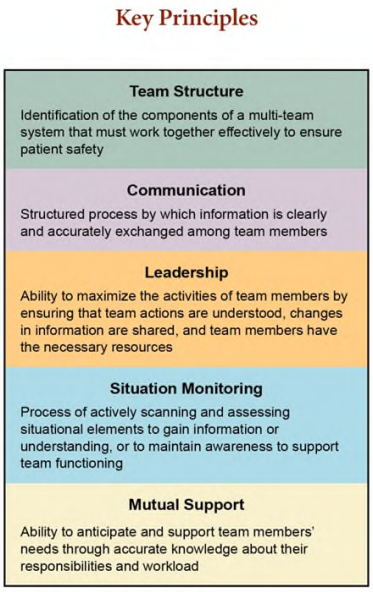
Key principles of TeamSTEPPS



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Evidence that TeamSTEPPS works

Capella, et al. (2010)

- Trauma resuscitation team implementation
- Pre- and post-TeamSTEPPS training results:
  - Team performance improved across all teamwork skills: leadership, situation monitoring, mutual support, communication
  - Significantly decreased times from arrival to CT scanner, endotracheal intubation, and operating room

Thomas & Galla (2013)

- System-wide implementation
- Pre- and post-TeamSTEPPS training results:
  - Significant improvement in HSOPSC scores on feedback and communication about error, frequency of events reported, hospital handoffs and transitions, and teamwork across units
  - Incremental changes evident through reduction of nosocomial infections, falls, birth trauma, and other incidents

More success stories: http://teamstepps.ahrq.gov/implementationstories.htm

Capella, J, et al. Teamwork training improves the clinical care of trauma patients . Journal of Surgical Education 2010 Nov-Dec;67(6):439-43.

Thomas, L., Galla, C. Building a culture of safety through team training and engagement. Postgrad Med Journal, 2013; 89:1053 394-401.

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High-performing team?

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Characteristics of high-performing teams

High-performing teams:

- Hold shared mental models
- Have clear roles and responsibilities
- Have clear, valued, and shared vision
- Optimize resources
- Have strong team leadership
- Engage in a regular discipline of feedback
- Develop a strong sense of collective trust and confidence
- Create mechanisms to cooperate and coordinate
- Manage and optimize performance outcomes

Baker, D., Day, R, & Salas, E. Teamwork as an Essential Component of High Reliability Organizations. Health Services Research. 2006 Aug; 41 (4Pt 2): 1576-1598.

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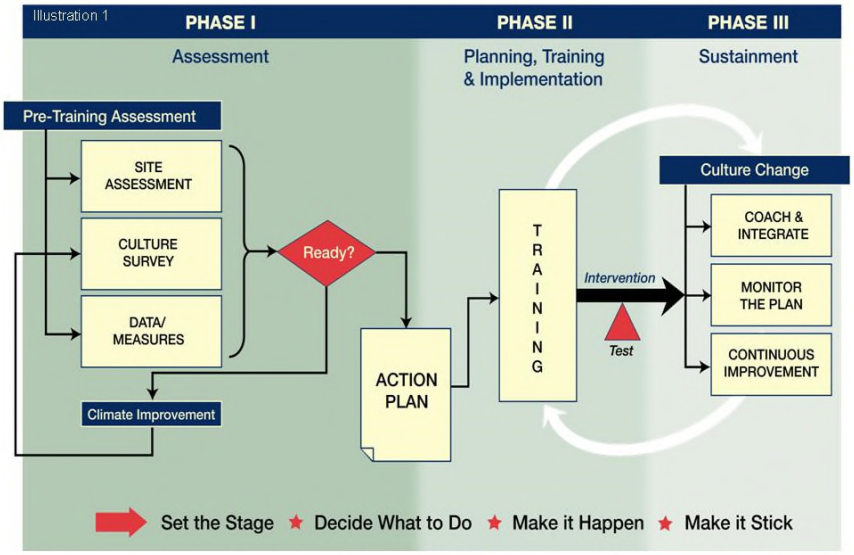
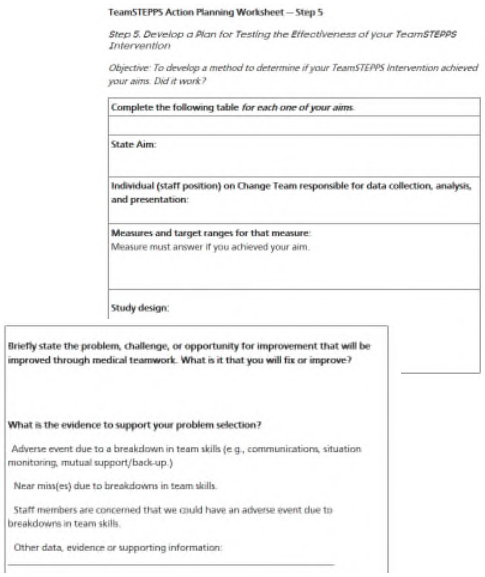
How does TeamSTEPPS work?



