TeamSTEPPS Implementation at Central Maine Healthcare

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Central Maine Healthcare
Central Maine Healthcare

• An integrated healthcare delivery system serving those individuals living in central, western, and mid-coast Maine.
Introduced to High Reliability

Institute for Healthcare Improvement
Characteristics of high reliability

**Sensitivity to Operations**
- Attention paid to the front line
- Notice anomalies when they are small
- Awareness + proactive approach

**Preoccupation with failure**
- Treat any lapse as a symptom that something is wrong with the system
- Work to fix these system issues

**Deference to Expertise**
- Encourage the expert to speak up
- Everyone is vigilant
- Everyone’s input is valued

**Resilience**
- Preparation
- Training
- Learning

**Reluctance to Simplify**
- No assumptions
- Listen to patients
- Listen to families

State of mindfulness
Journey towards High Reliability

CMH High Reliability Strategic Plan

Reliable Process
1. Process reliability is an expectation and reliable design principles will be used in improvement work.
2. Reduce practice variation.
3. Examine existing high risk processes for opportunities to improve using reliable design principles.

Transparency
1. Creation of a transparent world of identification and resolution process.
2. Patient and family expectations for clarity in communication and transparency are met.

Communication
1. Standard communication techniques to be used by all staff.
2. High risk patient events use enhanced communication techniques to ensure patient safety.
3. The results of learning will be shared across the organization.
4. Patient safety and quality data will be presented in a more effective and useful manner.

Leadership
1. Leadership will remove barriers that get in the way of safe patient care.
2. Leaders will develop and communicate vision.
3. Leaders will provide the environment that will allow reliable processes to function.
4. A strategic plan will be developed based on the principles of high reliability.
5. Board of directors becomes involved in developing vision and programs that will lead to high reliability.
6. The President will increase organizational situational awareness of all leaders.
7. Organizational structure supports the development of HRO.

Accountability
1. Just culture is a key component of HRO.
2. Patient safety concerns raised by any medical need to be acknowledged, acted upon, and followed up on.

Teamwork
1. Efficient effective and standardized teamwork is a key aspect to improving patient safety.
2. Improve operational and clinical situational awareness.
3. Include patient and family input on the care team.
4. Learning is shared in an open, honest, and productive way in the OR.

Continuous Learning
1. Use PDCA cycle for learning with resilience to those involved in them.
2. Learning from our events will develop a culture of preoccupation with failure.

Psychological Safety
1. Increase medical leadership involvement in adverse event management that involves providers.
2. Leadership supports a culture of accountability and psychological safety by developing and supporting policies and procedures that seek.

Phase 1 = Red text
Phase 2 = Blue text
Improving Communication & Teamwork using TeamSTEPPS

• Evidence-based curriculum aimed at optimizing patient outcomes by improving communication and teamwork skills


• Customizable to all care settings/audiences
## TeamSTEPPS Tools & Strategies Summary

### Tools and Strategies

#### Communication
- SBAR
- Call-Out
- Check-Back
- Handoff

#### Leading Teams
- Brief
- Huddle
- Debrief

#### Situation Monitoring
- STEP
- I’M SAFE

#### Mutual Support
- Task Assistance
- Feedback
- Assertive Statement
- Two-Challenge Rule
- CUS
- DESC Script

### Barriers
- 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 Coworkers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

### Outcomes
- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- Patient Safety!!
TeamSTEPPS Implementation

• Attended TeamSTEPPS master trainer training in April 2014

• Our initial focus in Peri-op areas
  – Surgical Safety Checklist
  – Stop the line when a patient safety concern is identified

• How would we accomplish training all of these staff and minimize negative impact to operations?
TeamSTEPPS Implementation

- Training conducted at Maine College of Health Professions

- Curriculum
  - TeamSTEPPS tools via modules
  - Simulations
    - Surgical safety checklist consent does not match (use Brief & Debrief)
    - Central line placement with a provider who exhibits disruptive behavior (use Advocacy and Assertion, Two-Challenge Rule, CUS, or DESC script)
    - Multiple specimens in an OR setting (use Call-out & Check-back)

- 7.2 hours CME/CNE

<table>
<thead>
<tr>
<th>Session Date</th>
<th># attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/3/2014</td>
<td>44</td>
</tr>
<tr>
<td>10/4/2014</td>
<td>20</td>
</tr>
<tr>
<td>10/10/2014</td>
<td>42</td>
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<tr>
<td>10/11/2014</td>
<td>18</td>
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<tr>
<td>TOTAL</td>
<td>124</td>
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Make-up session 12/12/2014

New TOTAL 140

SUSTAIN PLAN
Course is offered twice per year for new staff
TeamSTEPPS Implementation: Post Training Outcomes

- Customization of the surgical safety checklist
- Creation of a Debrief tool + feedback loop for learning
- Coach each surgical team during brief, timeout & debrief: October 28 – December 31, 2014

March 2015 audit results of Surgical Safety Checklist
- 92/168 or 55% of 1st cases over 20 days audited
- 89/92 (97%) = Yes
- 3/92 (3%) = No
Other TeamSTEPPS Activities 2014-2017

• Maternity
• Endoscopy
• Nurse/Provider Communication
• Stop the Line/ability to speak up
• Master trainer course offered on site
How Could We Increase Spread?

