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TeamSTEPPS® 2.0

Team Strategies and Tools to Enhance Performance and Patient Safety

Anthony Staines, PhD – February 1, 2022
CAHO-ISQua International Webinar Series

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

DHA
Defense Health Agency

Patient Safety Movement & Team Training

1995 — DoD MedTeams® ED Study

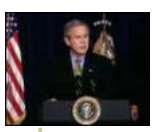
1999 — *"To Err Is Human"* IOM Report

2001 — Executive Memo from President

2003 — JCAHO National Patient Safety Goals

2004 — Institute for Healthcare Improvement 100K *lives* Campaign

2005 — TeamSTEPPS®



2006 — TeamSTEPPS Released to the Public

2007 — TeamSTEPPS National Implementation Program Began

2008 — National Implementation of CUSP

2011 — Centers for Medicare & Medicaid Services Partnership for Patients Campaign

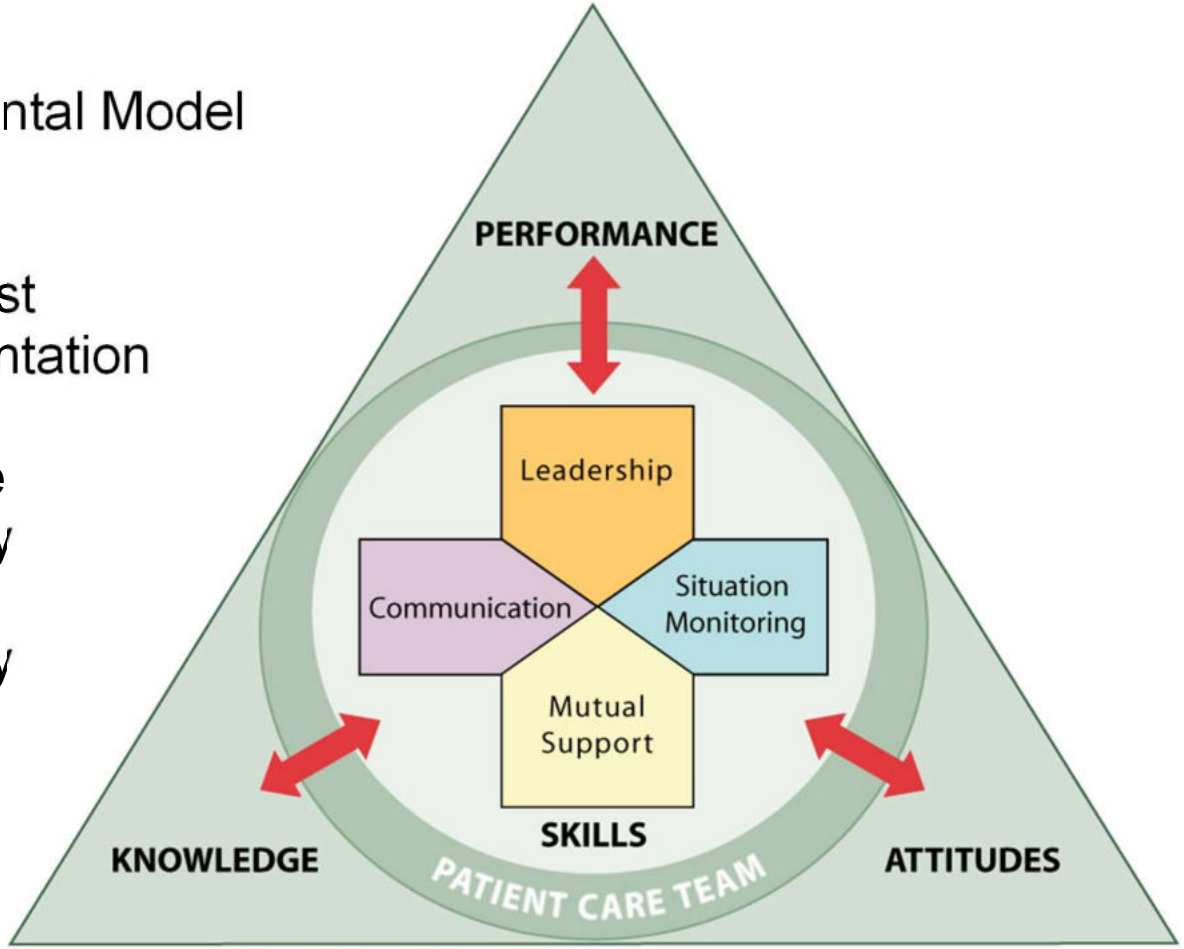
Medical Team Training

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

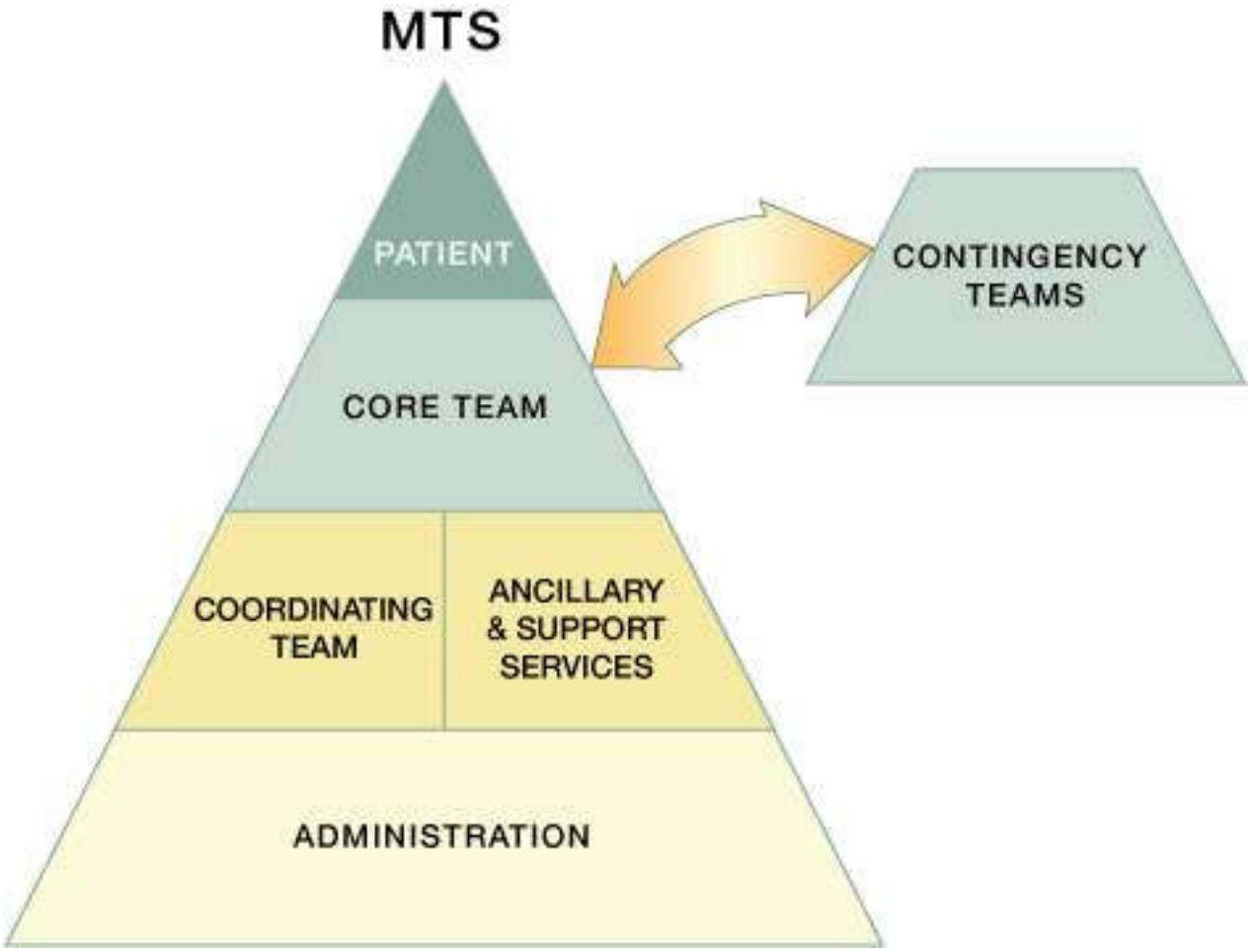
- **Knowledge**
  - Shared Mental Model
- **Attitudes**
  - Mutual Trust
  - Team Orientation
- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety



