From Baby STEPPS to Big Leaps:
A range of approaches to team training implementation

Providence Health & Services
Moderated by Marly Christenson, PhD, RN, FNP, CPHQ
System Director, Patient Safety

Washington Patient Safety Coalition
May 2014

Objectives

At the end of this session, you will be able to:

1. Discuss a range of options for Team STEPPS implementation

2. Start developing the best fit approach for your organization based on lessons learned at Providence.

3. Prepare for a successful Team STEPPS implementation.

TeamSTEPPS

"an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system." -http://teamstepps.ahrq.gov/

Promoting a Culture of Safety as a Patient Safety Strategy
A Systematic Review

Sallie J. Weaver, PhD; Lisa H. Lubomksi, PhD; Renee F. Wilson, MS; Elizabeth R. Pfoh, MPH; Kathryn A. Martinez, PhD, MPH; and Sydney M. Dy, MD, MSc

- A review of 33 studies on implementations to improve safety culture in healthcare settings

- 57% had multi-faceted interventions with the following components
  - 60% included team-training
  - 24% included executive walkrounds
  - 24% included comprehensive unit based safety program
- 72% significantly improved safety culture survey scores

# Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices

Weaver & Rosen (2013) found moderate to high quality evidence that systematic team-training programs can meaningfully improve care processes and outcomes

Reference: Chapter 40 of AHRQ's 2013 publication, "Making Healthcare Safer II"
and as presented on December 2013 AHRQ TeamSTEPPS Webinar

TeamSTEPPS across Providence

- We have a variety of implementation approaches underway across our system
  - Respecting the unique needs and capacity of each organization
- Today's panelists will present several examples
  - Selecting components of TeamSTEPPS
  - Full implementation in one clinical area
  - Implementation hospital-wide

Snapshot of Providence

Employees	56,667
Employed physicians	2,981
Physician clinics	400
Acute care hospitals	32
Acute care beds (licensed)	7,288
Hospice and home health programs	19
Home health visits	580,811
Hospice days	656,155
Assisted living and long term care facilities (free standing and co-located)	22
Supportive housing	Facilities: 14 Units: 693
Unique Patients Served	2,169,857
Community benefit and charity care costs	$823 million
Total net operating revenue	$10.6 billion
Total net operating income	$204 million
Total net income	$1.2 billion
Total net assets	$6.7 billion
PH&S 2012Bond ratings	Moody's Aa2 S&P AA Fitch AA
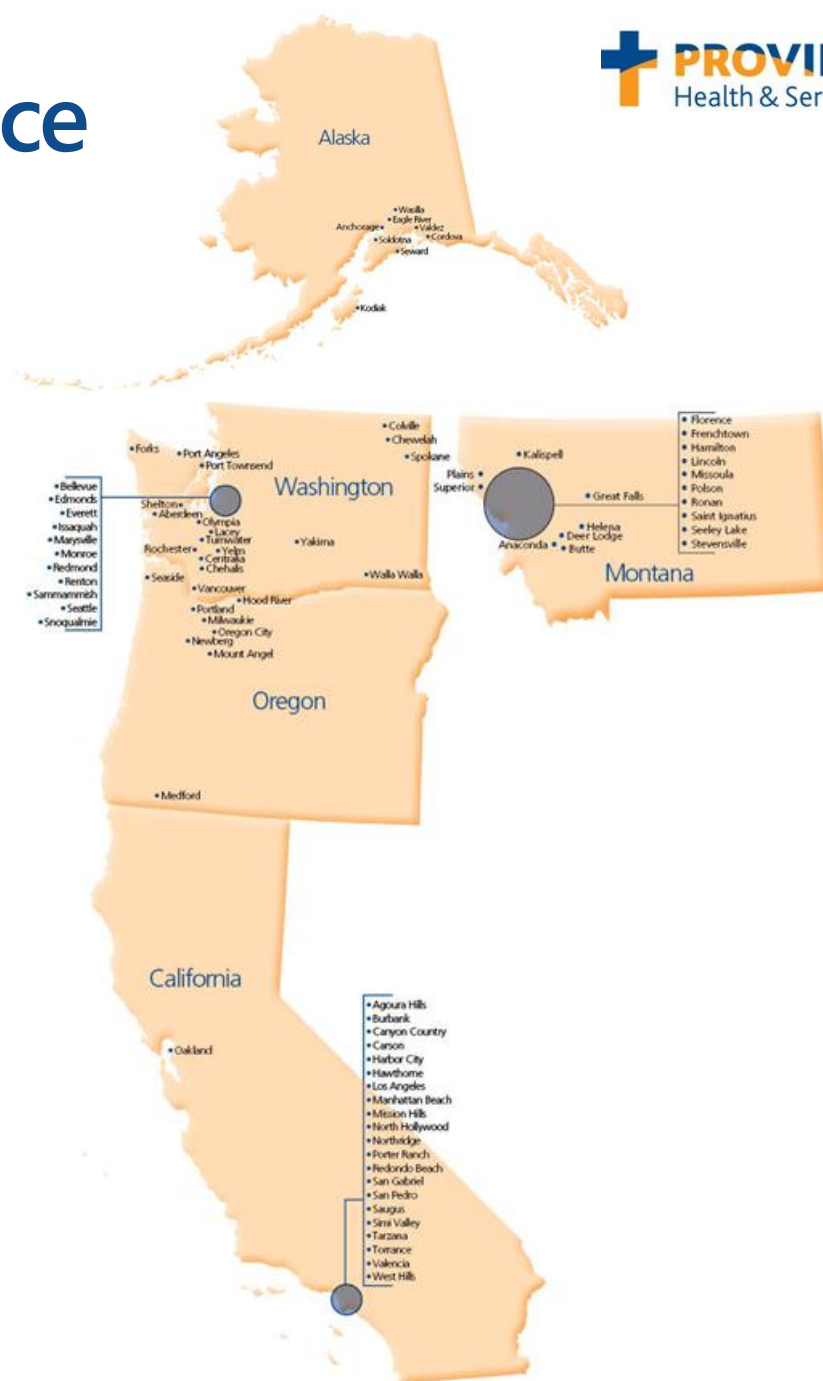
Our panelists

