

A7: TeamSTEPPS: the effective use of all team resources for patient safety



International Forum on
QUALITY & SAFETY
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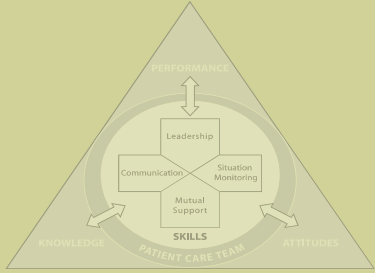
Adapting to a changing world: equity, sustainability
and wellbeing for all



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TeamSTEPPS® 2.0

**TeamSTEPPS: Patient Safety
through improved Teamwork**

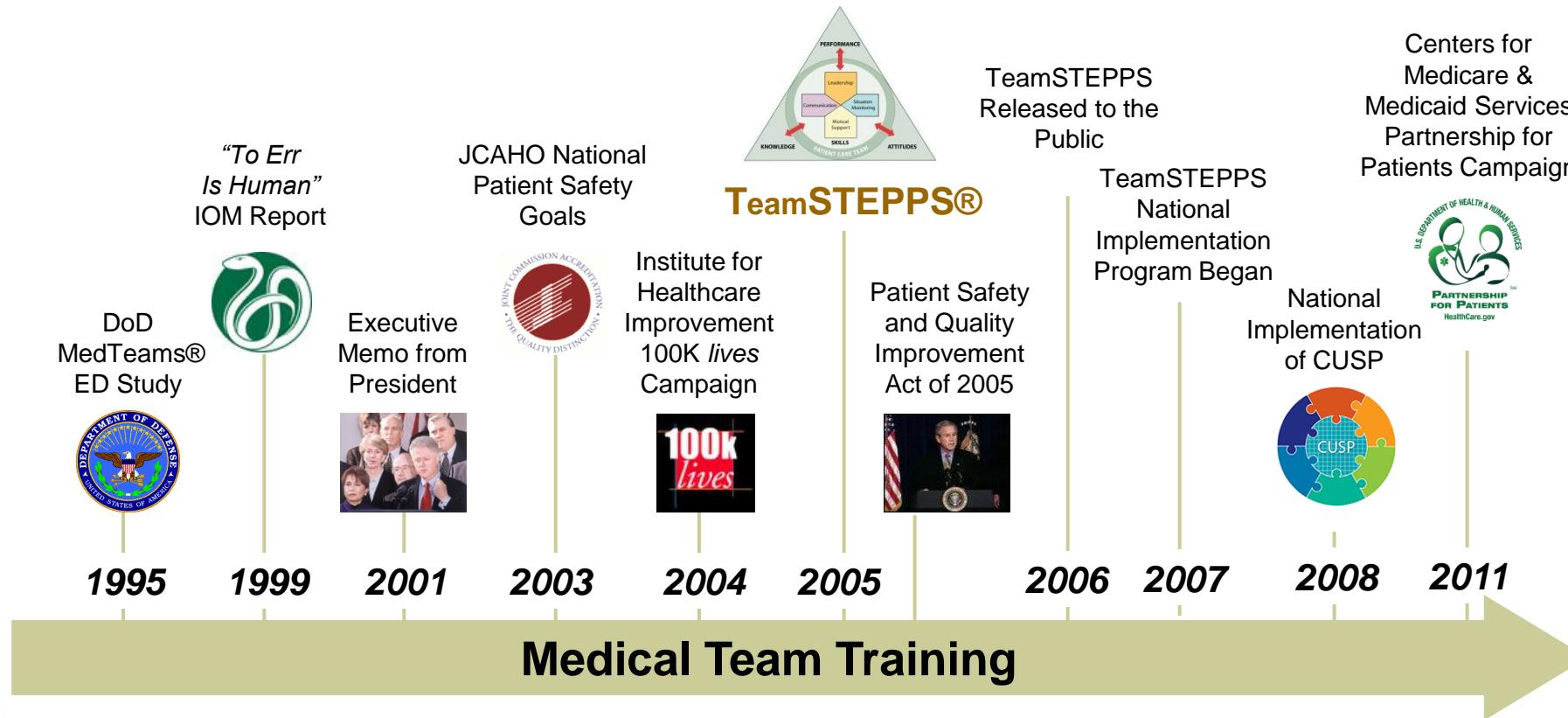
Anthony Staines, PhD – May 16, 2023
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Patient Safety Movement & Team Training



