TeamSTEPPSTM
National Implementation

Implementing TeamSTEPPS in Critical Access Hospitals

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Implementing TeamSTEPPS in Critical Access Hospitals (CAHs): Objectives

- List unique characteristics of CAHs

- Describe the process of implementing TeamSTEPPS in this collaborative of rural hospitals

- Identify aspects unique to implementing TeamSTEPPS in Nebraska CAHs

- Discuss characteristics of this implementation that are similar to all TeamSTEPPS implementations

- Adapt lessons learned from implementing TeamSTEPPS in small organizations to your setting
Critical Access Hospitals

- Balanced Budget Act 1997
- Purpose: maintain critical access to care in isolated rural areas by providing cost-based reimbursement
- Limited services
  - 25 inpatient beds
  - 96 hour avg length of stay
- Limited resources
  - Financial
  - Technological
  - Human

1,289 CAHs concentrated in Midwest; ¼ of general community hospitals in US
Nebraska Critical Access and Network Hospitals

2002 Rev 6
10/23/02

Regional Hub Hospitals
Critical Access Hospitals
Rural Hospitals

Nebraska TeamSTEPPS Community . . . 26/87 hospitals
NE CAH Implementation Background

- 7/2005 – 6/2007 AHRQ Partnerships in Implementing Patient Safety Grant (1 U18 HS015822)
  - Purpose: To implement the patient safety practices of voluntary medication error reporting and organizational learning in 24 Critical Access Hospitals.
  - Aim 1: Develop the organizational infrastructure for reporting and analyzing medication errors that is needed to identify system sources of error.
  - Evaluate impact on culture with Hospital Survey on Patient Safety Culture (HSOPS)
    - HSOPS results revealed need for teamwork
**Communication Openness**

1. Staff will freely speak up if they see something that may negatively affect patient care. (C2)

   - Positive: 83%
   - Neutral: 17%

2. Staff feel free to question the decisions or actions of those with more authority. (C4)

   - Positive: 50%
   - Neutral: 28%
   - Negative: 22%

3. Staff are afraid to ask questions when something does not seem right. (C6)

   - Positive: 72%
   - Neutral: 28%

**Teamwork Within Departments**

1. People support one another in this department. (A1)

   - Positive: 89%
   - Neutral: 11%

2. When a lot of work needs to be done quickly, we work together as a team to get the work done. (A3)

   - Positive: 94%
   - Neutral: 6%

3. In this department, people treat each other with respect. (A4)

   - Positive: 88%
   - Neutral: 12%

4. When one area in this department gets really busy, others help out. (A11)

   - Positive: 67%
   - Neutral: 17%
   - Negative: 17%
NE CAH Implementation Background

- 3/2008 Funding from AHRQ Office of Communications and Knowledge Transfer, Nebraska Rural Hospital Flexibility Program

- Purpose: To implement the patient safety practice of teamwork and communication training in 25 Critical Access Hospitals.

- Aim 1: Evaluate the impact of the TeamSTEPPS training program on safety culture using the rural-adapted version of the AHRQ Hospital Survey on Patient Safety Culture.
TeamSTEPPS

NE CAH Implementation Timeline

- March 2007 Baseline HSOPS Assessment
- March 2008 TeamSTEPPS Readiness Assessment
- April 14 – 16, April 23 – 25, 2008 TeamSTEPPS Train-the-Trainer…107 Master Trainers/ 27 hospitals
- May – Sept 2008 Bimonthly Conference Calls
- Oct. 6, 2008 TeamSTEPPS Fundamentals…57 Coaches from 17/27 hospitals
- Oct. 7, 2008 Lessons Learned Conference
TeamSTEPPS

NE CAH Implementation Timeline

- March 2009 HSOPS (37 Hospitals/4,602 employees)
  - Reassessment for 24 CAHs
  - Baseline for 13 CAHS
- June 2009 Webinar to report HSOPS results
- Aug. 2009 TeamSTEPPS Train-the-Trainer for 15 hospitals
- Sept. 2009 – Nov. 2010 Bimonthly Conference Calls
- Nov. 2009 Lessons Learned at CAH Quality Conference
- Dec. 2010 HSOPS Reassessment
Readiness Assessment

1. HSOPS
2. Site Assessment
3. Data/Measures
4. Culture infrastructure to support teamwork
   - Systematic error reporting
   - Just culture
   - Organizational learning practices
5. Letter of Support signed by administrator
**TeamSTEPPS**