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:

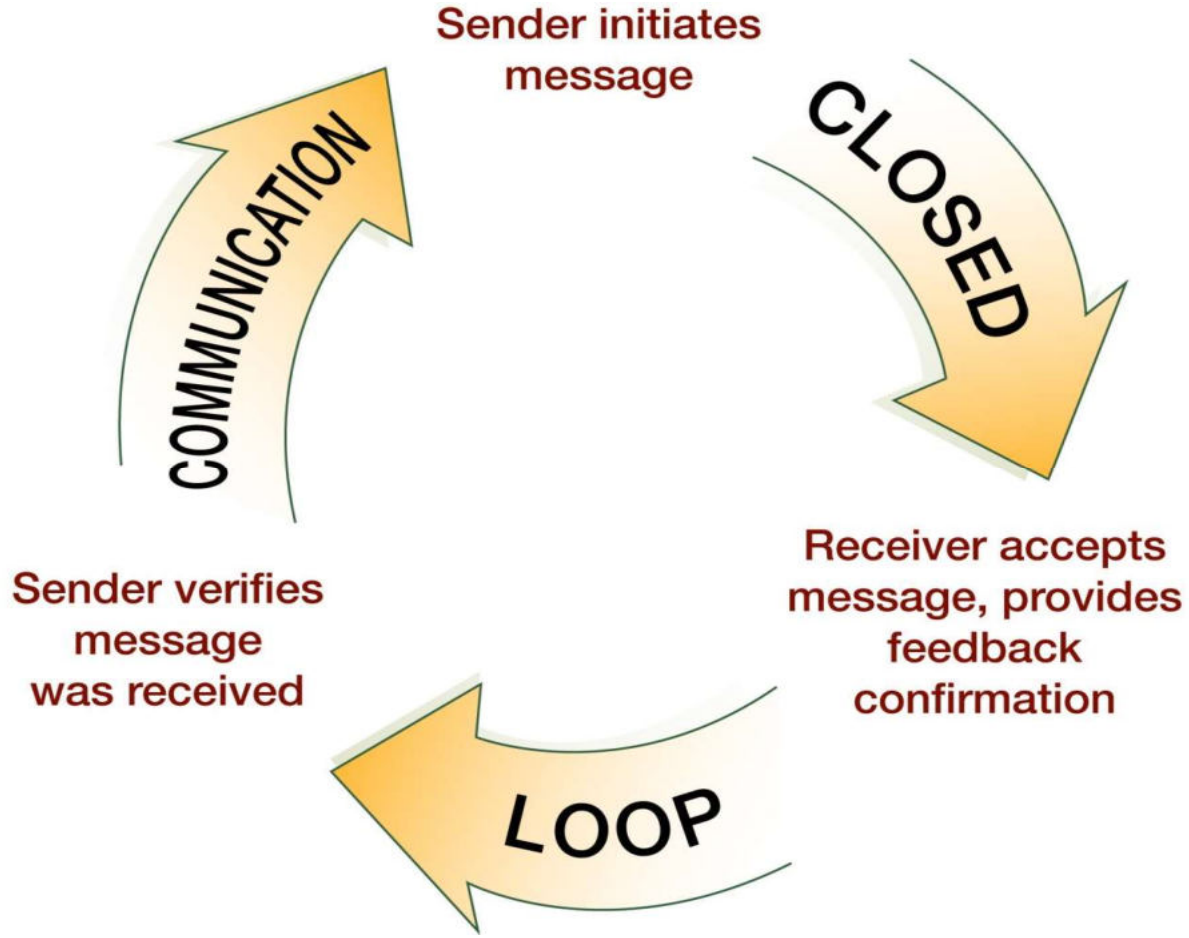
- **S**ituation—What is going on with the patient?
- **B**ackground—What is the clinical background or context?
- **A**ssessment—What do I think the problem is?
- **R**ecommendation—What would I recommend?