Resources

- Assessment
- Team development
- Leadership engagement
- Defining the problem
- Action planning worksheets
- Creating change teams
- And the list goes on



TeamSTEPPS Action Planning Worksheet – Step 5

Step 5. Develop a Plan for Testing the Effectiveness of your TeamSTEPPS Intervention

Objective: To develop a method to determine if your TeamSTEPPS intervention achieved your aims. Did it work?

Complete the following table *for each one of your aims.*

State Aim:

Individual (staff position) on Change Team responsible for data collection, analysis, and presentation:

Measures and target ranges for that measure:
Measure must answer if you achieved your aim.

Study design:

Briefly state the problem, challenge, or opportunity for improvement that will be improved through medical teamwork. What is it that you will fix or improve?

What is the evidence to support your problem selection?

Adverse event due to a breakdown in team skills (e.g., communications, situation monitoring, mutual support/back-up.)

Near miss(es) due to breakdowns in team skills.

Staff members are concerned that we could have an adverse event due to breakdowns in team skills.

Other data, evidence or supporting information:

Tools & strategies summary

BARRIERS

- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Complacency
- Varying communication styles
- Conflict
- Lack of coordination and follow-up with coworkers
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity

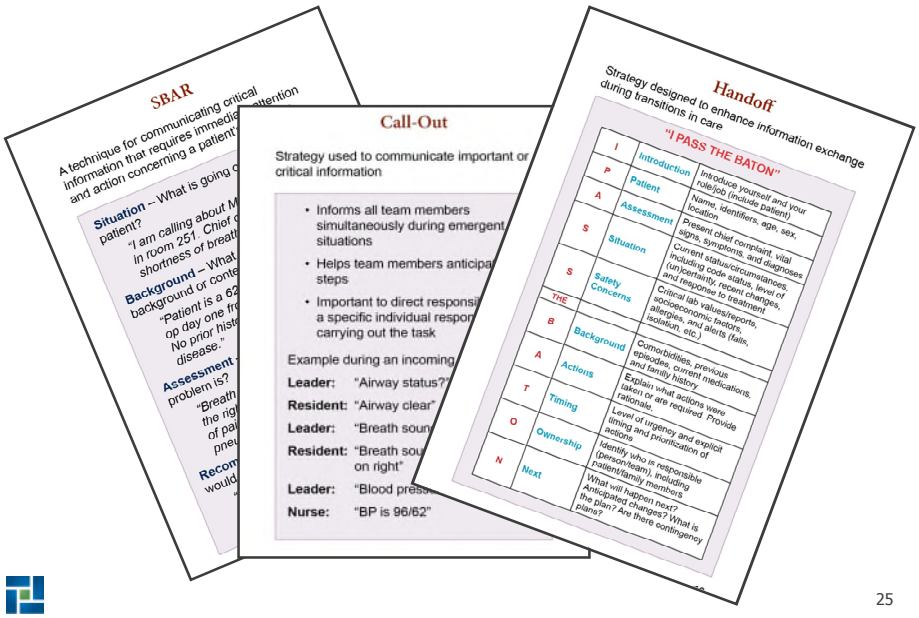
TOOLS/STRATEGIES

- Communication: SBAR, call-out, check-back, handoff
- Leading teams: brief, huddle, debrief
- Situation monitoring: STEP, I'M SAFE
- Mutual support: task assistance, feedback, assertive statement, two-challenge rule, CUS, DESC Script

OUTCOMES

- Shared mental model
- Adaptability
- Team orientation
- Mutual trust
- Team performance
- **Patient safety!**