**Readiness Assessment**

- Site Assessment
  - Impending changes/initiatives
  - Mission, Vision, Values, Strategic Goals
  - Previous team training experience and outcomes
  - Patient Satisfaction Survey—tools and results
  - Employee Satisfaction Survey—tools and results
  - HOSPS results focus on teamwork/communication
  - Data collection and Identification of top three patient safety issues (falls, med errors, HA infections)
  - Core Measures data collection and performance
Train-the-Trainer Sessions

- Interdisciplinary team attends training
  - Sr. leader
  - Nurse plus front-line worker from additional clinical area
- Pre-training survey with immediate feedback
- Coaching scenarios customized to CAH environment
- Site Assessment – SWOT – Action Plan with Elevator Speech
- Teach backs in teams that reflect environment
- Follow-up
  - Talking points to distribute to Medical Staff
  - Sample press release
Pre-Training Survey

TeamSTEPPS Pre-Training Survey (n=51)
Fundamentals Training Oct. 6, 2008

1 = Strongly Disagree to 5 = Strongly Agree

- The culture in my department makes it easy to learn from the mistakes of others.
- Our physicians, nurses, staff, and other team members work together as a well-coordinated team.
- Physicians, nurses, staff, and other team members in my department know and understand each other's respective responsibilities.
- My department does a good job of training new personnel.
- Teamwork deserves more attention in healthcare.
- I am confident about my ability to work effectively in a team.
- Teamwork is one of the most important skills in my clinical/administrative environment.
- People with strong teamwork skills are more likely to be successful in healthcare.
- It is impossible to function in healthcare without being a good team player.
Pre-Training Survey

TeamSTEPPS Pre-Training Survey (n=51)
Fundamentals Course Oct. 6, 2008

Have you ever worked in a healthcare team where you did not feel comfortable voicing your professional opinion?

Have you ever worked in a healthcare team where there was no clearly designated leader?

Have you ever felt pressured to perform a healthcare procedure that you felt uncomfortable doing?

Have you ever witnessed actual or potential harm to a patient that could have been prevented if the team had learned from past mistakes?

Have you ever witnessed a routine healthcare procedure that went wrong because the team did not adequately prepare before hand?
Customized Coaching Scenario

The Operating Room (OR) is quiet as a new specialist introduces himself to the team. He is an orthopedic surgeon who has just started operating in your hospital one day each month. The lead OR nurse calls for the time out procedure. The surgeon starts shouting out orders and insisting that he doesn’t have time for that and it isn’t necessary in this small hospital. The procedure goes smoothly, but the team is not happy. At the conclusion of the procedure, the lead OR nurse approaches the surgeon to discuss what happened.

Coaching Task: The coach is the lead OR nurse. How can you resolve this conflict with the surgeon and set the stage for successful teamwork in the OR that improves patient safety?
Action Plan with Elevator Speech

Step 1: Define the problem, challenge, opportunity

Step 2: Create the change team

Step 3: Define your aim(s)/goals

For example: We will use CUS to make it psychologically safe for staff to resolve informational conflicts within and across hospital departments. We will start with surgery and nursing; these departments will effectively use CUS by Sept. 1, 2009.

Step 4: Design a TeamSTEPPS Intervention

- Type of Change: Incremental/Transformational/Parallel
- Unit/department to begin
- How to organize training...by tool/by department/combo
Step 5: Decide Measures for your intervention (Consider incorporating into Balanced Scorecard)

- Observations
- Counts (e.g. # of Briefs, Huddles, Debriefs; # times staff nurses use SBAR)
- Outcome measures: rate of appropriate pre-op antibiotic usage; near-miss report, rate of discharge instructions for HF
- Repeat Safety Culture Survey March 2009
- Patient/Staff satisfaction
## Action Plan with Elevator Speech

**Step 6: Develop a plan**

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHEN</th>
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<tbody>
<tr>
<td>Obtain leadership support from Medical Staff (use Sue Sheridan video, Talking Points)</td>
<td></td>
</tr>
<tr>
<td>Obtain leadership support from Department Heads (use Sue Sheridan video, Talking Points)</td>
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<tr>
<td>Schedule training, education for initial group</td>
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<tr>
<td>Communicate aims, goals of plan</td>
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<tr>
<td>Conduct training</td>
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<td>Make revisions to training based on feedback</td>
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Action Plan with Elevator Speech

Step 7: How will you sustain and spread the change?

