Adapting the T-TPQ: Assessing Teamwork Support for Fall Risk Reduction

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**CAPTURE**

Collaboration and Proactive Teamwork Used to Reduce Falls

http://unmc.edu/patient-safety/capturefalls
CAPTURE Falls

- **Collaboration And Proactive Teamwork Used to Reduce Falls**

- Partnered with 17 TeamSTEPPS trained Nebraska Hospitals (16 Critical Access Hospitals)
  - Develop a customized CAPTURE Falls Action Plan
  - Support and evaluate program and action plan implementation
  - Interprofessional, multi-team approach to fall risk reduction
TeamSTEPPS Multi-Team System

Multi-team system framework applied to fall risk reduction designates role clarity and a chain of accountability for reducing patient fall risk.

Patient & Family
Role(s): Ask questions

Core Team
Direct Patient Care
Physician, Nursing, Nursing Assistants, PT/OT, Pharmacy, etc.
Role(s): Diagnosis and treatment plan, conduct fall risk assessment, implement fall reduction interventions, medication review, mobility assessment, report and learn from falls

Fall Risk Reduction “Coordinating” Team
Interprofessional Coordinating Team
Nursing, Quality Improvement, PT/OT, Pharmacy, etc.
Role(s): Implement fall risk reduction program, educate staff, audit processes, analyze and learn from falls, hold core team accountable

Ancillary & Support Services Team
Task Based Patient Care and Support
Radiology, Lab, Respiratory Therapy, Dietary, Speech Therapy, Tech Support, Housekeeping, etc.
Role(s): Know fall program policies, patient transfer rules, execute fall risk reduction role

*Contingency Team*
Conduct Post-Fall Huddle
Core and Fall Risk Reduction Team members
Role(s): Review and learn from fall, improve fall risk reduction interventions

Administration/Management Team
CEO/President, Director of Nursing, Members of Senior Leadership/Management Teams, etc.
Role(s): Create and visibly support a patient safety culture, aware of strengths and performance gaps, establish clear vision with goals and provide feedback, support and provide resources for Fall Risk Reduction Team and Core Team, hold Fall Risk Reduction Team accountable for implementation and evaluation of fall risk reduction program
The T-TPQ-“F”

Adaptation of the TeamSTEPPS Teamwork Perceptions Questionnaire\(^2\) and the Organizational Readiness for Change Assessment\(^3\) specific to fall risk reduction

**Teamwork Behaviors**

- **Situation Monitoring** \(\alpha = .90\)
- **Mutual Support** \(\alpha = .91\)
- **Communication** \(\alpha = .93\)
- **Team Structure** \(\alpha = .90\)
- **Leadership** \(\alpha = .94\)

**Organizational Context for Change**

- **Management/Senior Leadership** \(\alpha = .96\)
- **Opinion Leaders** \(\alpha = .90\)
- **Hospital Staff** \(\alpha = .91\)
- **Organizational Resources** \(\alpha = .84\)
Insights from the T-TPQ-F

T-TPQ-F Teamwork Behavior Results
Aggregated Across 17 Critical Access Hospitals

Educate administration and ancillary staff on their role(s) fall risk reduction
Understand and clarify coordinating team expectations for monitoring, support, and communication to all other teams

Team Structure
Leadership
Situation Monitoring
Mutual Support
Communication

- Administration/Management
- Coordinating Team
- Core Team
- Ancillary Team
- Support Services
Example: T-TPQ-F Results

T-TPQ-F Teamwork Behavior Results
Example Critical Access Hospital

Team Structure
Leadership
Situation Monitoring
Mutual Support
Communication

- Coordinating Team
- Core Team
- Ancillary Team
- Support Services Team
**Example: T-TPQ-F Action Planning**

**Opportunity:** Educate support staff to clarify their role in the multi-team system for fall risk reduction

- Staff within my unit/department understand their roles and responsibilities related to fall risk reduction (Team Structure)
  - Coordinating Team: 90%
  - Core Team: 93%
  - Ancillary Team: 100%
  - Support Services Team: 67%

**Opportunity:** Implement peer-to-peer fall risk reduction cross-monitoring to improve reliable implementation of fall risk reduction interventions

- Staff monitor each other’s performance when implementing fall risk reduction interventions (Situation Monitoring)
  - Coordinating Team: 44%
  - Core Team: 71%
  - Ancillary Team: 50%
  - Support Services Team: 44%

**Opportunity:** Implement a handoff tool, SBAR, and/or patient room white boards to standardize communication of patient fall risk information within and across departments

- Staff follow a standardized method of sharing fall risk information when handing off patients (Communication)
  - Coordinating Team: 60%
  - Core Team: 71%
  - Ancillary Team: 25%
  - Support Services Team: 25%
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- 17 small rural hospitals (16 CAHs)

- 1 PPS hospital