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	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Timeline and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen • Review safety issues
S	Synthesis by Receiver	• 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

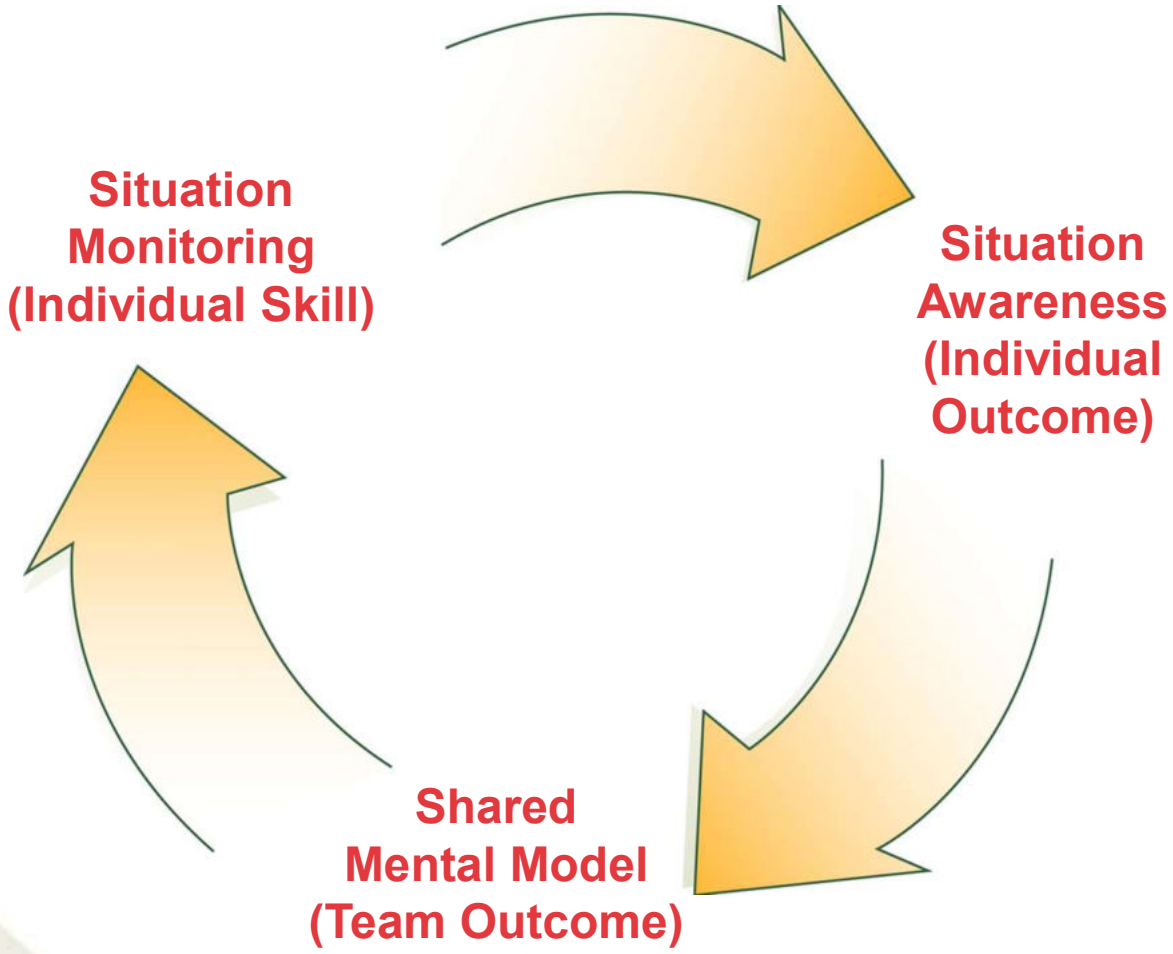
- Hold ad hoc, “touch base” meetings to regain situation awareness
- Discuss critical issues and emerging events
- Anticipate outcomes and likely contingencies
- Assign resources
- Express concerns