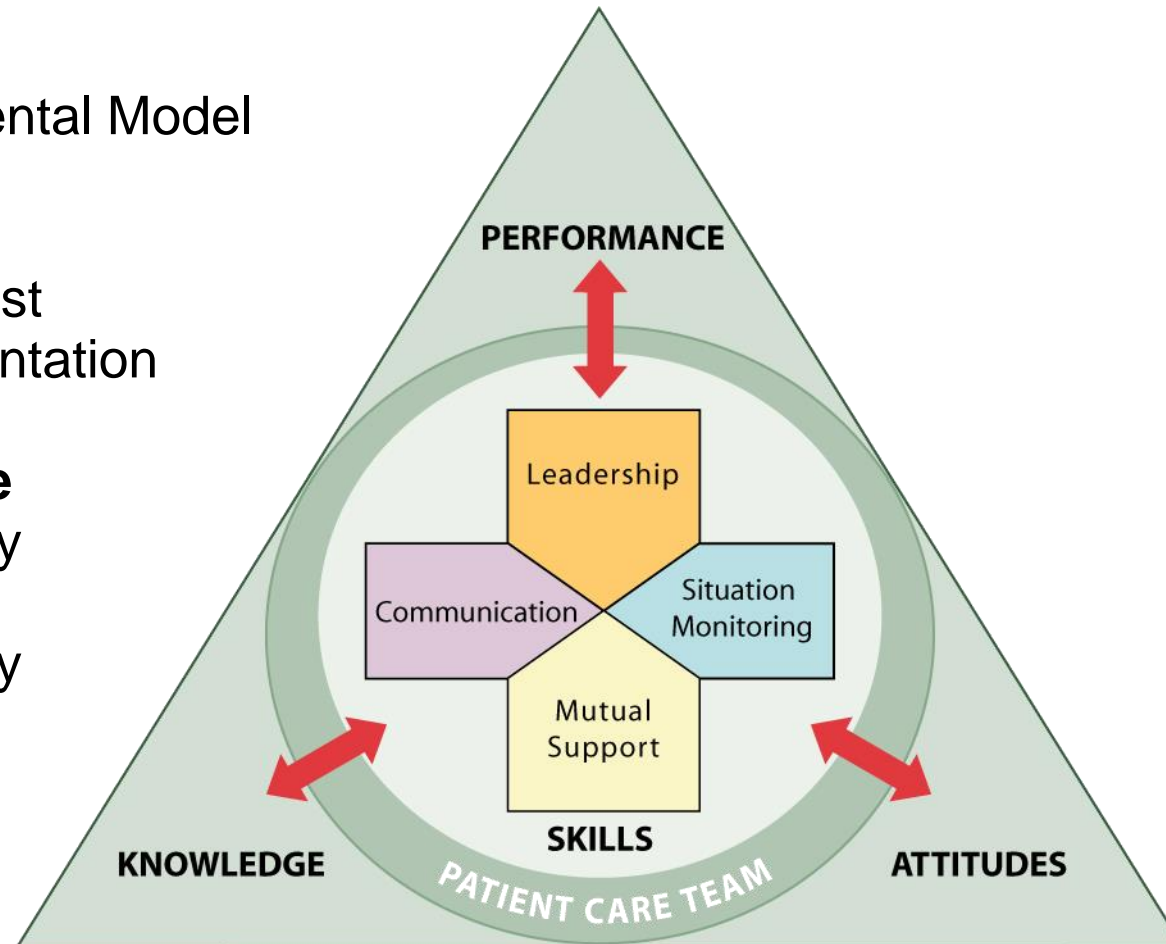
Barriers to Team Performance

- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Varying communication styles
- Conflict
- Lack of coordination and followup
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity



Outcomes of Team Competencies

- **Knowledge**
 - Shared Mental Model
- **Attitudes**
 - Mutual Trust
 - Team Orientation
- **Performance**
 - Adaptability
 - Accuracy
 - Productivity
 - Efficiency
 - Safety



Teamwork practice

- Objective: Make as long a paper chain as possible.
- Separate the paper into strips.
- Create links by taping the two ends of a paper strip cut to the width of an A4 sheet, forming a ring.
- Insert the next strip of paper into the first ring and tape the two ends to form the next link, and so on.
- Wait for the signal to start.
- You will have 2 minutes for the execution.