- **Mary Crawford, RN, BSN**, Clinical Educator, Supervisor Organizational Development, Providence St Mary Medical Center, Walla Walla WA

- **Jo K. Quetsch MA, RN, N**E-BC, Senior Director of Perioperative Services-Urban Hospitals, Providence Health Care Region, Spokane WA

- **Bernie Klein, MD**; CEO, Providence Holy Cross Medical Center, Mission Hills, CA

Mary Crawford, RN, Clinical Educator
Supervisor, Organizational Development
Providence St Mary Medical Center
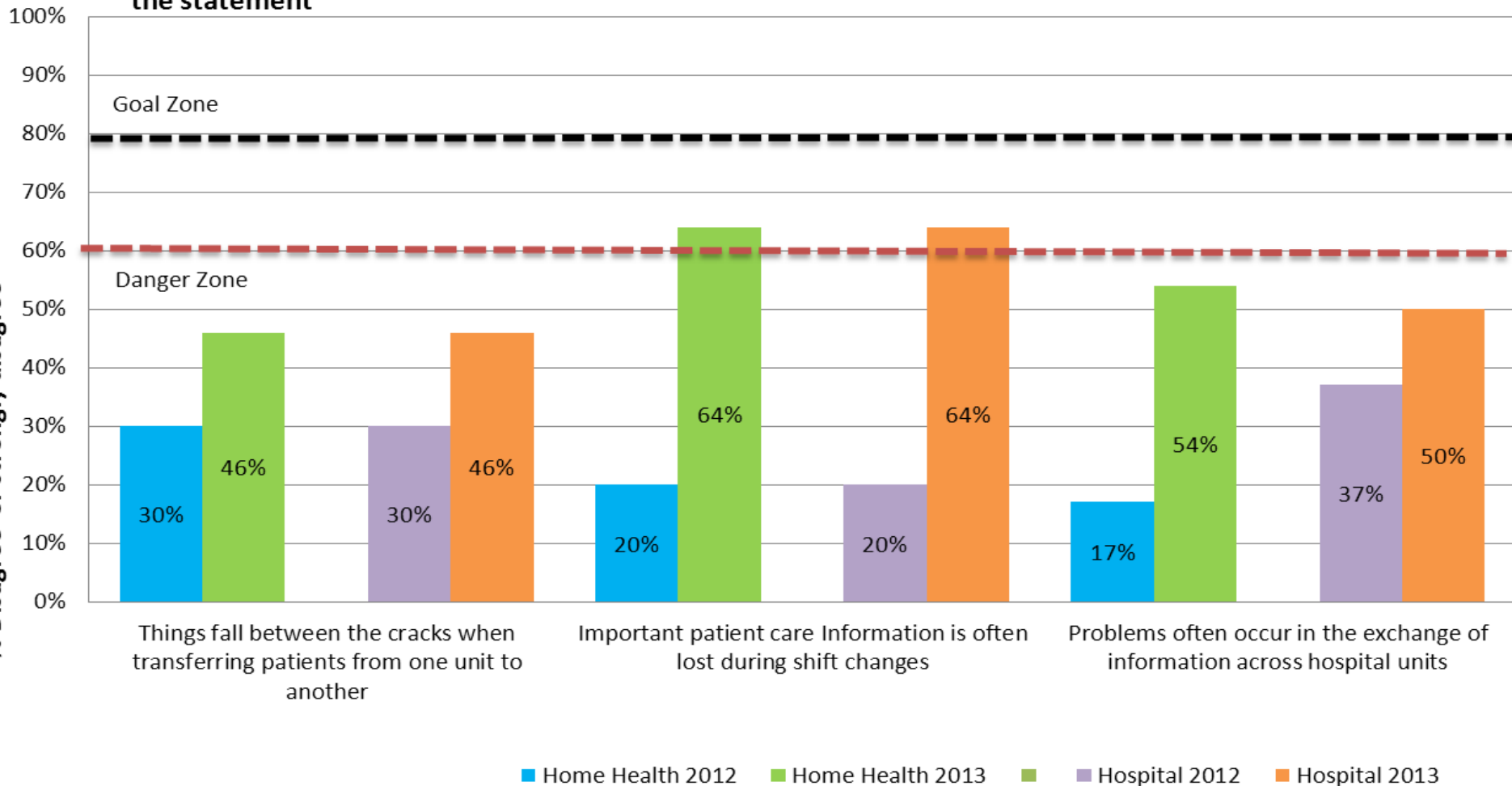### Walla Walla, WA

Our beginning

- First launch misfired
  - Back To the drawing board; then a "re-launch"
- Tools were selected
  - SBAR= **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation
  - Cross Check= Get it, Got it
  - Check-back = Get it, Got it, Did it
  - DESC = **D**escribe, **E**xpress, **S**uggest, **C**onsensus
  - CUS = **C**oncerned, **U**ncomfortable, **S**afety Issue
- Approach redesigned
- The inevitable challenges were tackled

Assessing progress

Our goal was to achieve 5% improvement in SAQ+ results from 2012 to 2013

SAQ+ Hosptial Handoff & Transition Items (from AHRQ's HSOPS)

Questions are negatively worded, scores display percent who disagree or strongly disagree with the statement

Goal Zone

Danger Zone

Things fall between the cracks when transferring patients from one unit to another
- Home Health 2012: 30%
- Home Health 2013: 46%
- Hospital 2012: 30%
- Hospital 2013: 46%

Important patient care Information is often lost during shift changes
- Home Health 2012: 20%
- Home Health 2013: 64%
- Hospital 2012: 20%
- Hospital 2013: 64%

Problems often occur in the exchange of information across hospital units
- Home Health 2012: 17%
- Home Health 2013: 54%
- Hospital 2012: 37%
- Hospital 2013: 50%

Y-axis: % Disagree or strongly disagree

Legend: ■ Home Health 2012 ■ Home Health 2013 ■ Hospital 2012 ■ Hospital 2013

Our work continues

2013 Training accomplishments

- 20 sessions (4 hours each)
  - Reaching almost 400 (40%) of our clinical and non-clinical staff
- 3 sessions (2 hours each) for our ambulatory medical group
- 8 sessions (1 hour each) as part of our new employee orientation