Reviewing the Team's Performance: Debrief

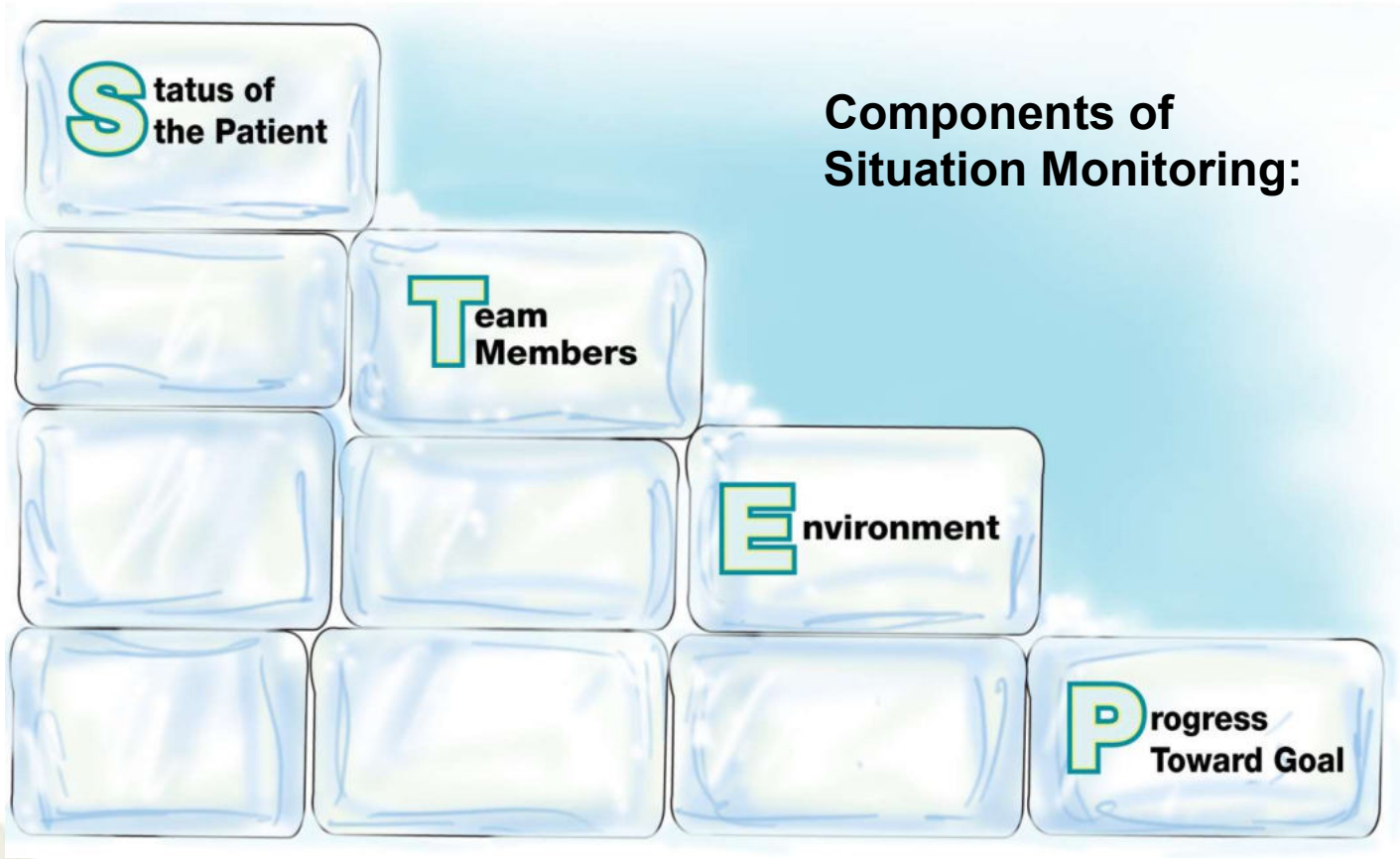
Process Improvement

- 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



Components of Situation Monitoring:

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.

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!