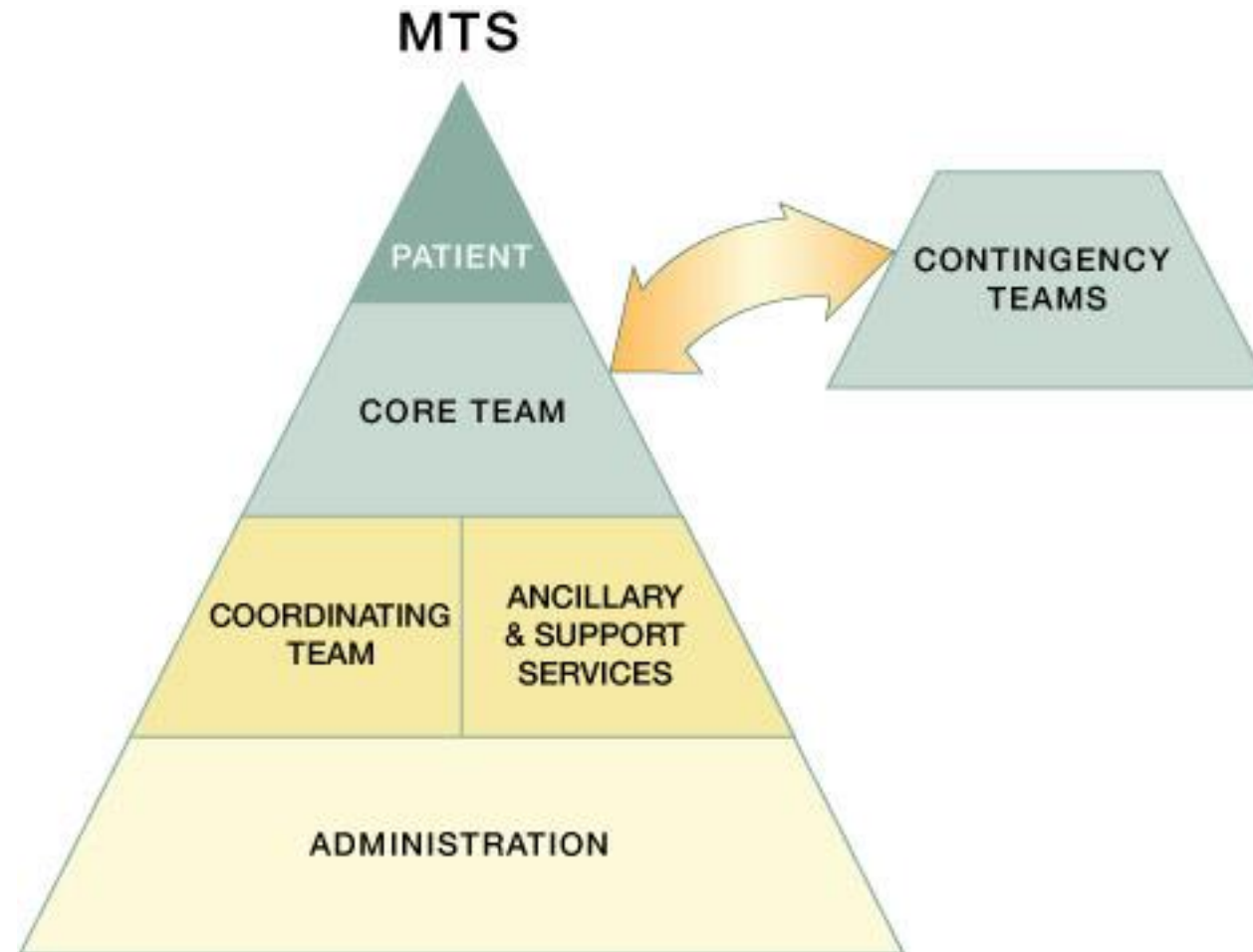


What Defines a Team?

Two or more people who interact dynamically, interdependently, and adaptively toward a common and valued goal, have specific roles or functions, and have a time-limited membership



Multi-Team System (MTS) for Patient Care



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 patient?
- **Background**—What is the clinical background or context?
- **Assessment**—What do I think the problem is?
- **Recommendation**—What would I recommend?



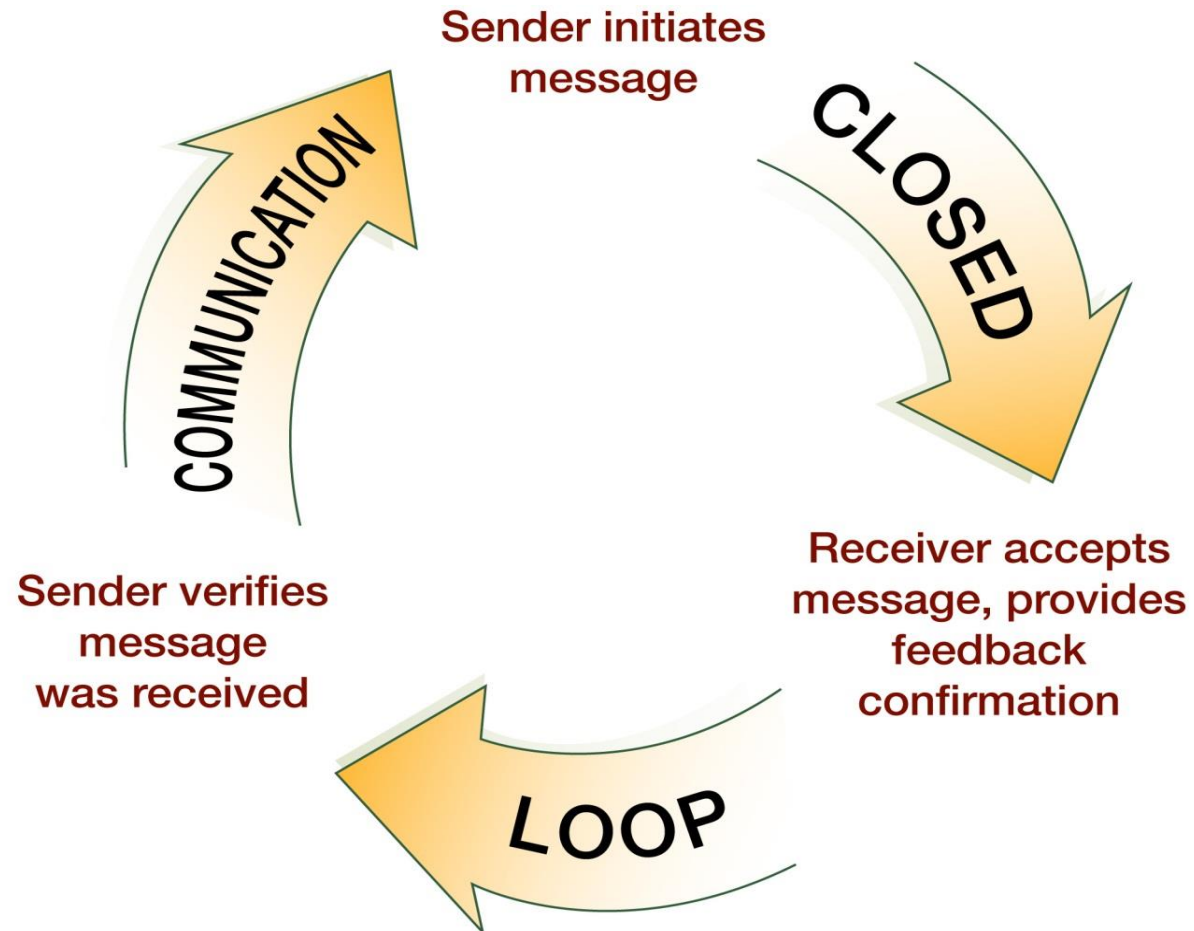
Call-Out is...