• Teach staff how we expect them to behave in regards to promoting patient safety

• Make the connection to our vision
Creation of Safety Behaviors

1. Communicate Clearly
2. Exhibit Teamwork
3. Display Personal Responsibility
4. Have a Questioning Mindset
5. Embrace Patients and Families as Partners in Patient Care
Error Prevention Toolkit

Everyone makes mistakes; however, when people in healthcare make mistakes, it can result in great inconvenience, harm or death. Although not everyone’s job at Central Maine Healthcare (CMH) has a direct impact on patients, we all make a contribution to the overall experience of patients, families, or visitors. An analysis of events that have occurred at CMH tells us ineffective communication plays a big role in many of the events. Our AHRQ culture of safety survey results point out that teamwork across units, hospital handoffs and transitions have opportunity for improvement, and 36% of staff do not always feel safe to speak up. CMH is focused on creating a reliable culture of safety. Use this toolkit to assist you in following the CMH safety behaviors.

I will follow CMH safety behaviors by using these error prevention tools ...

<table>
<thead>
<tr>
<th>1. Listen</th>
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<tbody>
<tr>
<td>• Focus on what is being said</td>
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<tr>
<td>• Listen without interrupting, disagreeing, or offering explanations.</td>
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<tr>
<td>• Observe non-verbal communication cues</td>
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<tr>
<td>• Ask clarifying questions:</td>
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<tr>
<td>≈ In all high risk situations</td>
<td></td>
</tr>
<tr>
<td>≈ When information is incomplete</td>
<td></td>
</tr>
<tr>
<td>≈ When Information is not clear</td>
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| Asking clarifying questions can reduce the risk of making an error by 2½ times! |

| 2. Don’t Assume – Seek to understand |  |

<table>
<thead>
<tr>
<th>3. Phonetic &amp; Numeric Clarifications</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>For sound alike words and letters, say the letter followed by a word that begins with the letter.</td>
<td>When communication involves sound alike numbers, say the number and then the digits.</td>
</tr>
<tr>
<td>A Alpha</td>
<td>S Sierra</td>
</tr>
<tr>
<td>B Bravo</td>
<td>T Tango</td>
</tr>
<tr>
<td>C Charlie</td>
<td>U Uniforms</td>
</tr>
<tr>
<td>D Delta</td>
<td>V Victor</td>
</tr>
<tr>
<td>E Echo</td>
<td>W Whiskey</td>
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<tr>
<td>F Foxtrot</td>
<td>X X-ray</td>
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<tr>
<td>G Golf</td>
<td>Y Yankee</td>
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<tr>
<td>H Hotel</td>
<td>Z Zulu</td>
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<td>I India</td>
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<td>J Juliet</td>
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<td>K King</td>
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<td>L Lima</td>
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<td>M Mike</td>
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<td>Q Quebec</td>
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<td>R Romeo</td>
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<td>S Sierra</td>
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<td>Z Zulu</td>
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<table>
<thead>
<tr>
<th>For Example:</th>
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<tbody>
<tr>
<td>15 ... that’s one-five</td>
</tr>
<tr>
<td>50 ... that’s five-zero</td>
</tr>
<tr>
<td>0.9 ... that’s zero-point-nine</td>
</tr>
</tbody>
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<thead>
<tr>
<th>4. SBAR provides a framework for team members to effectively communicate information to one another.</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Situation: What is the problem or patient or project?</td>
<td></td>
</tr>
<tr>
<td>• Background: What is the relevant information?</td>
<td></td>
</tr>
<tr>
<td>• Assessment: What is your read of the problem or patient?</td>
<td></td>
</tr>
<tr>
<td>• Recommendation: What is your request or recommendation?</td>
<td></td>
</tr>
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Patient Safety Education

• Developed an education program to teach the Safety Behaviors
• Pilot with new hires in 2016
• Required leadership to attend the pilot sessions in 2016
• Incorporated into New Employee Orientation March 2017
Serious Safety Event (SSE)

- Patient safety measurement system
- Distinguishes harm from bad outcomes
- GAPS (Generally accepted performance standards)
# Serious Safety Event Classification

<table>
<thead>
<tr>
<th>Serious Safety Event (SSE)</th>
<th>Code</th>
<th>Level of Harm</th>
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</thead>
<tbody>
<tr>
<td>SSE 1</td>
<td></td>
<td>Death</td>
</tr>
<tr>
<td>SSE 2</td>
<td></td>
<td>Severe Permanent Harm</td>
</tr>
<tr>
<td>SSE 3</td>
<td></td>
<td>Moderate Permanent Harm</td>
</tr>
<tr>
<td>SSE 4</td>
<td></td>
<td>Severe Temporary Harm</td>
</tr>
<tr>
<td>SSE 5</td>
<td></td>
<td>Moderate Temporary Harm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Precursor Safety Event (PSE)</th>
<th>Code</th>
<th>Level of Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSE 1</td>
<td></td>
<td>Minimal Permanent Harm</td>
</tr>
<tr>
<td>PSE 2</td>
<td></td>
<td>Minimal Temporary Harm</td>
</tr>
<tr>
<td>PSE 3</td>
<td></td>
<td>No Detectable Harm</td>
</tr>
<tr>
<td>PSE 4</td>
<td></td>
<td>No Harm</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Near Miss Safety Event (NME)</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NME 1</td>
<td></td>
<td>Unplanned Catch</td>
</tr>
<tr>
<td>NME 2</td>
<td></td>
<td>Last Strong Barrier Catch</td>
</tr>
<tr>
<td>NME 3</td>
<td></td>
<td>Early Barrier Catch</td>
</tr>
</tbody>
</table>
The serious safety event rate tells us how we are performing over time. It is calculated by taking the number of serious safety events for the past 12 months divided by the number of adjusted patient days and multiplied by 10,000. Reference: http://hpiresults.com/docs/PatientSafetyMeasurementSystem.pdf
Lessons Learned

• TeamSTEPPS is a key component when working to develop a Safety Culture
• Senior leadership support is key
  – Establish expectations
  – Provide resources
• Stay the course
  – Barriers will exist
  – Other priorities will materialize
• Changing culture is not easy but it is worthwhile
What questions do you have?