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

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Mutual Support

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

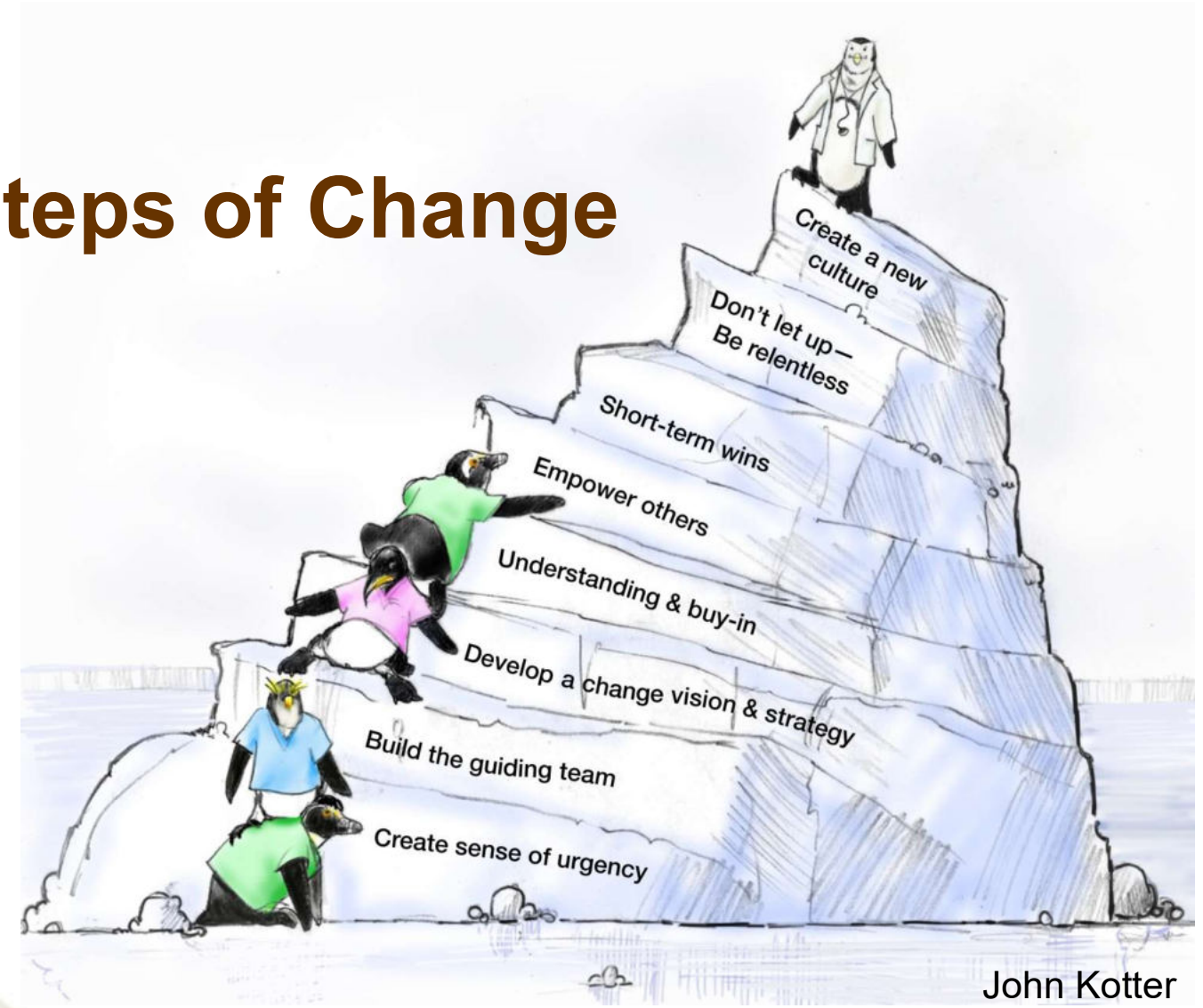