Tools — communication



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Communication — additional handoff tools

ANTICipate
- Administrative data; new clinical information; tasks to be performed; illness severity; contingency plans for changes

I PASS
- Illness severity; patient summary; action list for the new team; situation awareness and contingency plans; synthesis and "read back" of the information

SHARQ
- Situation; history; assessment; recommendations/ result; questions

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Tools — leadership

Brief Checklist

During the brief, the team should address the following questions:

- ☐ Who is on the team?
- ☐ Do all members understand and agree upon goals?
- ☐ Are roles and responsibilities understood?
- ☐ What is our plan of care?
- ☐ What is staff and provider's availability throughout the shift?
- ☐ How is workload shared among team members?
- ☐ What resources are available?

Debrief Checklist

The team should address the following questions during a debrief:

- ☐ Was communication clear?
- ☐ Were roles and responsibilities understood?
- ☐ Was situation awareness maintained?
- ☐ Was workload distribution equitable?
- ☐ Was task assistance requested or offered?
- ☐ Were errors made or avoided?
- ☐ Were resources available?
- ☐ What went well?
- ☐ What should improve?

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Tools — situation monitoring

STEP

A tool for monitoring situations in the delivery of health care

Components of Situation Monitoring:

Status of the Patient

Team Members

Environment

Progress Toward Goal

Cross-Monitoring

A harm error reduction strategy that involves:

- Monitoring actions of other team members
- Providing a safety net within the team
- Ensuring that mistakes or oversights are caught quickly and easily
- "Watching each other's back"

Each team member is responsible for assessing his or her own safety status

I'M SAFE Checklist

- ☐ **I** = Illness
- ☐ **M** = Medication
- ☐ **S** = Stress
- ☐ **A** = Alcohol and Drugs
- ☐ **F** = Fatigue
- ☐ **E** = Eating and Elimination

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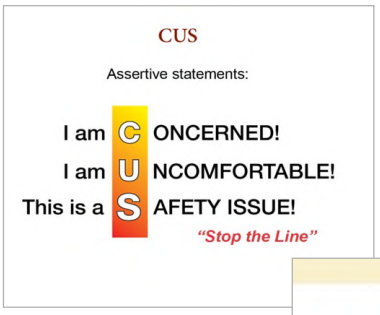
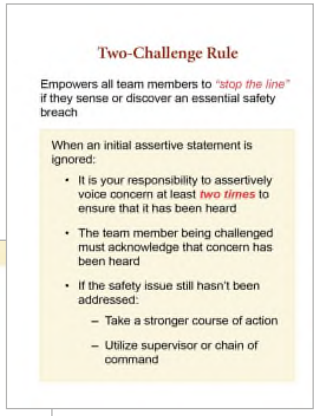
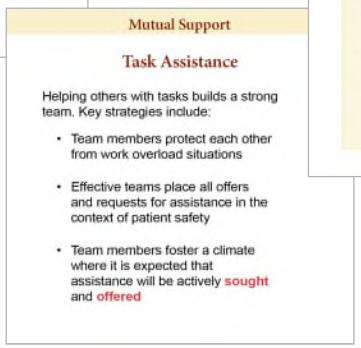
Tools — mutual support







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Video vignettes

- Based on tools
- Variety of practice settings
- Free
- Additional videos YouTube/Internet-based

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/videos/index.html

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Program training options — AHRQ

- **Train-the-trainer.** This 2-day training course is designed to create a cadre of teamwork instructors with the skills to train and coach other staff members.
- **Fundamentals.** This curriculum includes 4–6 hours of interactive workshops for direct patient care providers.
- **Essentials.** This curriculum is a 1- to 2-hour condensed version of the Fundamentals Course and is specifically designed for nonclinical support staff.
- **Online and in-person options** are available.