- Coaching plan
- Role modeling
- Monitoring
- Integrate into new employee orientation, competency testing

Step 8: Communication Plan

- Stakeholder analysis
  - Who needs to provide support?
  - Who needs to be brought over to your side?
  - Who needs to be marginalized/isolated/ignored?
Action Plan with Elevator Speech

Step 8: Communication Plan

Elevator Speech:
TeamSTEPPS is an evidence-based team training program. We have chosen to focus on ________________________ . It is important that we improve our teamwork skills because lack of teamwork and poor communication puts our patients at risk and impacts our performance. (Can provide detail with your data).

We need you to support our efforts by ____________________ .

Step 9: Write your final action plan covering steps 1 - 9.

Step 10: Review of plan by key personnel
**TeamSTEPPS**

**Train-the-Trainer Follow-up**

Talking Points for Medical Staff, Board of Directors, and Clinical Staff

- What is TeamSTEPPS training?
- Why are we participating in it? Provide data
- What exactly does the training entail?
- What we need from you…

We need you to support our efforts in team training; ask us to communicate in a structured fashion, ask us to give our assessment and recommendations, and give us honest feedback about how our team skills affect the clarity of our communication with you.
Train-the-Trainer Follow-up: Sample Press Release

Brown County Hospital focuses on teamwork to ensure safe care for patients

(NAME OF HOSPITAL) is working to improve staff members’ communication skills in an effort to make care even safer for all of its patients. Clinicians recently attended a specialized team training session in (LOCATION) that was designed to improve communications among doctors, nurses, pharmacists, and other health care providers who interact on a daily basis under fast-paced conditions.

Twenty-seven hospitals across Nebraska and parts of Iowa participated in the training, reflecting a regional effort to implement this nationally recognized teamwork curriculum that was developed in 2006 by the U.S. Agency for Healthcare Research and Quality and the Department of Defense.

According to (CEO name), health care providers who participated in the training will work with other hospital staff to implement TeamSTEPPS™ strategies and tools.

(QUOTE FROM HOSPITAL CEO)
Bimonthly Follow-up Calls May – Oct, 2008

Standard Agenda

- Roll Call
- Closing the loop…Ordering pocket guides, sharing training scenarios, teamwork videos
- Informal debriefs from the community
  - County Hospital used the Magic Wand Exercise to introduce TeamSTEPPS to surgery and found that the greatest concerns were about communication with other depts. The Magic Wand Exercise provided feedback that was richer than expected. County Hospital also implemented a comment box that invites employees to answer the question: “Did you CUS today?” Employees provide a description of how they did or could have used CUS.

- Huddle: Develop/share tools to track use of TeamSTEPPS skills
- Discussion of a teamwork related article

Brief: Planning for future conferences…interest in disruptive behavior
Lessons Learned Conference Oct. 7, 2008

- Survey of Staff Relations with feedback in pm
- Key Note Address Reporting and Management of Disruptive Behavior by Alan Rosenstein and Michelle O’Daniel
- Action Planning and Report Out to address Disruptive Behavior
- 7 Storyboards from the community
  - Invitations to training
  - Monitoring tools
- 6 Presentations from the community
Definition of Disruptive Behavior

Disruptive behavior is any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical or sexual harassment. Disruptive behavior causes strong psychological and emotional feelings, which can adversely affect patient care.

**Survey of Staff Relations (n = 69)**

**POSITIVE Communication**
- Somewhat effective and contributes to an acceptable level of staff morale. Advocacy and assertion for patients is accepted but not frequent. Disruptive behavior is rare, not reported, and ignored.
- 46%

**NEGATIVE Communication**
- Ineffective communication contributes to low staff morale. Advocacy and assertion for patients is rare. Disruptive behavior is frequent and accepted.
- 19%

**NEUTRAL Communication**
- Neither exceptionally effective nor exceptionally negative. Advocacy and assertion for patients is infrequent. Disruptive behavior is infrequent, not reported, and ignored.
- 26%

**POSITIVE/NEUTRAL**
- 9%
Number of Individuals Reporting the Frequency of Types of Disruptive Behavior
(n = 69)

**Abusive Anger**
- Frequently (more than 3x/year): 6
- Sometimes (2 - 3x/year): 9
- Rarely (1x/year): 24
- Never: 29

**Insults**
- Frequently (more than 3x/year): 6
- Sometimes (2 - 3x/year): 18
- Rarely (1x/year): 24
- Never: 24

**Condescension**
- Frequently (more than 3x/year): 4
- Sometimes (2 - 3x/year): 14
- Rarely (1x/year): 24
- Never: 25

**Berating patients**
- Frequently (more than 3x/year): 7
- Sometimes (2 - 3x/year): 11
- Rarely (1x/year): 22
- Never: 28

**Berating Colleagues**
- Frequently (more than 3x/year): 4
- Sometimes (2 - 3x/year): 16
- Rarely (1x/year): 18
- Never: 30