Situation Monitoring
- STEP
- I'M SAFE

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

OUTCOMES

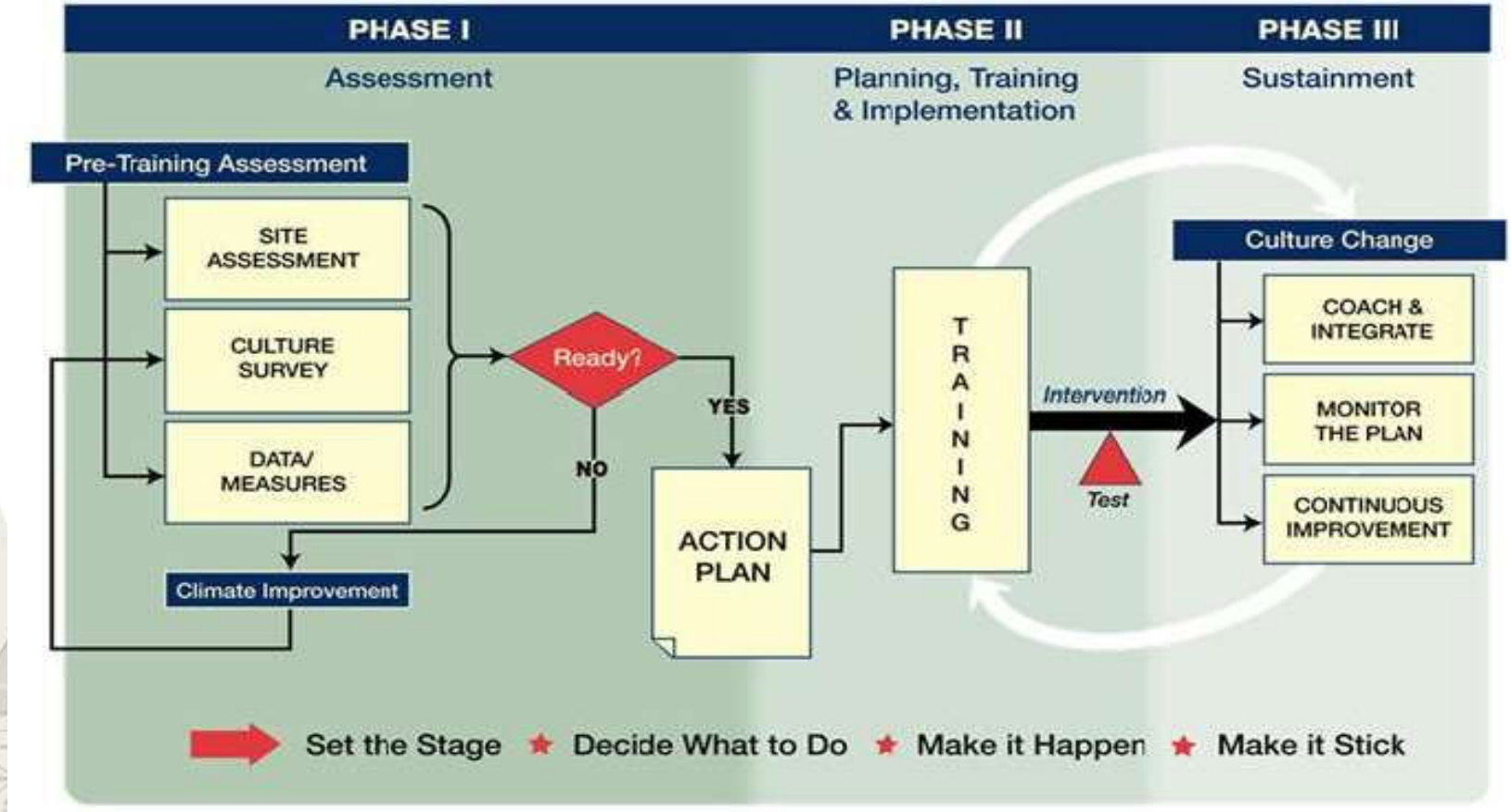
- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- *Patient Safety!!*

