*Team*STEPPS® for Long-term Care: Improving Outcomes Through Teamwork

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

Objectives

- Describe the *Team*STEPPS® teamwork system
- Discuss *Team*STEPPS® techniques to improve outcomes in long-term care
- Demonstrate *Team*STEPPS® 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.

Bonner, A . et al, "Patient Safety Culture: A Review of the Nursing Home Literature and Recommendations for Practice," *Annals of Long-Term Care* 16:3 (2008): 18–22.

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

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

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

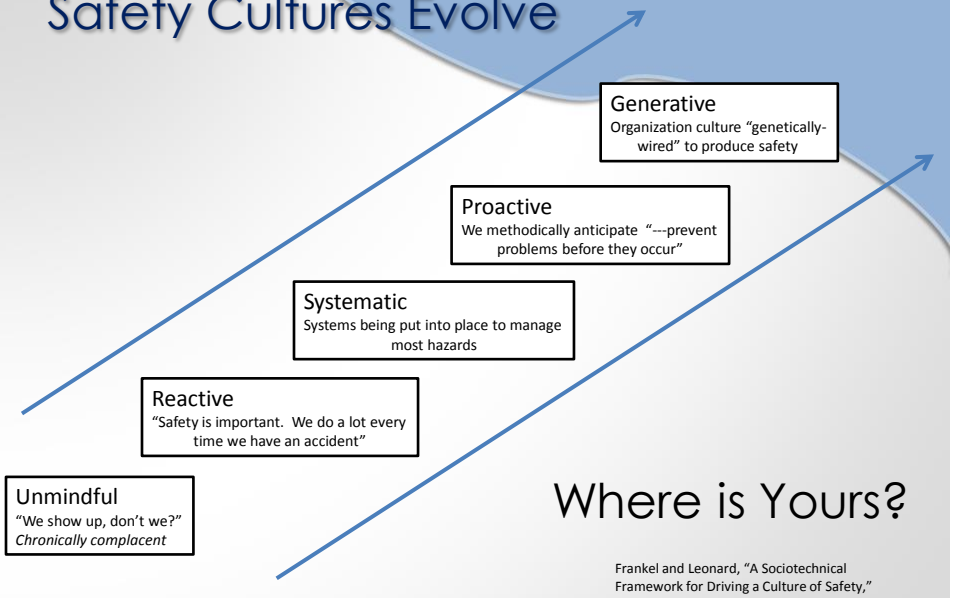
Allen Frankel, MD and Michael Leonard, MD, "A Sociotechnical Framework for Driving a Culture of Safety, Clinical Excellence, and Continual Learning and Improvement (Minicourse, Institute for Healthcare Improvement "Safe and Reliable Healthcare," January 2014).

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

Frankel and Leonard, "A Sociotechnical Framework for Driving a Culture of Safety," January 2014

Safety Cultures Evolve



Where is Yours?

Frankel and Leonard, "A Sociotechnical Framework for Driving a Culture of Safety," January 2014

SocioTechnical Framework

Unmindful Reactive Systematic Proactive Generative

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

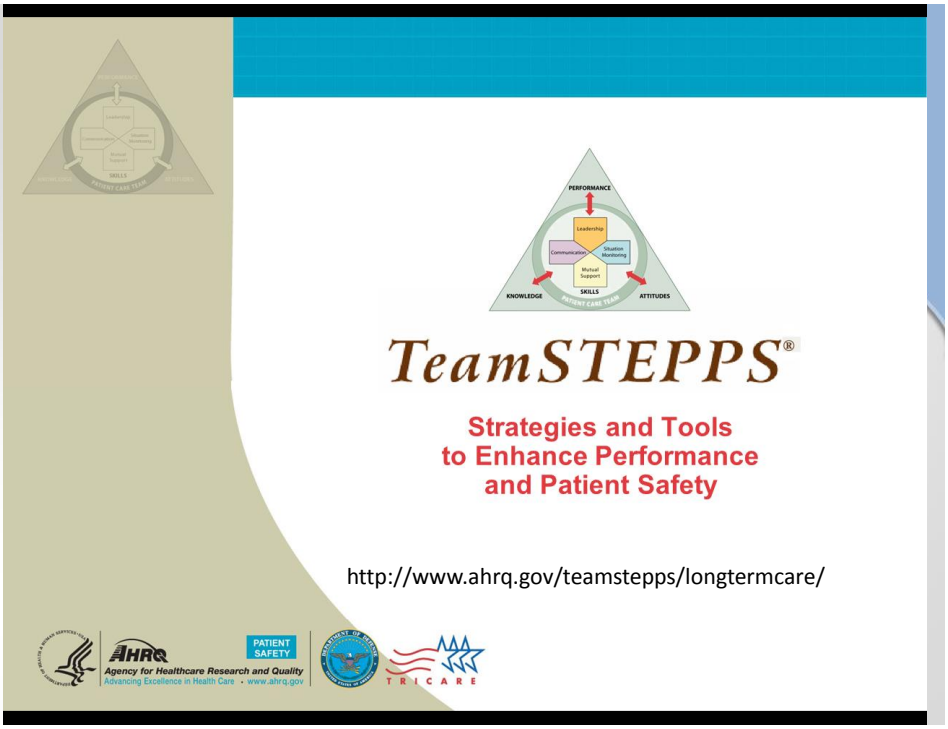
Frankel and Leonard, "A Sociotechnical Framework for Driving a Culture of Safety," January 2014

