TeamSTEPPS® for Long-term Care: Improving Outcomes Through Teamwork

Leading Age Michigan
Annual Conference and Trade Show
May 20, 2014

Objectives

• Describe the TeamSTEPPS® teamwork system
• Discuss TeamSTEPPS® techniques to improve outcomes in long-term care
• Demonstrate TeamSTEPPS® techniques to improve outcomes in subacute care
Background

“To Err is Human: Building a Safer Health System”

- 44,000 - 98,000 people die in hospitals each year as a result of medical errors
- Human error is the eighth leading cause of death

(Institute of Medicine 1999)

Safety Culture

Definition

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures.

Nursing Home Patient Safety Survey

- Developed by the Agency for Healthcare Research and Quality
- Designed specifically for nursing home staff
- 42 items assessing 12 dimensions of patient safety culture

Comparison With 40 Pilot Study Nursing Homes

<table>
<thead>
<tr>
<th>Patient Safety Culture Area</th>
<th>PR Aggregate % Positive</th>
<th>NH Pilot Study Comparison: Average % Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall Perceptions of Resident Safety</td>
<td>72</td>
<td>87</td>
</tr>
<tr>
<td>2. Feedback and Communication About Incidents</td>
<td>80</td>
<td>85</td>
</tr>
<tr>
<td>3. Supervisor/Manager Expectations and Actions Promoting Patient Safety</td>
<td>74</td>
<td>81</td>
</tr>
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<td>4. Organizational Learning</td>
<td>62</td>
<td>76</td>
</tr>
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<td>5. Management Support for Resident Safety</td>
<td>57</td>
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<td>6. Training and Skills</td>
<td>66</td>
<td>72</td>
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<td>7. Compliance With Procedures</td>
<td>56</td>
<td>67</td>
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<tr>
<td>8. Teamwork</td>
<td>50</td>
<td>67</td>
</tr>
<tr>
<td>9. Handoffs</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>10. Communication Openness</td>
<td>45</td>
<td>58</td>
</tr>
<tr>
<td>11. Nonpunitive Response to Mistakes</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>12. Staffing</td>
<td>43</td>
<td>48</td>
</tr>
</tbody>
</table>
Survey Comments

- We need better teamwork
- Overall, this nursing home does a great job with resident safety
- This nursing home concentrates on “putting out fires” rather than preventive thinking
- Management needs to improve on listening to the workers
- I honestly feel that we as a whole can do a lot better if we communicate more
- The staff here work together for the safety of our residents

“I think staff need to work together and be more of a team.”
Safety Culture

• Culture is behavior over time
• High-performing cultures are very clear about defining the behaviors that create value and the behaviors that create unacceptable risk
• The social glue that holds the care process together
• What we say vs. what we do is critical


Safety Culture

• Leadership is engaged
• Everyone knows what the plan is
• No one is ever hesitant to voice a concern about a resident
• Positive perceptions of teamwork and communication
• Everyone is treated with respect
• Nursing input is well received
• High quality care is delivered safely and efficiently

Safety Cultures Evolve

- Unmindful: "We show up, don't we?" Chronically complacent
- Reactive: "Safety is important. We do a lot every time we have an accident"
- Systematic: Systems being put into place to manage most hazards
- Proactive: We methodically anticipate "—prevent problems before they occur"
- Generative: Organization culture "genetically-wired" to produce safety

Where is Yours?


SocioTechnical Framework

- Patient & family-centered care
- Leadership—senior and clinical
- Psychological safety
- Organizational fairness
- Reliable processes of care
- Learning system – improvement
- Effective teamwork

**TEAMS**

- **What Teams Do:**
  - Plan forward
  - Reflect back
  - Communicate clearly
  - Manage conflict

- **The Associated Behaviors**
  - Brief, huddle, pause, timeout, check-in
  - Debrief
  - Structured communication-SBAR and repeat-back
  - Critical language

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TeamSTEPPS®

• Team strategies & tools to enhance performance & patient safety

"Initiative based on evidence derived from team performance... leveraging more than 25 years of research in military, aviation, nuclear power, business and industry... to acquire team competencies"
TeamSTEPPS® & Teamwork

• Goal: Produce highly-effective medical teams that optimize the use of information, people and resources to achieve the best clinical outcomes

