Panel Discussion of Master Trainers about Implementation Successes and Barriers

March 31, 2011

TeamSTEPPS training for Master Trainers

Question 1: What data and/or stories did you use to define the need to improve communication and teamwork? (How did you emotionally engage staff in the need to change?)

We found that a big problem was timely information exchange with doctors so we designed an SBAR fax form. Communication turn-around went from two weeks to one day. This first small win created buy-in with TeamSTEPPS from staff & doctors.

We showed the Sue Sheridan video and shared our error rates to encourage buy-in; also distributed several copies of the Kotter book—Our Iceberg is Melting.

I shared the fact that medical errors nearly took my daughter’s life; consequently patient safety has become my mission. I shared with my employees how the HSOPS identifies the gap between our values/belief and our behaviors.

We looked for stories after showing the Sue Sheridan video, shared local examples of errors, and used the “Beyond Blame” video.

We set the stage with Kotter’s book first, all employees read the book. Then the CEO explained the need for change. Signs for the tools were posted around the facility before training, and the Magic Wand was used to identify opportunities for improvement during training.

We used the Sue Sheridan video, allowed people time to absorb the message and to share thoughts – a powerful experience – also shared data, stories, and personal experiences.

Question 2: How did you make it clear to staff that the structured communication and teamwork behaviors taught in TeamSTEPPS are consistent with your organization’s overall mission, vision and values?

To emphasize that TeamSTEPPS is not another “flavor of the month”, we incorporated it into our vision and mission of “servant living;” TeamSTEPPS is another way to achieve this mission. We also used photos of existing teams within the hospital.

Our CEO spoke, gave support and linked TeamSTEPPS to our mission and vision.

Question from the audience: How do you achieve buy-in throughout the organization?

Buy-in started with the CEO, then we presented to the Board of Directors – which was the hardest, they are not medically trained, had to focus on how team training will decrease risk for the hospital and increase safety for patients.
Senior leadership had to be involved first. Began with the CEO, so that he knew quality measures would be expected to improve with training. Next presented to the hospital board, 20 minutes only, showed the Sue Sheridan video and gave local examples of medical errors that could have been prevented with better teamwork. Next presented to the medical staff – they wanted specific goals, so gave examples of the tools. Next, presented to directors and supervisors. The National Implementation web site has a video detailing how to obtain buy-in (makes the point that all persons are fallible and teamwork is a safety net.)

The CEO supported the concept of team training but front line people and human resources were not as receptive. Emphasize that errors affect patients AND staff – staff need these tools.

Bottom Line: improving teamwork is the right thing to do; staff will be more satisfied (decrease staff turnover) and we can avoid an errors (patient safety).

**Question 3 : Describe the resources that your organization allocated to support TeamSTEPPS training and implementation.**

We trained the whole hospital. For 230 employees, 4 master trainers and one CEO – training, snacks, and materials, we budgeted $30,000, which includes four hours of staff training.

Can introduce one tool at a time. Focus on one problem and get the tool to fix it. Identify the specific problem, and fix one at a time pointing out how the tool worked.

We talked to managers of departments and did training as part of mandatory monthly meetings.

**Question 4: How do staff know that their supervisors and senior management is supportive of the training and new behaviors?**

If the training is mandatory. The barrier was that the CEO and CNO were in favor, the CFO and HR thought it was a clinical nursing issue. Perhaps point out the benefits of reducing turnover and reducing the costs associated with errors.

If no cooperation in training, then mandate it must be completed by a certain date. Mandate that people must SBAR to each other every week – mandate a huddle and assign who will call it.

**Question 5 : Describe your plan to train your staff.**

Find someone you can influence, or who is influential and will listen to you – get that person on board, then go with them to use the tools. The buy in and role modeling of an influential person is very helpful.

We had management buy in. First upper management was trained – CEO, CFO, CNO and all – needed them to model the behavior. Second all employees were trained – two sessions a week, interdisciplinary, all part of a team, 4-5 hours training but paid for 8-4, and they received a free lunch. Third after all were trained, a TeamSTEPPS Champion was chosen in each department, so that each department would have a role model.
Training was mandatory for all – the CQO and CNO attended training – all management supported it. The full course was four hours, the essentials course was 10 minutes. The Board, department heads, some medical staff, all took four hours. Trained 36 people in one week, for those who were ill there was an essentials follow up.

Audience question- How can one ask physicians to take the training when they are independent of the hospital? How does one make the tools work when there’s resistance?

You have to take extra effort to get MDs on board, try introducing one tool at a time before a full training.

Audience question – What if you get lip service but no buy in from MDs?

We approached MDs at their meeting, and asked them how they would like to learn. They wanted to watch the video and read slides. Two months later, observation showed that the message was not hitting home for the MDs. Then we had a physician champion come out and spoke to the MDs. In a fifteen minute conversation this champion told our MDs how TS impacted his practice and the improvements that happened. Now more MDs are on board.

Present TeamSTEPPS to MDs like any other evidence – poor communication and lack of teamwork are factors in sentinel events. “Your role is leadership” – call briefs, huddles, de-briefs. Let the nurse know you appreciated the SBAR.

Figure out what evidence is needed by studying your audience.

Our success story – started with employees and then offered MD training separately – about ⅔ were trained and they were given no preferential treatment (included exercises and practice.) For SBAR, the focus was on nursing communication – suggested the nurse write down the information before the call in SBAR format – nurse should evaluate MD response, and MD should evaluate SBAR communication.

Share the impact of training on your HSOPS results; after training, we increased in every category; especially in overall perceptions of patient safety, non-punitive response to error, and hand-offs.

We provide rewards include using a goose theme, and at the end of the training each employee receives a goose lapel pin.

We use bee pins – MDs get them when they are caught using TS tools.

We have shirts that say “Penguin Power!” These are worn by coaches, given away in drawings during TS month, penguin pins are worn.

Pins and shirts are a tangible symbol that administration is supportive of training

Question 6: Describe your plan to “coach” new behaviors and the role of coaches in your implementation plan.
After training, departments with TS champions and Master Trainers did better; TS Champions were coaches; a person has to choose to be a coach.

Question from audience: in a small facility, will it stop after training? All employees wear many hats – how do you find the energy and the $$ to sustain it?

You just defined the need for teamwork.

Sustaining is the hardest part. You have to decide if this is something you want to do. Decide what is on your plate and offload what you can to make room. Conference calls & emails from UNMC make up a wide support group to whom you can turn for advice and encouragement.

We began with SBAR and CUS – we kept plugging and added tools at small meetings, that way it is not so overwhelming – then re-visit it with a “Tool of the Month.”

Hard wire the change by including use of the tools in job descriptions and performance appraisals. Organizations get what they measure.

The hardest part is the coaching – make it the first thing instead of the last thing.

Question 7: What one thing did you do that you would definitely do differently and how would you do it differently?

We will repeat smaller “just in time” trainings, one tool at a time at monthly all-staff meeting. Use HSOPS results to choose better communication tools.

We would create a very focused action plan.

Some people are not using the terms but they are using the tools. One thing we would do differently would be the need to spell it out better for non-clinical people, present it differently.

We would have changed the timing of the roll-out, it was done one month after another new program was introduced, so we should have waited longer. And we would try more for physician engagement, get them to buy in and participate.

We would train some coaches and champions before we trained the general employees so that when they went back to their area, they had some feedback when they first used the tools. Give each employee a pocket guide – good idea.

Do not train department managers separately, there is not as much buy in and participation in the training.

We started at the top and then trained everybody.

We should have brought the medical staff into training and made it a mixed group, with assigned seating.