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 is...

- The transfer of information during transitions in care across the continuum
- Includes an opportunity to ask questions, clarify, and confirm



I-PASS for structured handovers

I	Illness Severity	<ul style="list-style-type: none"> Stable, “watcher,” unstable
P	Patient Summary	<ul style="list-style-type: none"> Summary statement Events leading up to admission Hospital course Ongoing assessment Plan
A	Action List	<ul style="list-style-type: none"> To do list Timeline and ownership
S	Situation Awareness and Contingency Planning	<ul style="list-style-type: none"> Know what’s going on Plan for what might happen Review safety issues
S	Synthesis by Receiver	<ul style="list-style-type: none"> Receiver summarizes what was heard Asks questions Restates key action/to do items

Starmer et al. Pediatrics. 2012 Feb;129(2):201-4.



Types of Team Leaders

- **Designated** – The person assigned to lead and organize a team, establish clear goals, and facilitate open communication and teamwork among team members
- **Situational** – Any team member who has the skills to manage the situation at hand



Effective Team Leaders

- Define, assign, share, monitor, and modify a plan
- Review the team's performance
- Establish “rules of engagement”
- Manage and allocate resources effectively
- Provide feedback regarding assigned responsibilities and progress toward the goal
- Facilitate information sharing
- Encourage team members to assist one another
- Facilitate conflict resolution
- Model effective teamwork



Sharing the Plan: Briefs

- A team briefing is an effective strategy for sharing the plan
- Briefs should help:
 - Form the team
 - Designate team roles and responsibilities
 - Establish climate and goals
 - Engage team in short- and long-term planning



Monitoring & Modifying the Plan: Huddle

Problem Solving

- 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



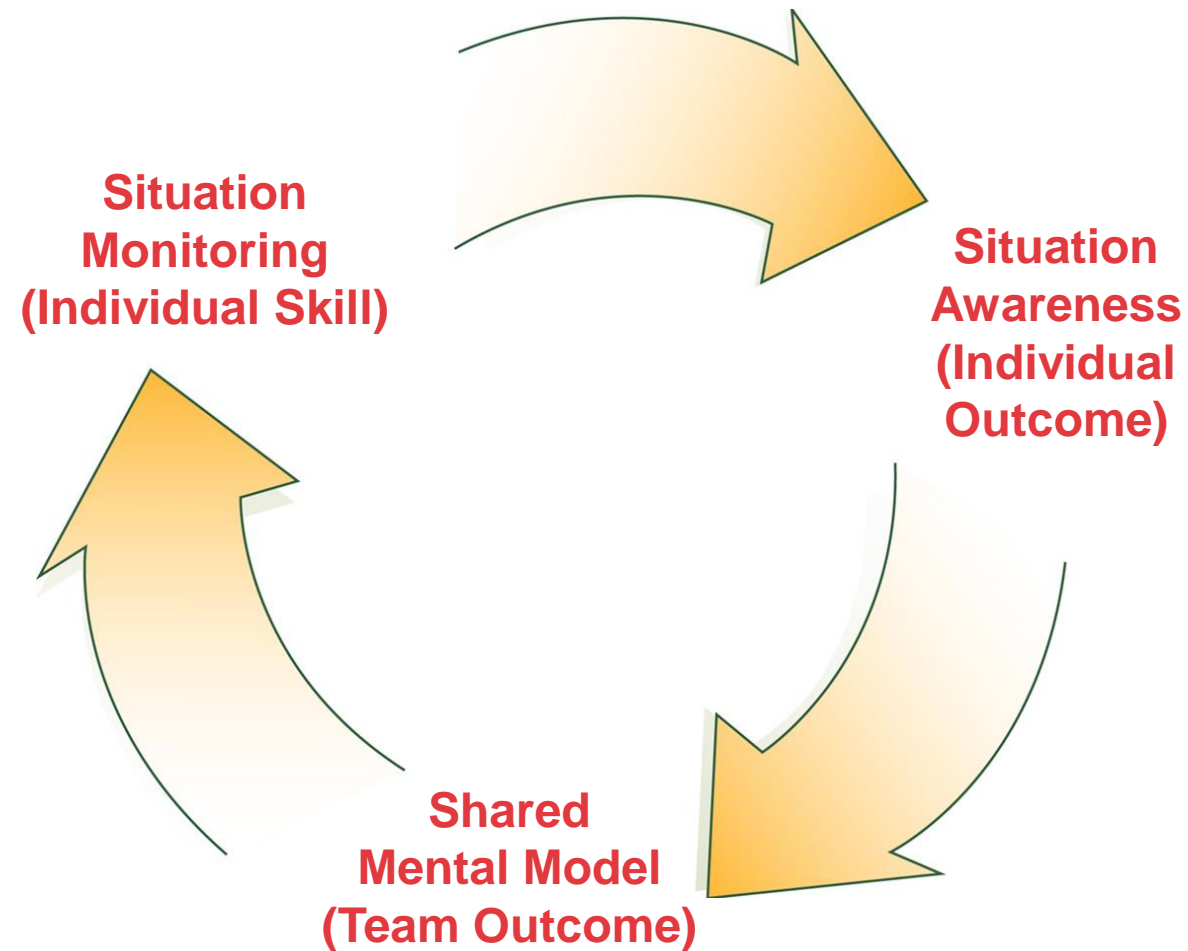
Reviewing the Team's Performance: Debrief