2014 Training plans

- More of our Providers
- Broader across our hospital
- Additional sessions for our ambulatory medical group

Jo K. Quetsch MA, RN, NE-BC
Senior Director of Perioperative Services
Urban Hospitals
Providence Health Care Region, Spokane WA

Enhancing team communication in the perioperative care setting

The supporting evidence

- Significant issues raised concerns about team functioning
  - Confirmed in patient safety reporting, safety culture surveys, and other comments from staff
    - *"I feel ostracized in that many of my co-workers do not want to work with me, surgeons, tech, other nurses".*
    - *"People talk about me and describe my actions to adhere to our safety standards as a negative thing, I just wonder why the other providers let things slide!"*
    - *"There is an enormous amount of social pressure to NOT get on anyone's bad side. Very unsafe environment for patient safety"*

Our goal

- To improve team communication in the perioperative care setting to maximize patient safety, as measured by:
    - Effectiveness of physician and nurse care coordination
    - Ability to speak up
    - Resolution of disagreements, not who is right but what is right for the patient

Launched September 2012

- Established a change team with a multidisciplinary approach

- Utilized Kotter's change model

- Used train the trainer model with small audiences

- Reduced OR volume on designated training days

- Conducted follow up sessions in conflict simulation

- Reinforced at weekly huddles

- Coached at unit level by leadership

Assessing progress
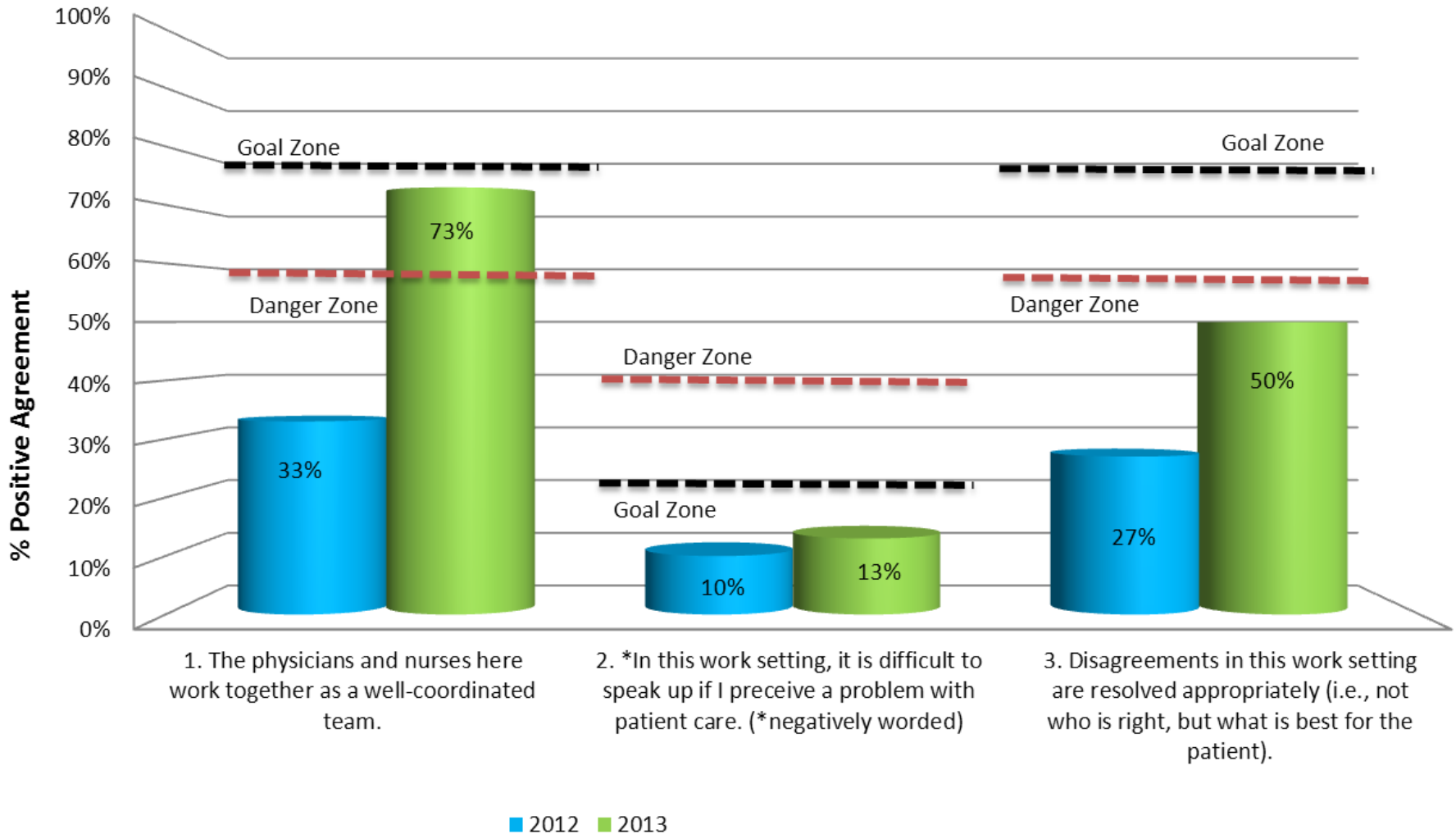
Our future

- Up next
  - Ongoing training sessions
  - Site-specific targeted plans (i.e. "improving ability to speak up")
- Sustainability
  - Yearly competencies via on-line training module
  - Customization for team specific needs
  - Monthly phone calls with other TeamSTEPPS sites
- Adoption
  - Spokane organizational wide adoption at urban campuses

Bernie Klein, MD
Chief Executive Officer
Providence Holy Cross Medical Center
Mission Hills, CA

Patient Safety Toolkit

Communication is a vital component of patient safety. The purpose of the PHCMC Patient Safety Toolkit is to ensure excellent communication for every patient, every time, whether it concerns a "hand-off", a need to inform others of an escalation in a patient's condition or when one needs to ask a clarifying question… And always make sure to have a Wingman!