Register for **free** training or learn more: http://teamstepps.ahrq.gov/

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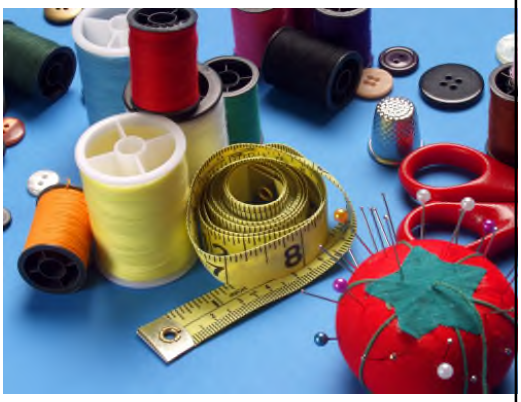
Tailoring your program

- Limited English proficiency
- Dental
- Primary care
- Medical specialties
- Long-term care
- Rapid response
- CUSP toolkits
- CLABSI tools
- Chronic care
- Shared decision-making
- Rapid response systems



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Medpro Group commitment

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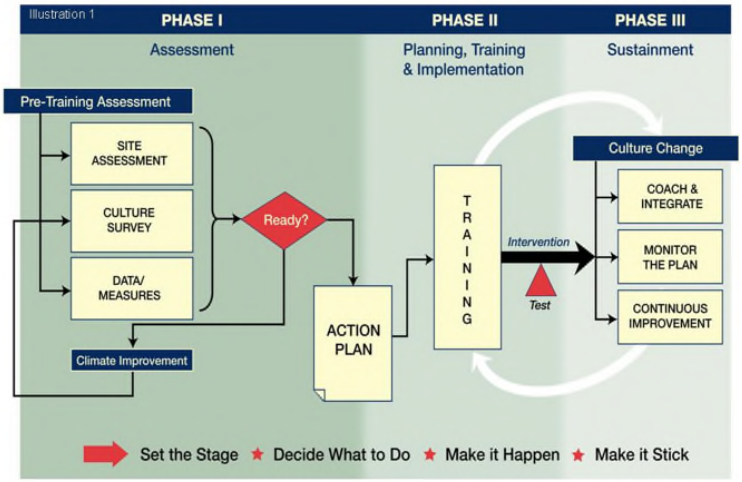
Recap of phases



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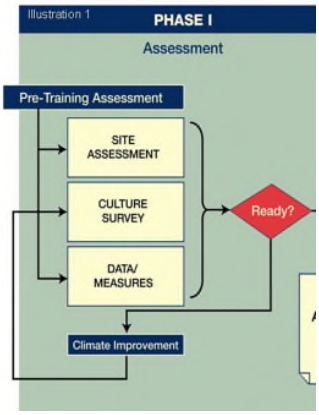
Phase 1

- Complete site assessment evaluation
- Review data
- Provide feedback on worksheets/plans



Set the Stage ★ Decide What to Do ★ Make it Happen ★ Make it Stick

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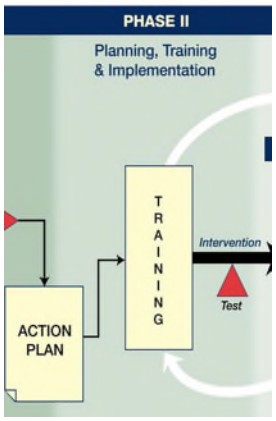
Phase 2

- Review action plan
- Review training plan
- Troubleshoot when complications occur



Set the Stage ★ Decide What to Do ★ Make it Happen ★ Make it Stick

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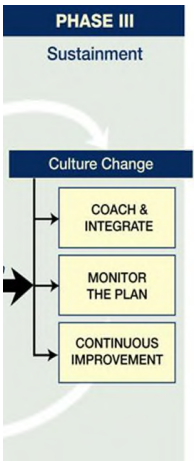
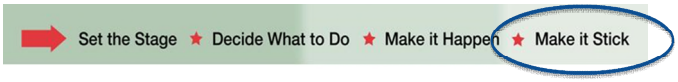
Phase 3

- Review outcomes
- Recommend adjustments to action plans





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The real world — interview with a TeamSTEPPS facility

CASS COUNTY HEALTH SYSTEM
Atlantic, Iowa

Jennifer Arp, BSN, RN, CPHQ
Performance Improvement Director
Quality/Risk Mgmt./Safety/Infection Control
Employee Health/Care Coordination

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What questions do you have?

Disclaimer

The information contained herein and presented by the speaker is based on sources believed to be accurate at the time they were referenced. The speaker has made a reasonable effort to ensure the accuracy of the information presented; however no warranty or representation is made as to such accuracy. The speaker is not engaged in rendering legal or other professional services. If legal advice or other expert legal assistance is required, the services of an attorney or other competent legal professional should be sought.