Process Improvement

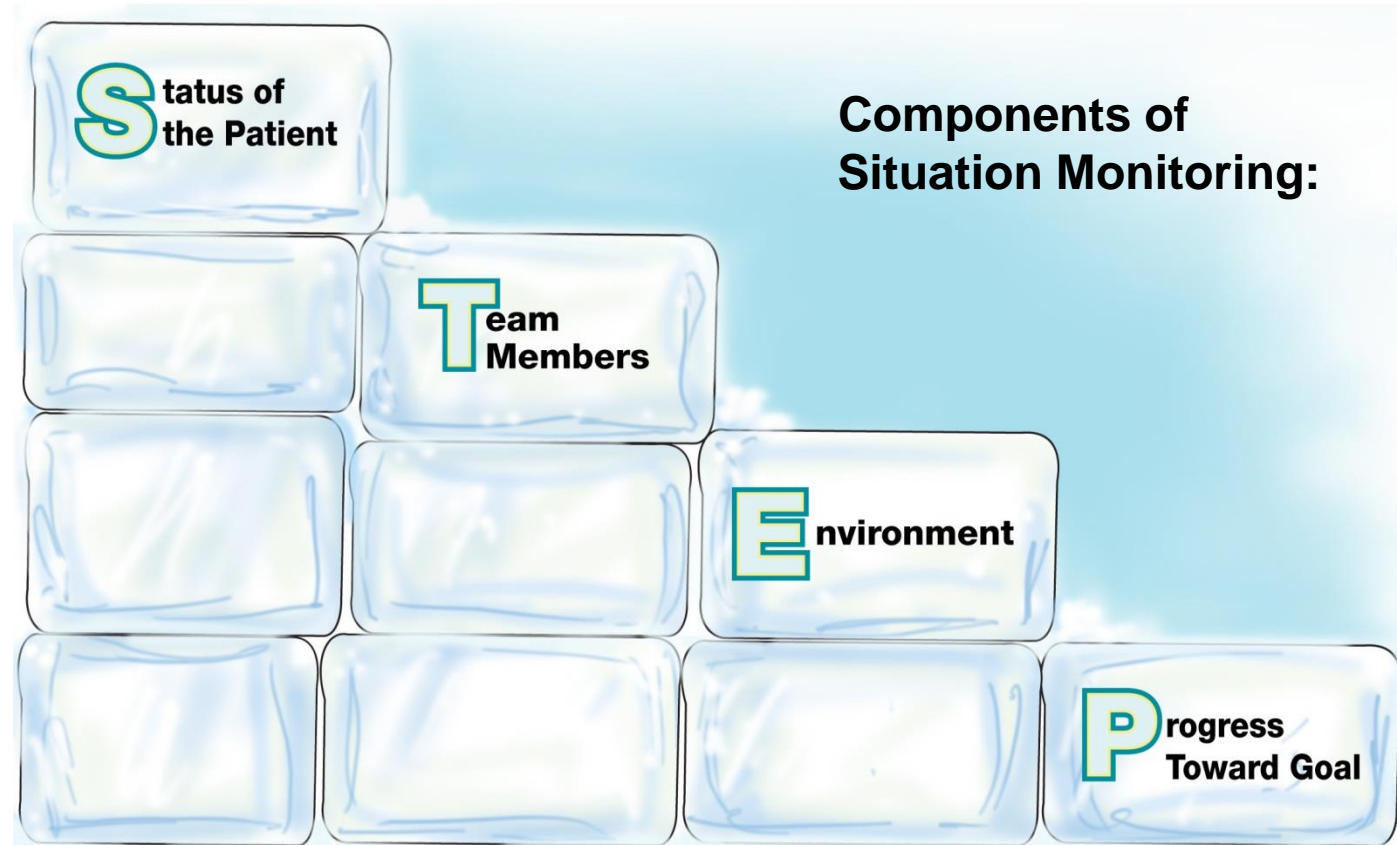
- Brief, informal information exchange and feedback sessions
- Occur after an event or shift
- Designed to improve teamwork skills
- Designed to improve outcomes
 - An accurate recounting of key events
 - Analysis of why the event occurred
 - Discussion of lessons learned and reinforcement of successes
 - Revised plan to incorporate lessons learned