TEAMS

- What Teams Do:
- **The Associated Behaviors**

Plan forward	Brief, huddle, pause, timeout, check-in
Reflect back	Debrief
Communicate clearly	Structured communication-SBAR and repeat-back
Manage conflict	Critical language

Frankel and Leonard, "A Sociotechnical Framework for Driving a Culture of Safety," January 2014



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

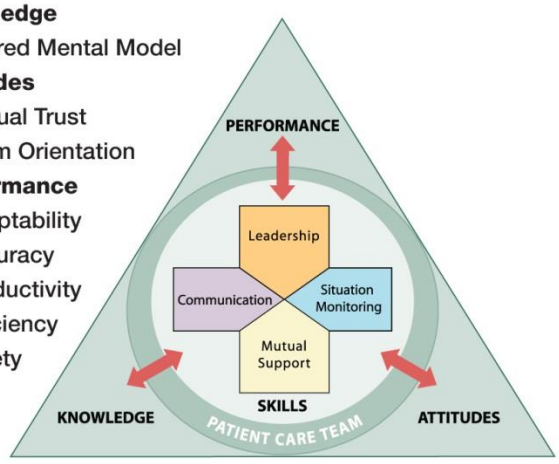
TeamSTEPPS®

Team Competency Outcomes

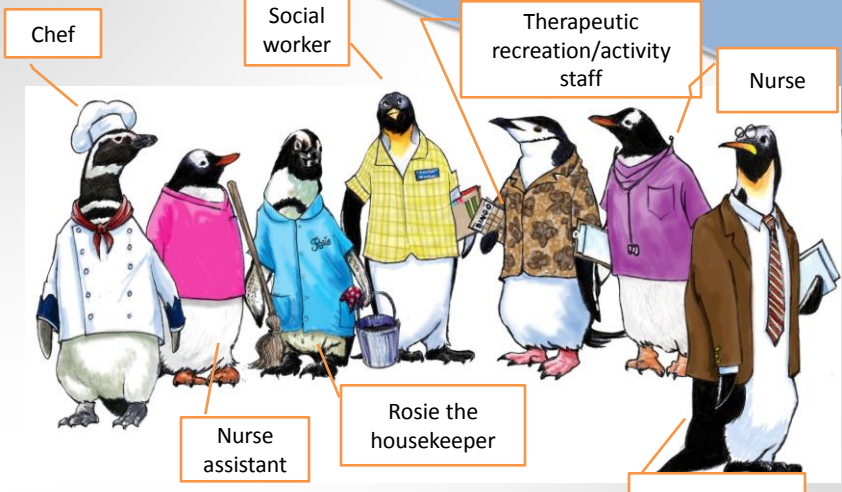
Knowledge
- Shared Mental Model

Attitudes
- Mutual Trust
- Team Orientation

Performance
- Adaptability
- Accuracy
- Productivity
- Efficiency
- Safety



Long-term Care Team



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

TOPIC
Who is on core team?
All members understand and agree upon goals?
Roles and responsibilities understood?
Plan of care?
Staff availability?
Workload?
Available resources?