• Teams of individuals who communicate effectively and back each other up dramatically reduce the consequences of human error

• Team skills are not innate; they must be trained
TeamSTEPPS®

Team Competency Outcomes

Knowledge
- Shared Mental Model

Attitudes
- Mutual Trust
- Team Orientation

Performance
- Adaptability
- Accuracy
- Productivity
- Efficiency
- Safety

Long-term Care Team

- Chef
- Social worker
- Therapeutic recreation/activity staff
- Nurse assistant
- Rosie the housekeeper
- Nurse
- Administrator
Leadership Strategies

- **Brief:**
  - A short session prior to start to form team & establish roles
- **Huddle:**
  - Ad hoc team meeting to share info and adjust plans
- **Debrief:**
  - After action review to provide feedback & improve team performance

**Briefing Checklist**

<table>
<thead>
<tr>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is on core team?</td>
</tr>
<tr>
<td>All members understand and agree upon goals?</td>
</tr>
<tr>
<td>Roles and responsibilities understood?</td>
</tr>
<tr>
<td>Plan of care?</td>
</tr>
<tr>
<td>Staff availability?</td>
</tr>
<tr>
<td>Workload?</td>
</tr>
<tr>
<td>Available resources?</td>
</tr>
</tbody>
</table>

- **Sample core team**
  - B hall
    - Activity aide
    - Dietary aide
    - Housekeeper
    - CNA
    - Charge nurse
  - Meet daily beginning & end of shift
  - Coordinate breaks
  - Coordinate two-person assists
  - Ask for additional help at key risk times
Huddle

• Hold ad hoc, “touch-base” meetings to regain situation awareness
• Discuss critical issues and emerging events
• Anticipate outcomes and likely contingencies
• Assign resources
• Express concerns

Debrief Checklist

<table>
<thead>
<tr>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication clear?</td>
</tr>
<tr>
<td>Roles and responsibilities understood?</td>
</tr>
<tr>
<td>Situation awareness maintained?</td>
</tr>
<tr>
<td>Workload distribution?</td>
</tr>
<tr>
<td>Did we ask for or offer assistance?</td>
</tr>
<tr>
<td>Were errors made or avoided?</td>
</tr>
<tr>
<td>What went well, what should change, what can improve?</td>
</tr>
</tbody>
</table>
Debrief

Process improvement

• Brief, informal information exchange and feedback sessions
• Occur after an event or shift
• Designed to improve teamwork skills
• Designed to improve outcomes
  – An accurate reconstruction of key events
  – Analysis of why the event occurred
  – What should be done differently next time

Team Worksheet

Instructions: This tool is used upon Debrief, which can be used as a means of the day or the shift. Follow the steps provided:

<table>
<thead>
<tr>
<th>Team Leader</th>
<th>Shift</th>
<th>Date</th>
</tr>
</thead>
</table>

**BRIEF**

- Information from previous shift
- Discussion of special needs
  - New admissions
  - Labs not
  - All risk for pressure ulcer

- Weight
- Nourishment
- Medication
- Allergies
- Ambulation/Range of Motion
- Unit cleaning duties

- Critical hours - e.g., barriers, acute change of condition, site, etc.
- Assignment changes
- New Admissions

<table>
<thead>
<tr>
<th>DEBRIEF</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>All assignments completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What did we do well today?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lessons learned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Walking Rounds Checklist

Instructions: On-coming CNA walks with off-going CNA and visually checks each resident. Keep voices low to protect the privacy of the resident. Discuss pertinent information briefly.

These are a few items to address during your rounds. This list is not meant to be an all-inclusive list. Please use your best judgment on important needs to be shared with the oncoming shift.

- Positioning—is the resident comfortable?
- Time of last toileting or brief change
- Pain
- Personal items within reach?
- Change in status (weak, poor appetite, more confused, drowsy)
- Risk factors—falls, skin?

Comments:

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

## Effective Communication

- SBAR
- Call-out
- Check-back
- Handoff
SBAR provides...

- A framework for team members to effectively communicate information to one another
- Communicate the following information:
  - Situation—What is going on with the resident?
  - Background—What is the clinical background or context?
  - Assessment—What do I think the problem is?
  - Recommendation—What would I recommend?