A Continuous Process



STEP





I'M SAFE Checklist

- I = Illness**
- M = Medication**
- S = Stress**
- A = Alcohol and Drugs**
- F = Fatigue**
- E = Eating and Elimination**



Mutual Support

Mutual support involves members:

1. Assisting each other
2. Providing and receiving feedback
3. Exerting assertive and advocacy behaviors when patient safety is threatened



Task Assistance

Team members foster a climate in which it is expected that assistance will be actively *sought* and *offered* as a method for reducing the occurrence of error.



What Is Feedback?

Feedback is information provided for the purpose of improving team performance



Characteristics of Effective Feedback

Effective feedback is—

- Timely
- Respectful
- Specific
- Directed toward improvement
 - Helps prevent the same problem from occurring in the future
- Considerate



Please Use CUS Words but *only* when appropriate!

I am **C**oncerned!

C



I am **U**ncomfortable!

U



This is a **S**afety Issue

S

STOP!



Conflict Resolution DESC Script

**A constructive approach for
managing and resolving conflict**

D—**Describe** the specific situation

E—**Express** your concerns about the action

S—**Suggest** other alternatives

C—**Consequences** should be stated



Tools & Strategies Summary

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

TOOLS and STRATEGIES

Communication

- SBAR
- Call-Out
- Check-Back
- Handoff

Leading Teams

- Brief
- Huddle
- Debrief

Situation Monitoring

- STEP
- I'M SAFE

Mutual Support

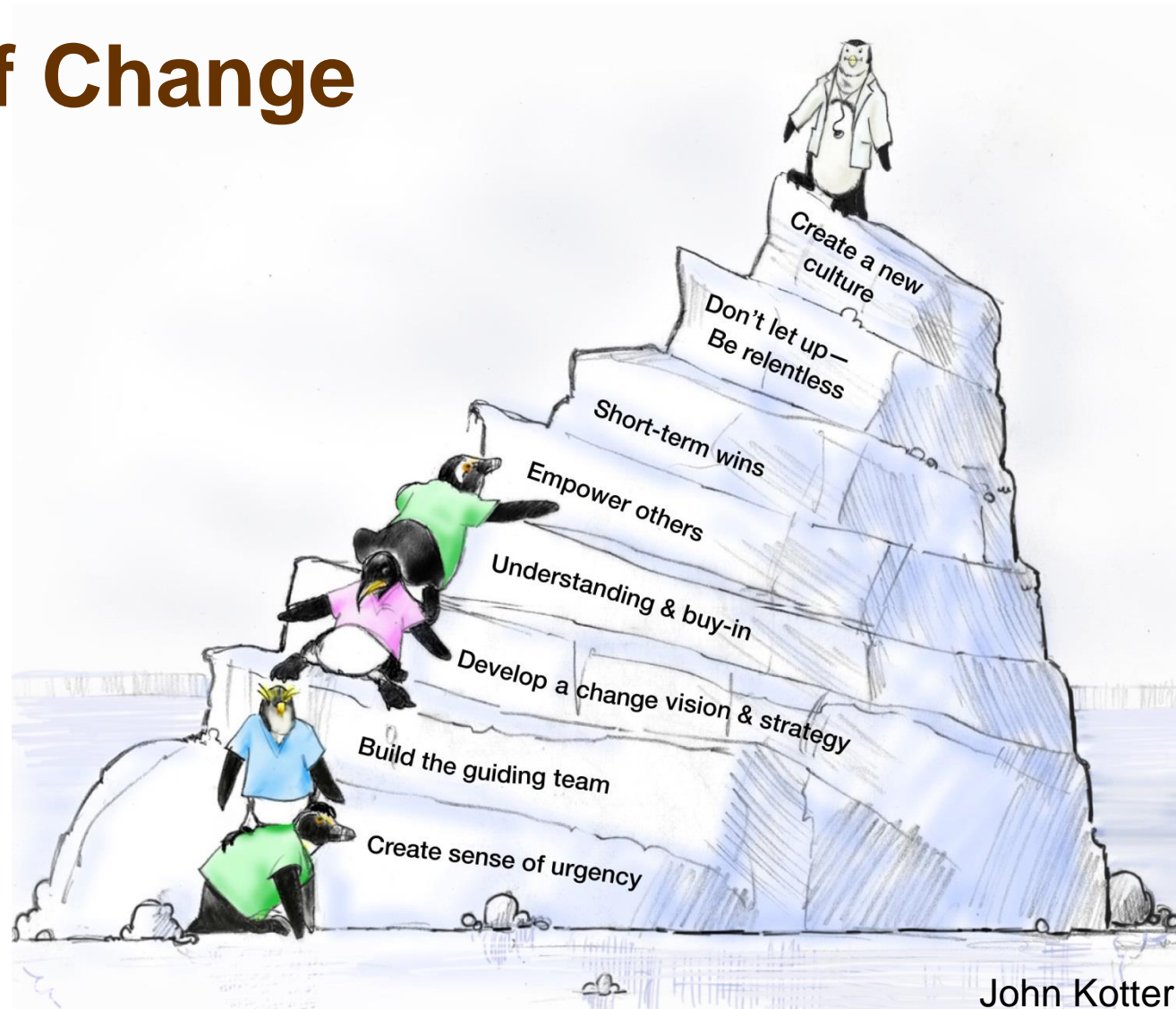
- Task Assistance
- Feedback
- Assertive Statement
- Two-Challenge Rule
- CUS
- DESC Script

