Team Strategies and Tools to Enhance Performance and Patient Safety

Make it Happen, Make it Stick

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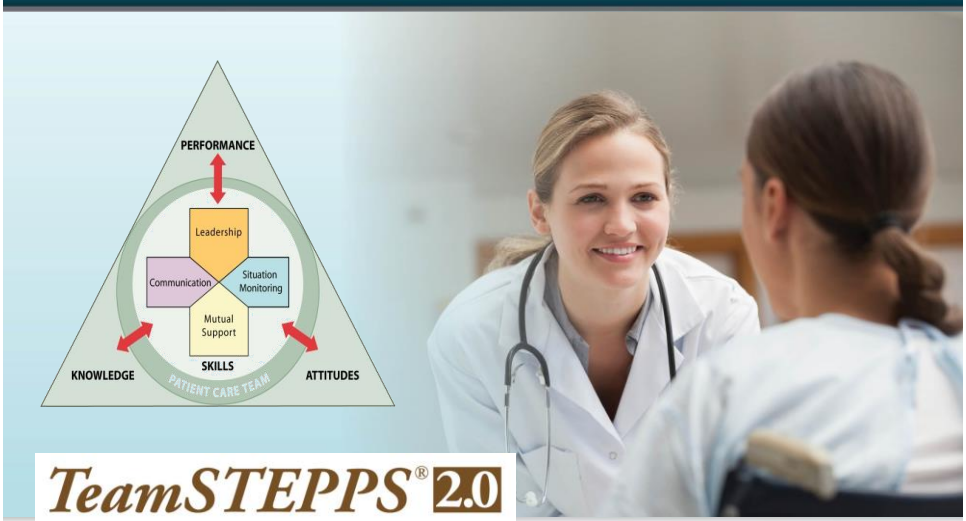
Welcome!



TeamSTEPPS® 2.0

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Foundation for Change

How Do You Define Culture?

The set of shared attitudes, values, goals, and practices that characterizes an institution, organization or group

Human Factors: Inevitability of Error

*Limited memory capacity: 5-7 pieces of information in short term memory

*Negative effects of stress – error rates

* Tunnel vision

*Negative influence of fatigue and other physiological factors

*Limited ability to multitask – cell phones and driving

- Errors of Omission
  - 1 in 100
    - Example: Forget to turn on a pump
- Errors of Commission
  - 3 in 1000
    - Misread a label on a drug

Salvendy and Park
Compendium of Human Factors

Human Error Rates

Activity (Assume no undue time pressure or stresses)	**Rate**
Error of commission, e.g. misreading a label	.003
Error of omission without reminders	.01
Error of omission when item is embedded in a procedure	.003
Simple arithmetic errors with self checking	.03
Monitor or inspector fails to recognize an error	.1
Personnel on different shifts fail to check the condition of hardware unless directed by a checklist	.1
Error rate under very high stress when dangerous activities are occurring rapidly	.25

Source:Adapted from: Park K. Human error. In: Salvendy G, ed. *Handbook of human factors and ergonomics.* , New York: John Wiley & Son, Inc. 1997: 163

Complex Systems

40 steps Medication Delivery process
1 in 100 Intrinsic error rate in EACH step:
- Calculation: 0.99 X 0.99 X 0.99 etc.

66% Perfect end product
Conclusion: **34 of 100** imperfections

40 steps Medication Delivery process
1 in 1000 Intrinsic error rate in EACH step:
- Calculation: 0.999 X 0.999 X 0.999 etc.

96% Perfect end product
Conclusion: **4 of 100** imperfections

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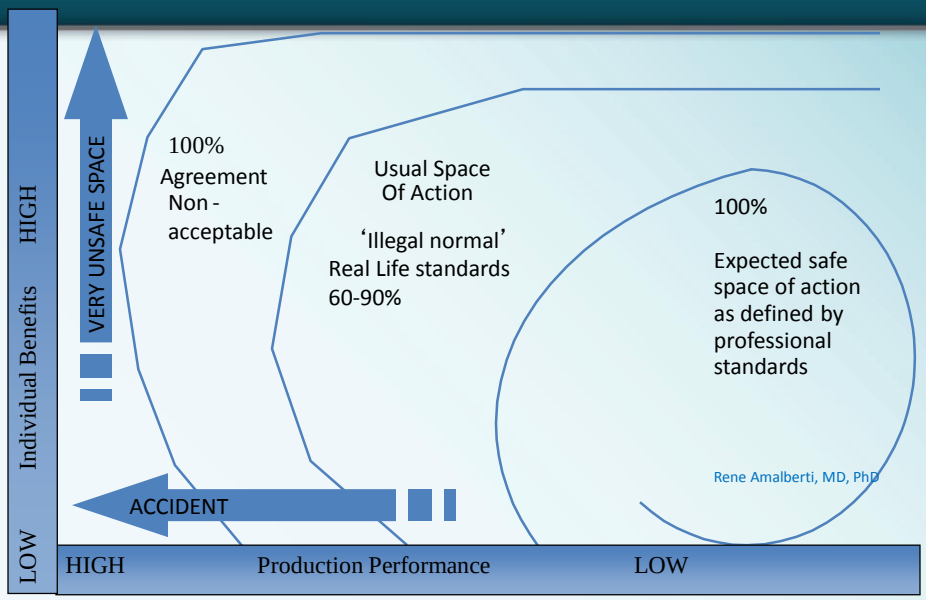
Systemic Migration of Boundaries: Deviation is Normal



TeamSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety

- Based on more than 30 years of research and evidence
- Team training programs have been shown to improve attitudes, increase knowledge, and improve behavioral skills
- Salas, et al. (2008) meta-analysis provided evidence that team training had a moderate, positive effect on team outcomes ($\rho = .38$)

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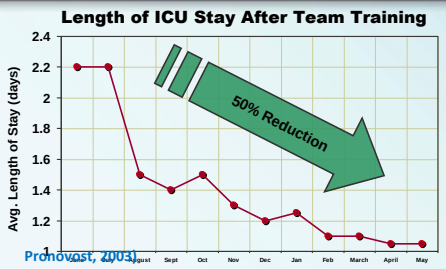
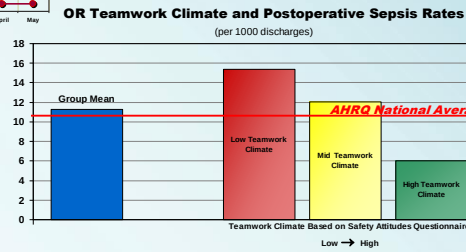
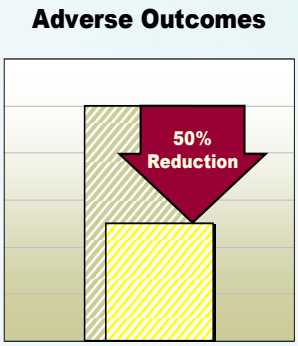
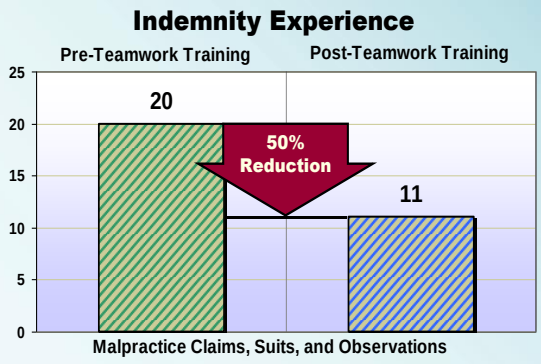


Pronovost, 2003)
Johns Hopkins
Journal of Critical Care Medicine



(Sexton, 2006)
Johns Hopkins





(Mann, 2006)
Beth Israel Deaconess Medical Center
Contemporary OB/GYN

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

Rapid Response Systems
Enhancing Safety for Patients with LEP
Dental
Long Term Care
Primary Care
Simulation

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Communication and Team Skills

Accuracy	*Assertion*
Call Out	CUS
Check Back	DESC
SBAR	

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Accuracy

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Call-Out is…

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

…In your work area, what information would you want called out?

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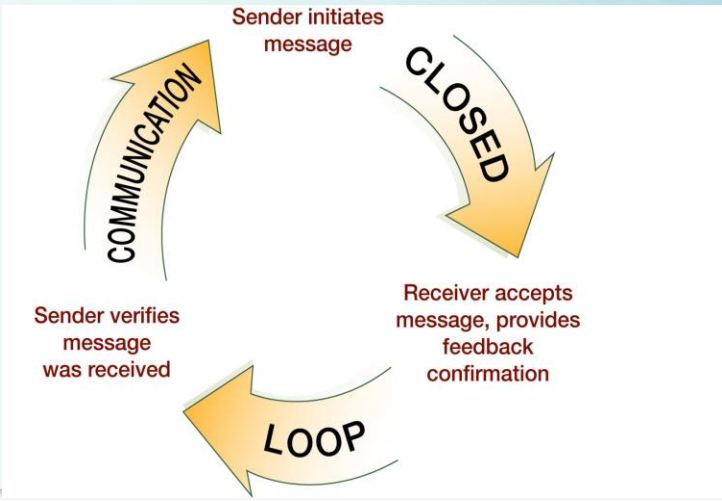
Check-Back is…



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What is SBAR?