Call Out

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
Check-back is...

Handoff

- The transfer of information (along with authority and responsibility) during transitions in care across the continuum; includes an opportunity to ask questions, clarify and confirm
I Pass the Baton

Introduction: Introduce yourself and your role/job (include resident)

Patient/resident: Identifiers, age, sex, location

Assessment: Relevant diagnoses and complaints, vital signs and symptoms

Situation: Current status (e.g., ADL status, intake, elimination, behavior, cognition), including code status, level of uncertainty, recent changes and response to treatment

Safety: Critical lab values/reports, allergies and alerts (falls, isolation, etc.)

THE Background: Other diagnoses, previous episodes, current medications, history

Actions: What actions were taken or are required? Provide brief rationale

Timing: Level of urgency and explicit timing and prioritization of actions

Ownership: Who is responsible (nurse/doctor/APRN/nursing assistant)? Include patient/family responsibilities

Next: What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

Question, Clarify and Confirm

Two-challenge Rule

Invoked when an initial assertion is ignored…

It is your responsibility to assertively voice your concern at least two times to ensure that it has been heard

The member being challenged must acknowledge the concern

If the outcome is still not acceptable:

Take a stronger course of action

Use supervisor or chain of command
Please use CUS words but *only* when appropriate!

Mutual Support
Teams Back Each Other Up

• Shared mental model
• Situation monitoring
• Situation awareness
• Task assistance
• Cross monitoring
### Mutual Support

#### BARRIERS
- Hierarchical Culture
- Lack of Resources or Information
- Ineffective Communication
- Conflict
- Time
- Distractions
- Workload
- Fatigue
- Misinterpretation of Data
- Failure to Share Information
- Defensiveness
- Conventional Thinking

#### TOOLS and STRATEGIES
- Brief
- Huddle
- Debrief
- STEP
- Cross-Monitoring
- Feedback
- Advocacy and Assertion
- Two-Challenge Rule
- CUS
- DESC Script
- Collaboration

#### OUTCOMES
- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- Resident Safety!

### A Shared Mental Model is...

The perception of, understanding of or knowledge about a situation or process that is shared among team members through communication.
### Barriers to Team Effectiveness

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>TOOLS and STRATEGIES</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistency in Team Membership</td>
<td>Cross-Monitoring</td>
<td>Shared Mental Model</td>
</tr>
<tr>
<td>Lack of Time</td>
<td>Feedback</td>
<td>Adaptability</td>
</tr>
<tr>
<td>Lack of Information Sharing</td>
<td>Advocacy and Assertion</td>
<td>Team Orientation</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>Two-Challenge Rule</td>
<td>Mutual Trust</td>
</tr>
<tr>
<td>Defensiveness</td>
<td>CUS</td>
<td>Team Performance</td>
</tr>
<tr>
<td>Conventional Thinking</td>
<td>DESC Script</td>
<td>Resident Safety!!</td>
</tr>
<tr>
<td>Complacency</td>
<td>Collaboration</td>
<td></td>
</tr>
<tr>
<td>Varying Communication Styles</td>
<td>SBAR</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>Call-Out</td>
<td></td>
</tr>
<tr>
<td>Lack of Coordination and Followup With Co-Workers</td>
<td>Check-Back</td>
<td></td>
</tr>
<tr>
<td>Distractions</td>
<td>Handoff</td>
<td></td>
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<tr>
<td>Fatigue</td>
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<td></td>
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<tr>
<td>Workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misinterpretation of Cues</td>
<td></td>
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<tr>
<td>Lack of Role Clarity</td>
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### Situation Awareness is...

- Knowing the status of a particular event
- Knowing the status of the team’s patients
- Understanding the operational issues affecting the team
- Maintaining mindfulness
Task Assistance

• A form of mutual support:
  – Team members protect each other from work overload situations
  – Team members foster a climate where it is expected that assistance will be actively **sought and offered** in the context of patient safety

Cross Monitoring is...

• **Process of monitoring the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors**
  – Way of “watching each other’s back”
  – Mechanism to help maintain accurate situation awareness
  – Ability of team members to monitor each other’s task execution and give feedback during task execution
Questions?

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