OUTCOMES

- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- *Patient Safety!!*



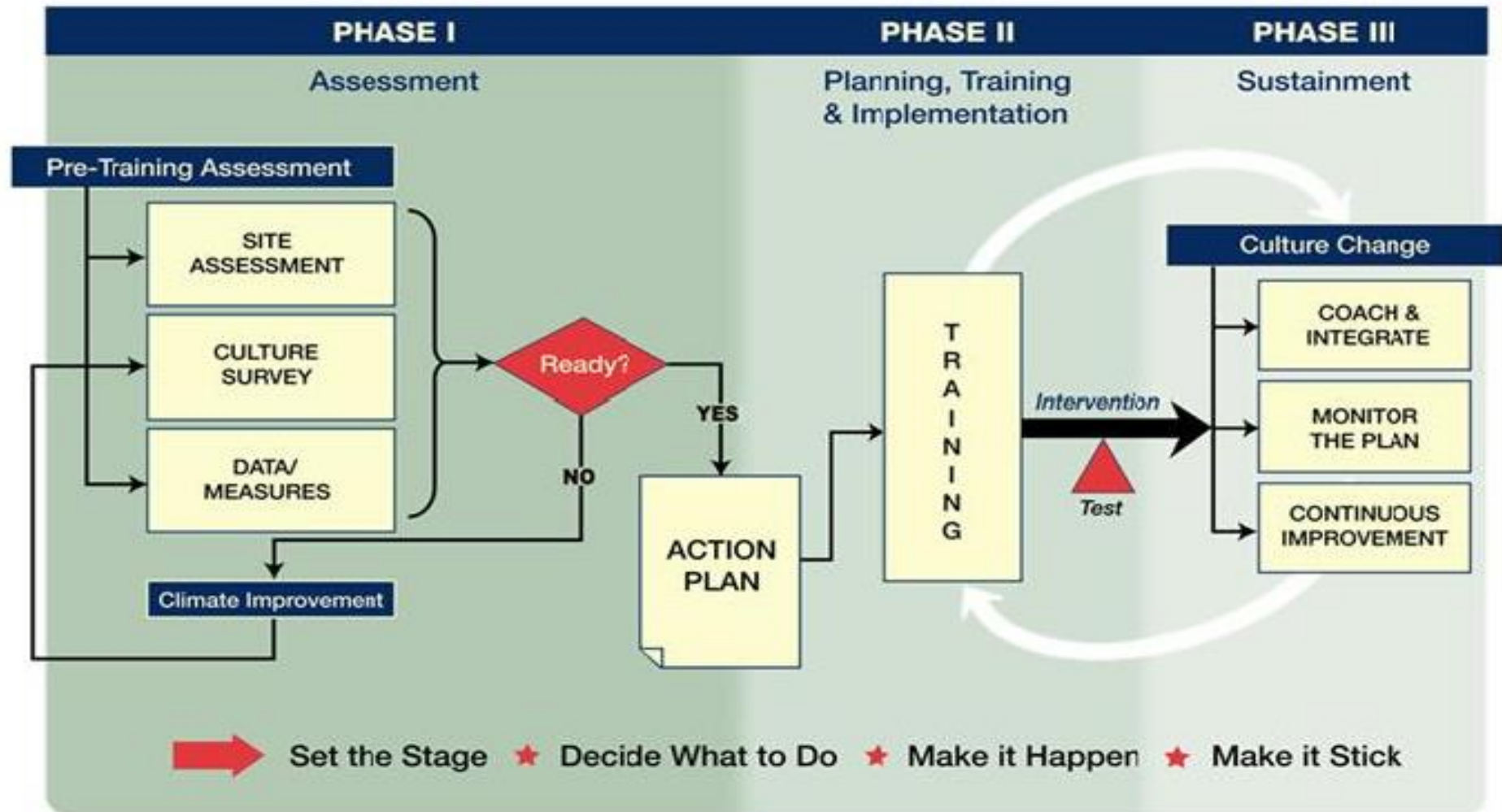
8 Steps of Change



John Kotter



TeamSTEPPS Change Model



Coaching

- Involves providing instruction, direction, and prompting
- Includes demonstrating, reinforcing, motivating, and providing feedback
- Requires monitoring and ongoing performance assessment
- Continues even after skills are mastered to ensure sustainment



10 Steps of Implementation Planning

1. Create a Change Team
2. Define the problem, challenge, or opportunity for improvement
3. Define the aim(s) of your TeamSTEPPS intervention
4. Design a TeamSTEPPS intervention
5. Develop a plan for testing the effectiveness of your TeamSTEPPS intervention
6. Develop an implementation plan
7. Develop a plan for sustained continuous improvement
8. Develop a communications plan
9. Develop a TeamSTEPPS Implementation Plan timeline
10. Review your TeamSTEPPS Implementation Plan with key stakeholders and modify according to input



Article

Impact of TeamSTEPPS on patient safety culture in a Swiss maternity ward

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Abstract

Objective: To assess the impact of implementation of the TeamSTEPPS teamwork improvement concept on patient safety culture.