**Abusive Language**
- Frequently (more than 3x/year): 9
- Sometimes (2 - 3x/year): 15
- Rarely (1x/year): 19
- Never: 25

**Disrespectful**
- Frequently (more than 3x/year): 2
- Sometimes (2 - 3x/year): 10
- Rarely (1x/year): 19
- Never: 26

**Yelling/Raising Voice**
- Frequently (more than 3x/year): 7
- Sometimes (2 - 3x/year): 14
- Rarely (1x/year): 20
- Never: 27
Number of Individuals Reporting Triggers of Disruptive Behavior (n=69)

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- **Requests for task assistance**
- **Communication btw different generations**
- **Communication btw genders**
- **Vertical Communication**
- **Horizontal Communications**
- **Availability of Equip. & Supplies**
- **Scheduling**
- **Staffing**

**Frequently (more than 3x/yr)**

**Sometimes (2-3x/yr)**

**Rarely (1x/yr)**

**Never**

**Number of Individuals**
Lessons Learned Conference Oct. 7, 2008

- Disruptive Behavior: Old frame of reference
  - Tolerate the behavior as a way of doing business
  - Shrug off problem; minor occurrence, no ill effects to patients or staff

- Disruptive Behavior: New frame of reference
  - Disruptive behaviors have profound effect on safety and quality
  - Not unique to physicians or healthcare
  - Consequences permeate the organization
    - Affect staff morale, patient and family
    - Community perceptions and hospital reputation.
  - Hospitals can no longer take a passive approach to disruptive behaviors

Lessons Learned Conference Oct. 7, 2008
Address Disruptive Behavior

- Raise awareness – survey
- Develop policies/procedures
  - Code of behavior
  - Confidential reporting system
  - Enforcement—interdisciplinary staff relations committee
  - Follow-up and feedback to reporters and all staff
- Education
  - Link behavior to adverse events
  - Communication and teamwork--TeamSTEPPS

Lesson Learned: Individuals operate within teams. To function effectively in a team, each individual must be valued and treated with respect.
Lessons Learned Conference Oct. 7, 2008

Shared Successes

- Interdisciplinary change team as a role model
- Small rewards after training to create interest (pins, Stepping Up)
- Key tools: SBAR for shift change; CUS for all; Huddles, Briefs, Debriefs
- Integrate Essentials into new employee orientation
- Be accountable to board for implementing plan
- Front line staff as Master Trainers are effective—creates buy-in
- Non-clinical depts use tools effectively
- Foundation of transformational change
  - Fundamentals training for all clinical staff
  - Intro and Essentials for Medical Staff and Board
TeamSTEPPS

Lessons Learned Conference Oct. 7, 2008

- Shared Suggestions
  - Use Magic Wand ex to open discussion…which tools will help you achieve your dream?
  - Have change team read “My Ice Berg is Melting”
  - Integrate TeamSTEPPS tools into RCA action planning
  - Multiple formats for SBAR…customize according to discipline
  - Role play is critical for practicing skills…The Oscar goes to!
  - Structure follows strategy…shut down the OR for an entire day to train all together
Unique Attributes of NE TeamSTEPPS Training

- Network of hospitals with a four-year history of functioning as a community with a shared purpose to improve the culture of safety
- Data driven action plans
  - Baseline HSOPS Results
  - Medication error data from MEDMARX
- Action Planning Integrated into Train-the-Trainer Course
- TeamSTEPPS integrated into action research related to improving safety culture in small organizations
Universal Lessons Learned

- Manage the relationship between incremental and transformational change
- Use the role playing, and opportunities for practice offered in the curriculum...active learning trumps lecture every time
- Create buy in
  - Use data to demonstrate need for TeamSTEPPS
  - Front line staff are Master Trainers
- Use rewards, make it fun
- Start with the end in mind...change your culture of safety...plan for reassessment with HSOPS
Attitudes Toward Transformational Change

TeamSTEPPS

- Embrace and absorb
- Skeptical then connect
- Resistant and defensive

Lesson Learned

INFORMED = SAFE = HRO

LEARNING

FLEXIBLE

JUST

REPORTING

INFORMATION

LEARNING

FLEXIBILITY

JUDGEMENT

REPORTING

TEAM STEPPS

INDIVIDUALS FEEL VALUED

INDIVIDUALS ARE TREATED WITH RESPECT

Team Strategies & Tools to Enhance Performance & Patient Safety
Contact Information

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Web site where safety culture tools are posted

www.unmc.edu/patient-safety/