A. The 5 P's of hand-off communication:

- **P**atient (identify)
- **Pl**an (plan of care: fluids, intake, output, intravenous access)
- **P**urpose of plan (clinical findings supporting plan of care, goals to be achieved)
- **P**roblem (abnormal findings, pain scale, vital signs, assessment)
- **P**recaution (isolation, allergies, etc.)

A "hand-off" communication is real time, interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for ensuring the continuity and safety of the patient's care.

B. SBARR (Situation, Background, Assessment, Request, Read Back):

- **S** = Situation (a concise statement of the problem)
- **B** = Background (pertinent and brief information related to the situation)
- **A** = Assessment (analysis and considerations of options—what you found/think)
- **R** = Request (action requested/recommended—what you want)
- **R** = Read back

SBARR is an effective and efficient way to communicate important information to physicians. SBARR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

C. If you have a concern, ask a "Clarifying Question":

- Ask (for more information/clarification about an order or intervention)
- Request (an intervention if the MD has not ordered something)
- Concern (state concern if the MD dismisses the collaboration)
- Chain of Command (elevate the concern through the chain of command)

AND ALWAYS have a "Wingman," a co-worker you trust and respect to:

- Provide you with support, including checking your work to prevent an error.
- Provide you with peer coaching, encouragement and praise for performing correct behaviors and discouraging incorrect behaviors.
- Be a mutually supportive team member, creating a safe environment to identify and correct safety risks.

Mutual support implies "You are not alone – I've got your back!"

Team STEPPS

PROVIDENCE
Health & Services

PROVIDENCE
Holy Cross
Medical Center

Providence Holy Cross Medical Center

Overview

TeamSTEPPS is an evidence-based teamwork approach used to improve communication among health care professionals and ensure patient safety. TeamSTEPPS looks at how we optimize performance and enable caregivers to respond quickly and effectively to changes in the patient care environment.

Goal:

To understand how to leverage teamwork to standardize communication, improve patient care and prevent medical care.