Situational Briefing Model

- S Situation
- B Background
- A Assessment
- R Recommendation

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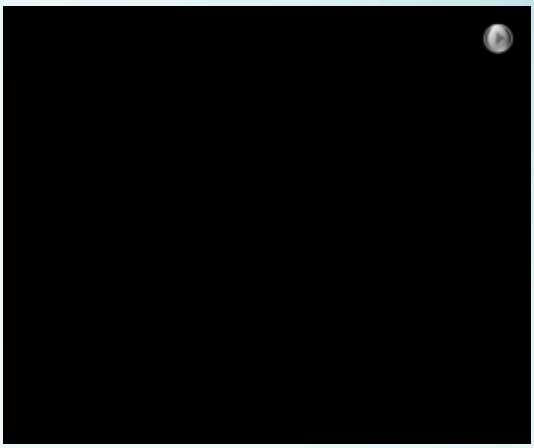
Needs SBAR



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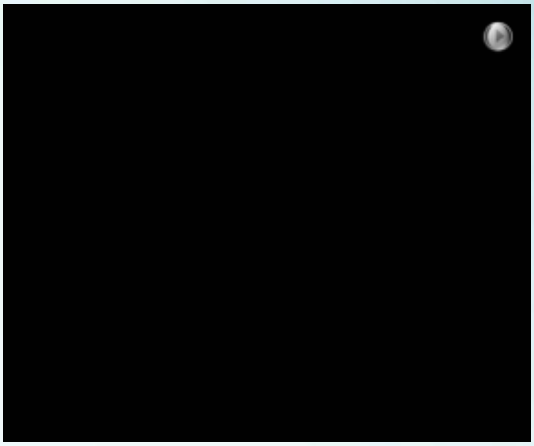
Better with SBAR



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Scenario

Linda is a 55 year old woman who is having some shoulder pain. She goes to her primary care physician's office to see about it. She can only lift her right arm about halfway up, and it hurts. She had a frozen shoulder on that side 10 years ago, which felt something like this but not exactly. Her doctor comes in and says "what seems to be wrong?"

- S
- B
- A
- R

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Scenario

Mary is the on-call nurse for the weekend in PACU. Her patient Mr. Smith is 62 yrs old; s/p emergency appy.; has h/o previous CABG, L knee arthroscopy 1999; Type 2 DM. BP 90/50, P 120 with occasional PVCs, RR is 30. Mr. Smith is c/o nausea ; is pale and diaphoretic. Mary's concerned he may be having a cardiac event. She calls the physician.

- S:
- B:
- A:
- R:

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Your scenario?

Where do you need SBAR in your setting?

What issues might SBAR solve for you?

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Assertion

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The Assertive Statement

- Respectful and supportive of authority
- Clearly asserts concerns and suggestions
- Is nonthreatening and ensures that critical information is addressed
- Five-Step Process:

1. Open the discussion
2. State the concern
3. State the problem—real or perceived
4. Offer a solution
5. Obtain an agreement

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Stop the Line!

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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Please Use CUS Words but *only* when appropriate!

"I'm **C**oncerned…"

I'm **U**ncomfortable…"

"This is a **S**afety issue…"

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CUS

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Other Critical Language

"I need clarity…"

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Scenario

You are working in a busy Clinic. You notice that the physician who is working with you does not wash his hands between patients.

You know that the spread of infection can be prevented by good hand hygiene

Your office policies discuss the Joint Commission NPSG about the importance of preventing infection and handwashing.

WHAT DO YOU DO?

Your Scenario?

When do you need CUS in your setting?

What problems might CUS solve?

Conflict Resolution

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

Let's "DESC-It!"

DESC-It

- Have timely discussion
- Work on win-win
- Frame problem in terms of your own experience
- Choose a private location
- Use "I" statements; avoid blaming statements
- Critique is not criticism
- Focus on what is right, not who is right

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A DESC Scenario

A nurse feels that a patient no longer needs a Foley catheter. There is no nurse driven protocol in place, so the nurse mentions removing the Foley to the resident during rounds. The resident orders the Foley to be removed. When the attending later realizes that the order was given without his consent, he raises his voice to the resident in front of staff and the patient.

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DESC Scenario

You are in a meeting that includes a conference call with external stakeholders. The meeting tone is tense and there are some disagreements in approach. Your team leader, who is facilitating the call, puts the phone line on mute and says “I HATE working with these people!”, then unmutes the line. You get through the meeting, but you feel uncomfortable about the leader’s comment. The next day you approach him to discuss it.

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Your Scenario?

When do you need to use DESC in your setting?

What problem might be improved with DESC?