8 Steps of Change



John Kotter

TeamSTEPPS Change Model

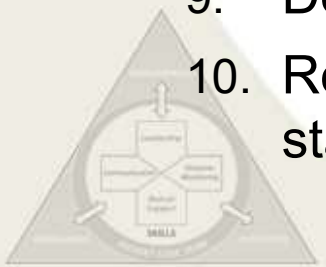


Coaching

- 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



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Article

Article

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

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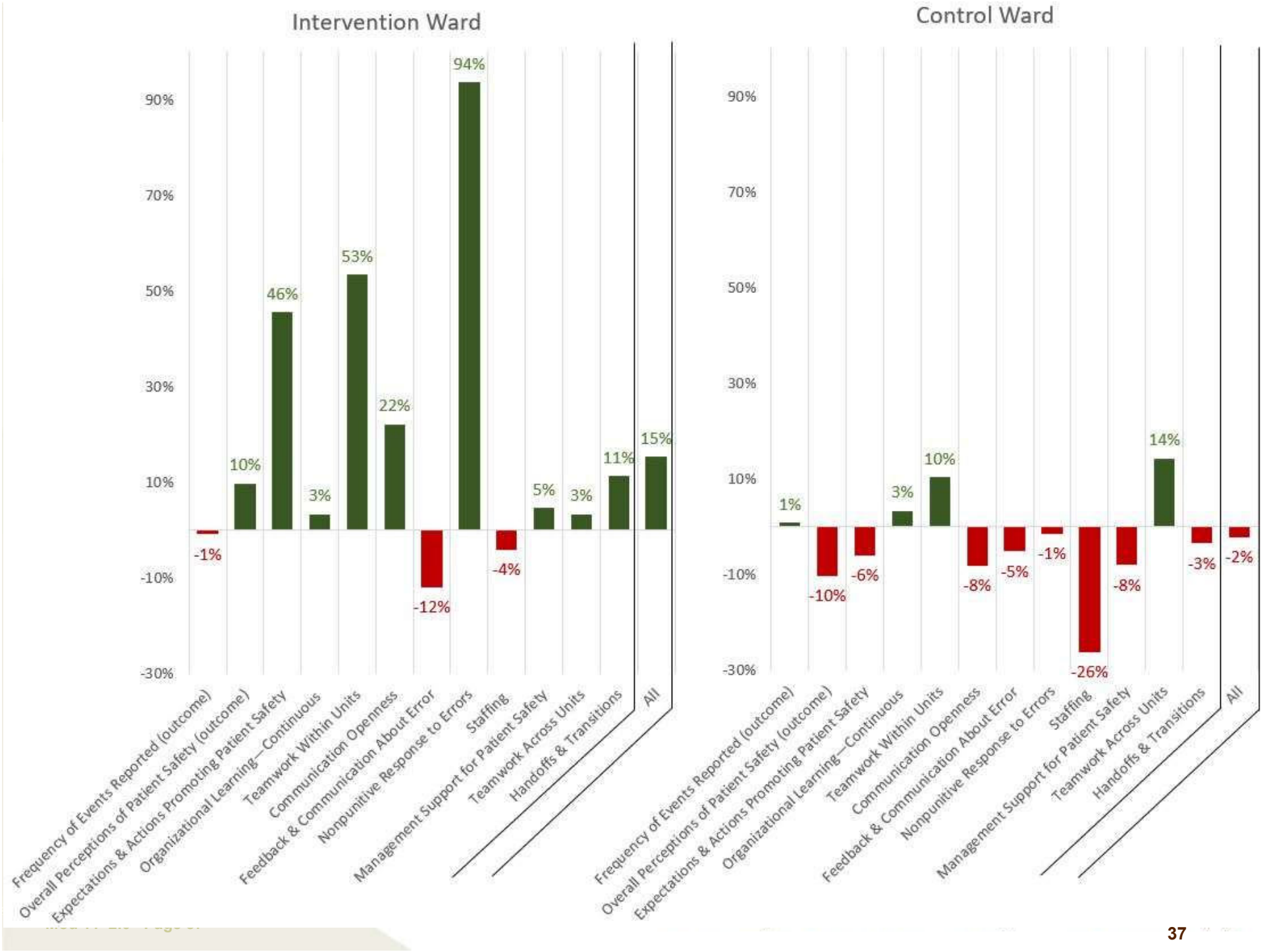
Abstract

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 $P < 0.005$).


Intervention Ward
90%
70%
50%
30%
10%
-10%
-30%
-1%
10%
46%
3%
53%
22%
-12%
94%
-4%
5%
3%
11%
15%
Frequency of Events Reported (outcome)
Overall Perceptions of Patient Safety (outcome)
Expectations & Actions Promoting Patient Safety
Organizational Learning—Continuous
Teamwork Within Units
Communication Openness
Feedback & Communication About Error
Nonpunitive Response to Errors
Staffing
Management Support for Patient Safety
Teamwork Across Units
Handoffs & Transitions
All
Control Ward
90%
70%
50%
30%
10%
-10%
-30%
1%
-10%
-6%
3%
10%
-8%
-5%
-1%
-26%
-8%
14%
-3%
-2%
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Overall Perceptions of Patient Safety (outcome)
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