Design: Pre-post culture assessment using the Hospital Survey on Patient Safety Culture, at baseline and one year after implementation of TeamSTEPPS.

Setting: Two maternity wards within the same 480-bed multisite teaching hospital.

Intervention: Implementation of the TeamSTEPPS teamwork improvement concept.

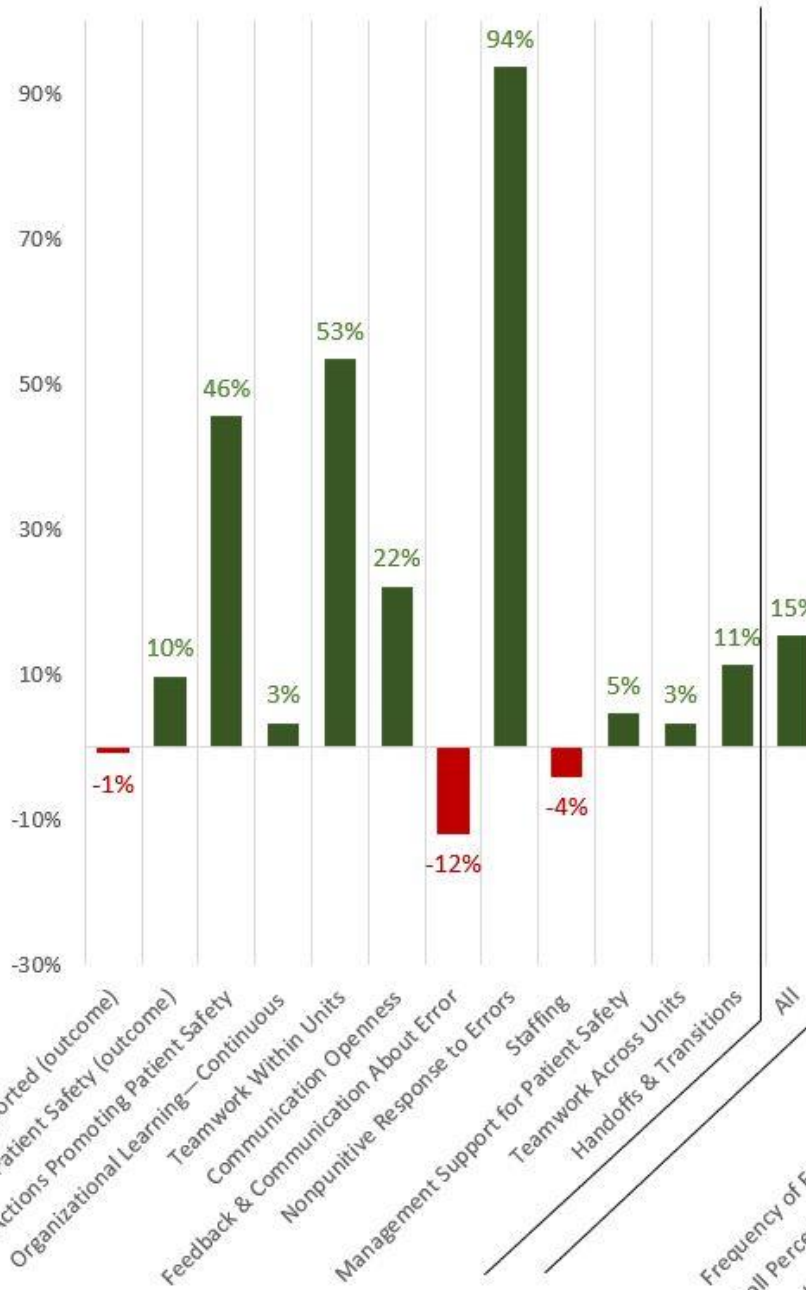
Main Outcome Measures: Analysis of variation of the percentage of positive responses (score) in both wards (intervention and control) was conducted.

Results: There was a significant increase in scores in three dimensions of patient safety culture in the intervention ward: Supervisor/Manager Expectations and Actions Promoting Safety increased from 48.7% in 2015 to 70.8% in 2016 ($P < 0.005$); Teamwork Within Units increased from 35.5% in 2015 to 54.5% in 2016 ($P < 0.005$); Nonpunitive Response to Errors increased from 16.7% in 2015 to 32.3% in 2016 ($P < 0.005$). Other dimensions showed no significant changes. In the control ward, there was a significant decrease in scores in one dimension. A secondary analysis of differences in differences still shows significant improvement in one dimension (Supervisor/Manager Expectations and Actions Promoting Safety $P < 0.005$).



Team

Intervention Ward



Control Ward