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Implementation: Change Management

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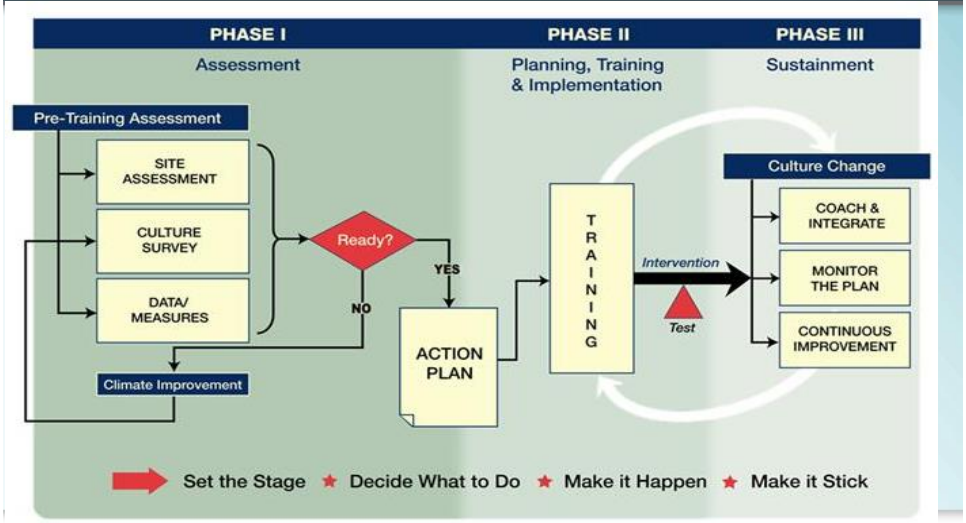
Implementation Planning



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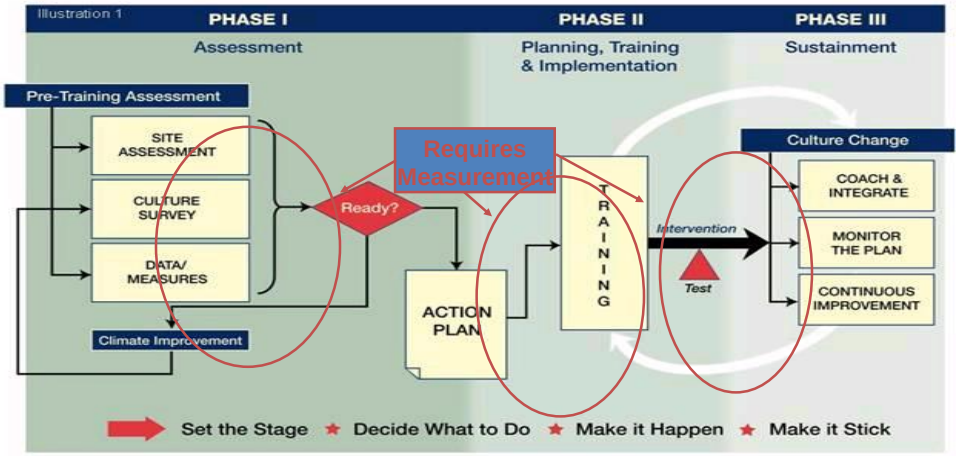
TeamSTEPPS Phases



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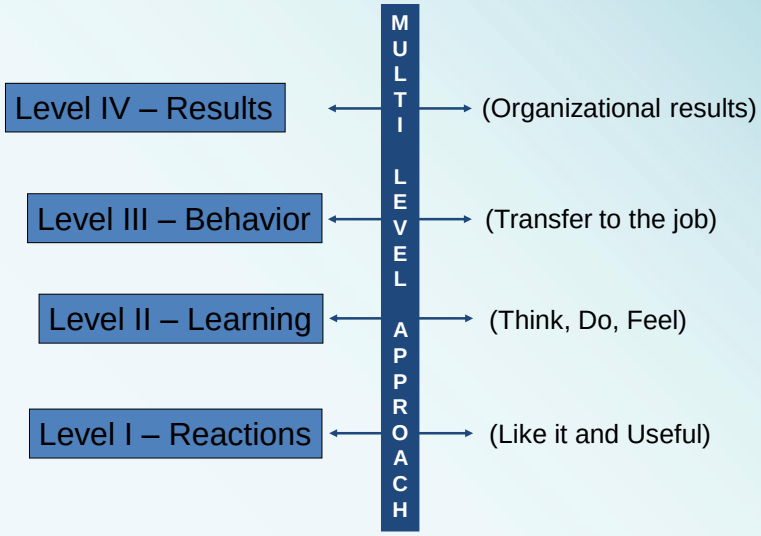
How to Measure - Kirkpatrick



Planning Worksheets

2. What's the problem? What metrics define the problem?
3. What will you improve, where, how much?
   How will you know the improvement happened?
4. What TeamSTEPPS tools to use? What order?

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Scenario

Where?
What's happening there?
When?
Who's involved?
How will the tool/skill help?

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Debrief

What went well?

What could have gone better?

What should I do differently next time?

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Contact Information

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

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