- 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

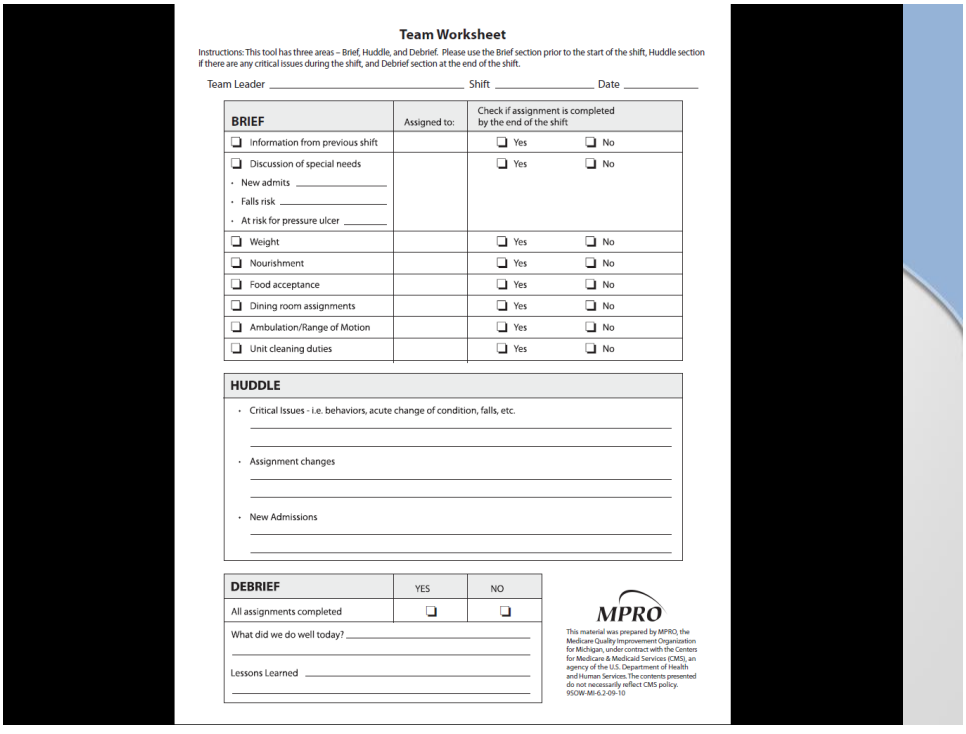
Debrief Checklist

TOPIC
Communication clear?
Roles and responsibilities understood?
Situation awareness maintained?
Workload distribution?
Did we ask for or offer assistance?
Were errors made or avoided?
What went well, what should change, what can improve?

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 has three areas – Brief, Huddle, and Debrief. Please use the Brief section prior to the start of the shift, Huddle section if there are any critical issues during the shift, and Debrief section at the end of the shift.

Team Leader _____ Shift _____ Date _____

BRIEF	Assigned to:	Check if assignment is completed by the end of the shift
❑ Information from previous shift		❑ Yes ❑ No
❑ Discussion of special needs • New admits _____ • Falls risk _____ • At risk for pressure ulcer _____		❑ Yes ❑ No
❑ Weight		❑ Yes ❑ No
❑ Nourishment		❑ Yes ❑ No
❑ Food acceptance		❑ Yes ❑ No
❑ Dining room assignments		❑ Yes ❑ No
❑ Ambulation/Range of Motion		❑ Yes ❑ No
❑ Unit cleaning duties		❑ Yes ❑ No

HUDDLE

- Critical Issues - i.e. behaviors, acute change of condition, falls, etc.
- Assignment changes
- New Admissions

DEBRIEF	YES	NO
All assignments completed	❑	❑

What did we do well today? _____

Lessons Learned _____

MPRO

This material was prepared by MPRO, the Medicare Quality Improvement Organization for Michigan, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9SOW-MI-6.2-09-10

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.

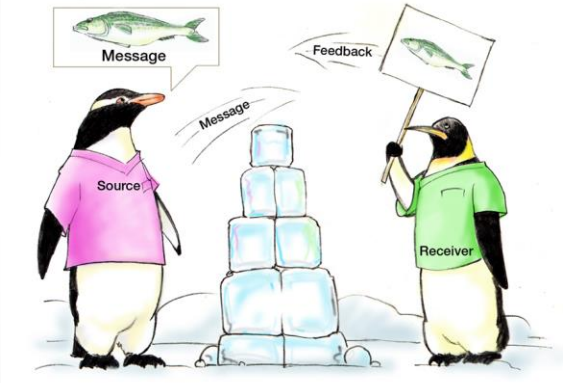
- Positioning—is the resident comfortable?
- Time of last toileting or brief change
- Pain
- Personal items within reach?
- Change in status (weak, poor appetite, more confused, drowsy)
- Risk factors—falls, skin?