Background:

Staff indicated through the Culture of Safety Survey that the communication and teamwork climate at Providence Holy Cross had a great opportunity for improvement, specifically in the areas of handoff and transition.

Plan:

This year, we plan to implement TeamSTEPPS in 5 Clinical Areas: Acute Rehab, PACU, Cath Lab, Tele, and GI. To ensure multi-disciplinary collaboration, the Ancillary and Support Services staff will be integrated into the clinical area training.

Patient Safety Toolkit

- 5P Handoff
- SBAR-R Communication
- Timeout (stop the line)
- 2-way Communication
- Debrief
- Wingman

Dr. Mike Sarti | Physician Champion
(818) 496-1955

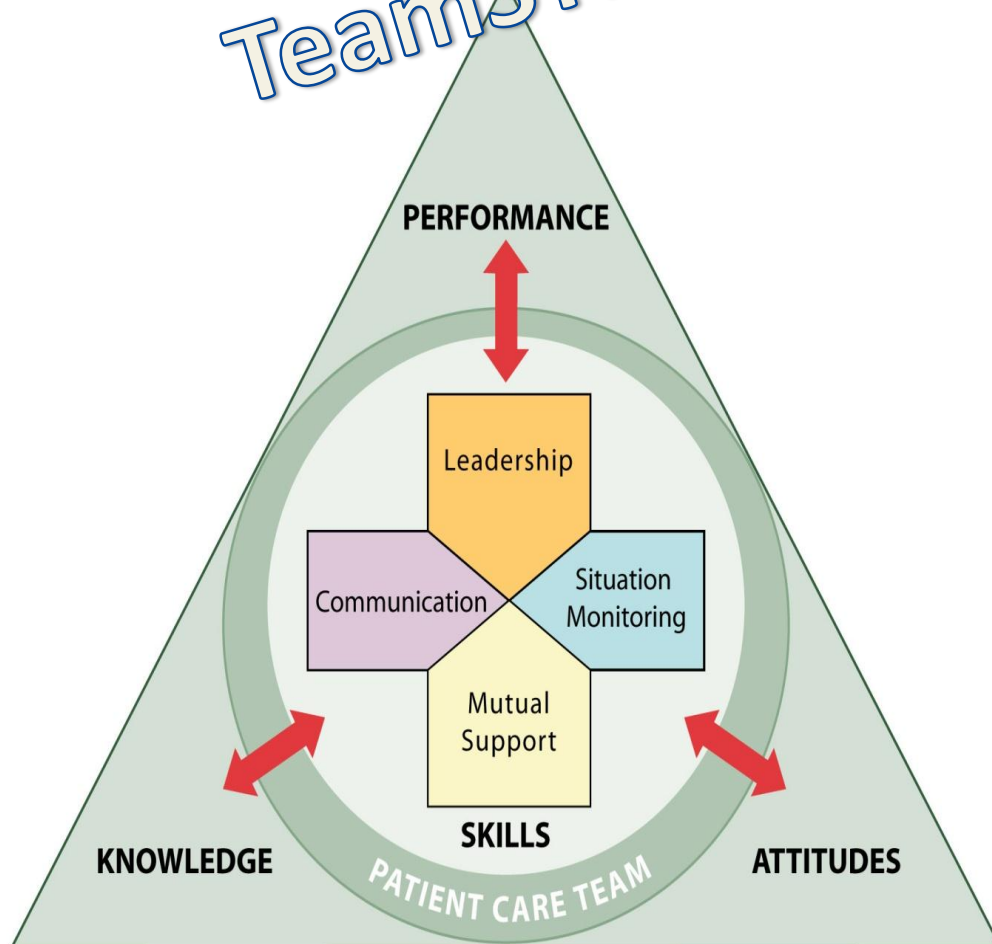Andrew Ibrahim | Project Manager
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Culture of Safety at Providence Holy Cross Medical Center
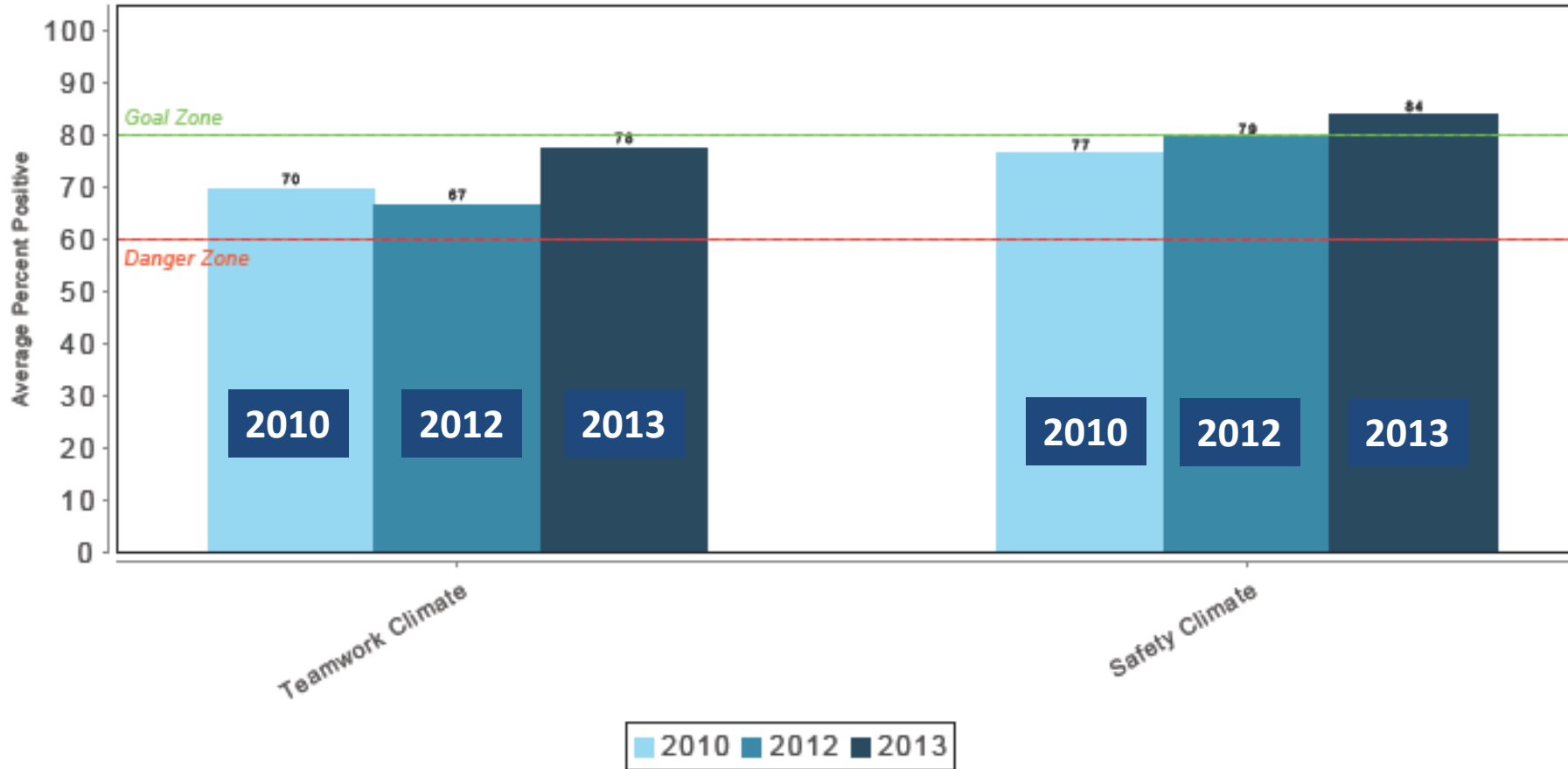

Our patient safety toolkit

- 5P Handoff
- SBARR Communication
- Timeout (stop the line)
- 2-way Communication
- Debrief
- Wingman

2012	2013
GI	OR/PACU
Rehab	Women's Health
Cardiology	
Short Stay	
Cath Lab/Specials	

Assessing progress

How Healthy Is Our Culture?
Safety Attitudes Questionnaire Domain Scores

How Healthy Is Our Culture?

Safety Attitudes Questionnaire Plus Domain Scores

Scores for: PHS PHCMC-Cardiology
(1/1 Work Settings)*
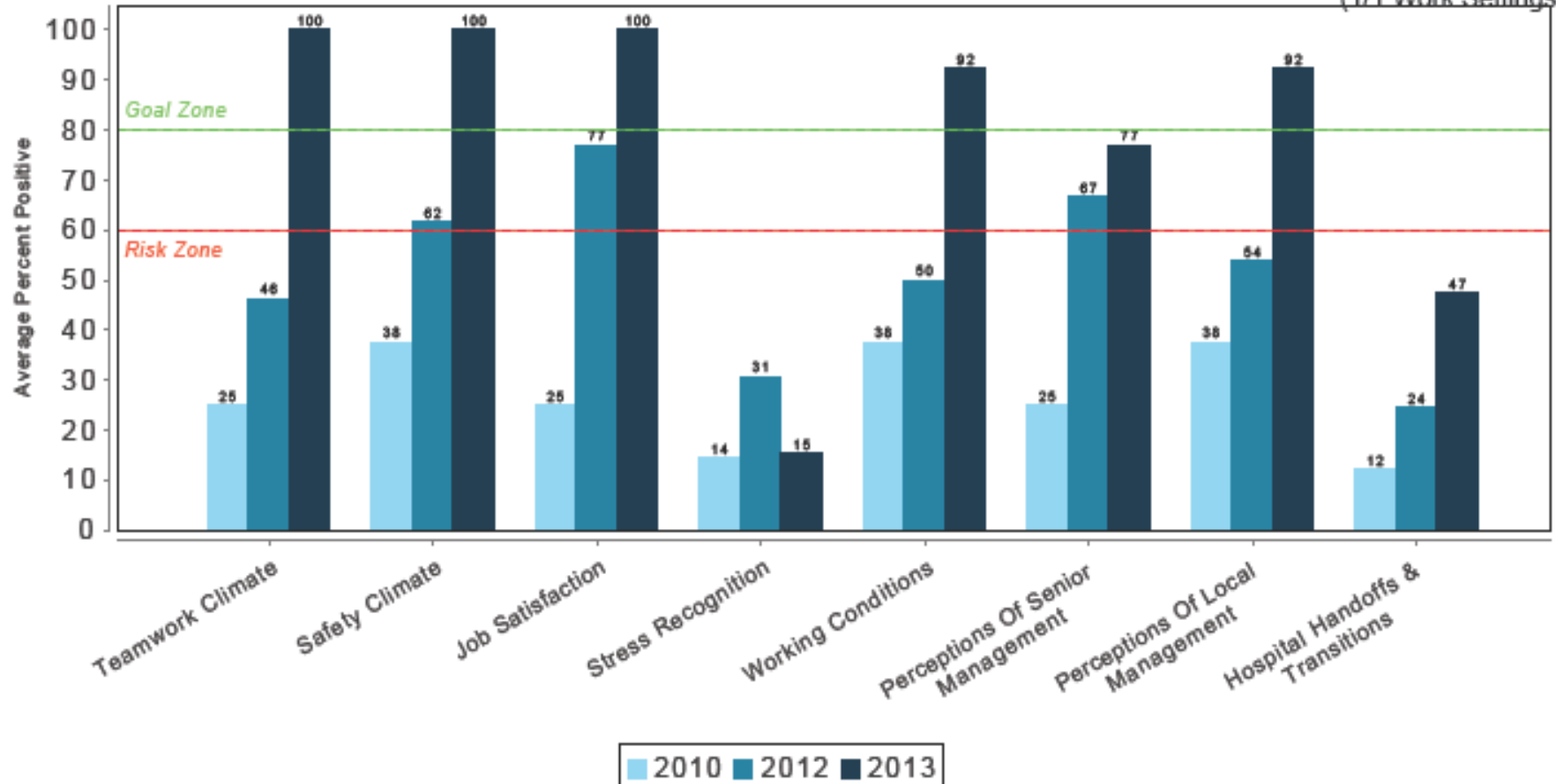
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Questions
&
Discussion