Comments:

Date:

Effective Communication

- SBAR
- Call-out
- Check-back
- Handoff



SBAR provides…

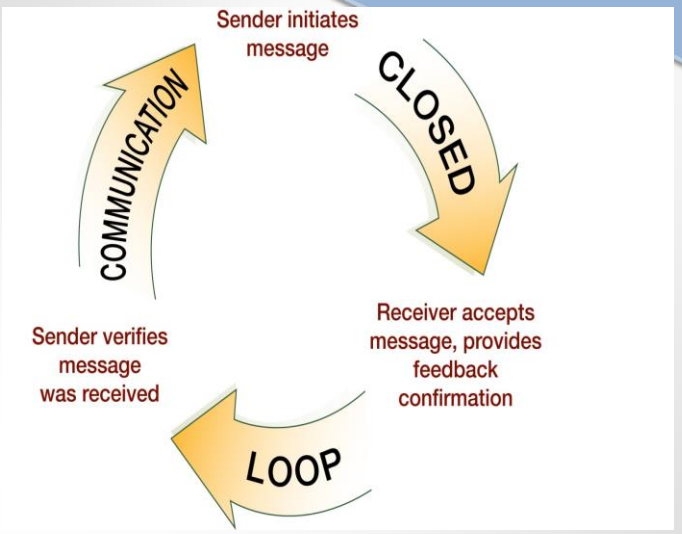
- A framework for team members to effectively communicate information to one another
- Communicate the following information:
  - Situation—What is going on with the resident?
  - Background—What is the clinical background or context?
  - Assessment—What do I think the problem is?
  - Recommendation—What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

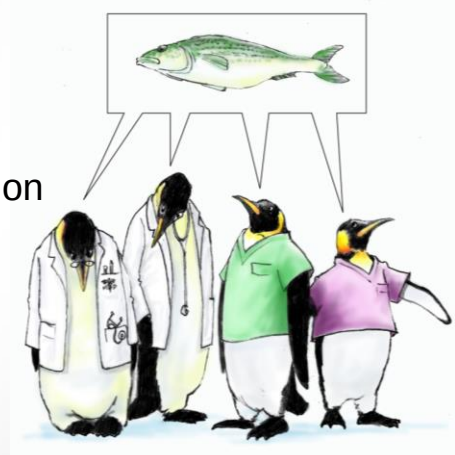
Collaboration

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

BARRIERS	TOOLS and STRATEGIES	OUTCOMES
■ Inconsistency in Team Membership ■ Lack of Time ■ Lack of Information Sharing ■ Hierarchy ■ Defensiveness ■ Conventional Thinking ■ Complacency ■ Varying Communication Styles ■ Conflict ■ Lack of Coordination and Followup With Co-Workers ■ Distractions ■ Fatigue ■ Workload ■ Misinterpretation of Cues ■ Lack of Role Clarity	Brief Huddle Debrief STEP Cross-Monitoring Feedback Advocacy and Assertion Two-Challenge Rule CUS DESC Script Collaboration SBAR Call-Out Check-Back Handoff	■ Shared Mental Model ■ Adaptability ■ Team Orientation ■ Mutual Trust ■ Team Performance ■ *Resident Safety!!*

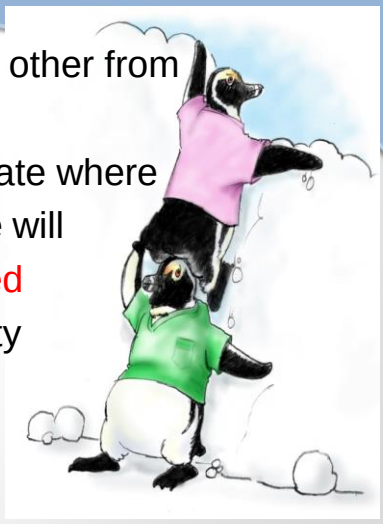
Situation Awareness is…

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

40

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

"I've seen the error of my ways and I've decided to start being more respectful to my coworkers. Hey, bozo, I'm talking to you!"

Questions?

Contact us:

- Yvette McKenzie, R.N., BSN
  ymckenzi@mpro.org
  248-465-7327
- Audrey Stob, R.N., CPHQ
  astob@mpro.org
  248-465-7321

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

MPRO

This material was prepared by MPRO, the Medicare Quality Improvement Organization for Michigan, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-MI-C.7-14-179