

## ***Introduction to TeamSTEPPS***

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## ***TeamSTEPPS***

***Strategies and Tools  
to Enhance Performance  
and Patient Safety***



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## *What is Your Perception of Safety?*

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## *Perception of Safety*



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## *Perception of Safety*



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*Information for Health Care Improvement*

HSAG

## *Perception of Safety*



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*Information for Health Care Improvement*

HSAG

## Perception of Safety



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## The IoM Report

- 1999 *To Err is Human*
  - “at least 44,000 Americans die each year as a result of medical errors” . . . “results of the New York Study suggest that number may be as high as 98,000.”



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## ***TeamSTEPPS History***

- Developed by the Department of Defense
- Agency for Healthcare Research and Quality
- Goal is to produce highly effective medical teams
- Scientifically rooted in over 20 years of research and lessons learned
- Evidence-based framework to optimize team performance

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## ***Introduction***

### Evolution of TeamSTEPPS

#### **Curriculum Contributors**

- Department of Defense
- Agency for Healthcare Research and Quality
- Research Organizations
- Universities
- Medical and Business Schools
- Hospitals—Military and Civilian, Teaching and Community-Based
- Healthcare Foundations
- Private Companies
- Subject-Matter Experts in Teamwork, Human Factors, and Crew Resource Management (CRM)

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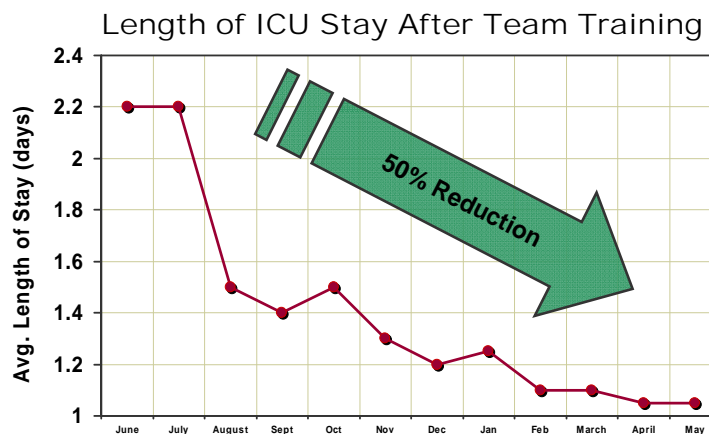
## TeamSTEPPS

*“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”*

**Let's see some results.**

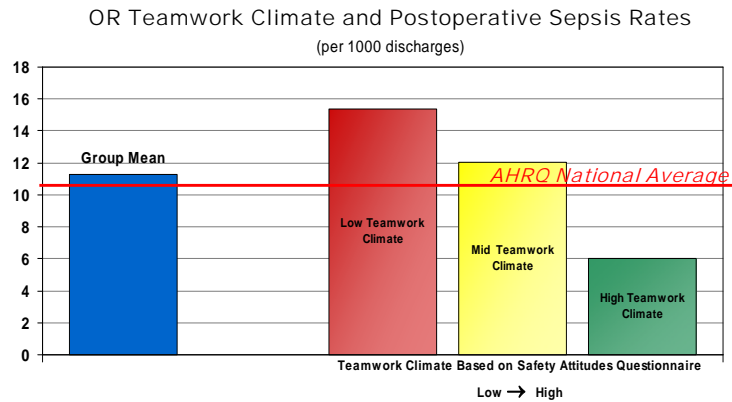
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## Proven Results of Teamwork



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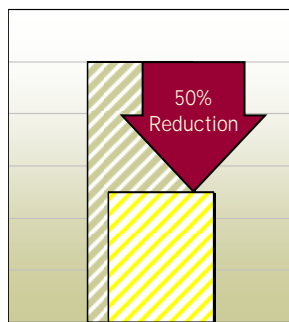
## Proven Results of Teamwork



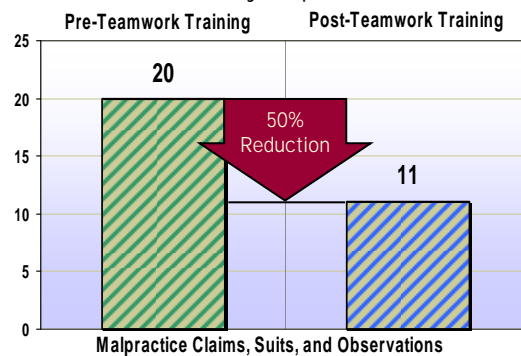
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## Proven Results of Teamwork

Adverse Outcomes



Indemnity Experience



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## **TeamSTEPPS**

*“Providing strategies, skills, and knowledge to improve patient safety, enhance team performance, and reduce adverse events through a culture of safety.”*

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## **Why Do Errors Occur?**

- Within your group, spend 5 minutes listing all of the reasons why you believe errors occur.
- At the end of the 5 minutes you will need to share your list.

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## Why Do Errors Occur?

- Workload fluctuations
- Interruptions
- Fatigue
- Multi-tasking
- Failure to follow up
- Poor handoffs
- Ineffective communication
- Not following protocol
- Excessive professional courtesy
- Halo effect
- Passenger syndrome
- Hidden agenda
- Complacency
- High-risk phase
- Strength of an idea
- Task (target) fixation

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## Joint Commission Sentinel Events

### Root Causes of Sentinel Events

(All categories; 1995-2005)



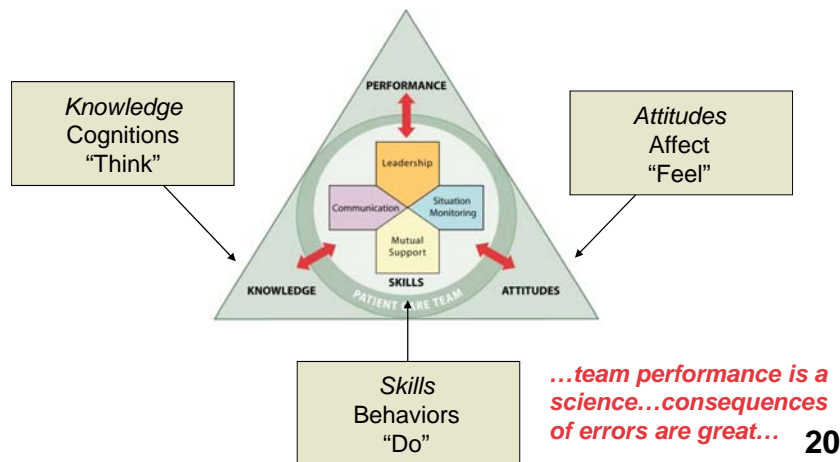
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## Teamwork is Essential

- What can be done to improve teamwork?  
(Describe some strategies that you think would improve teamwork within your organization.)

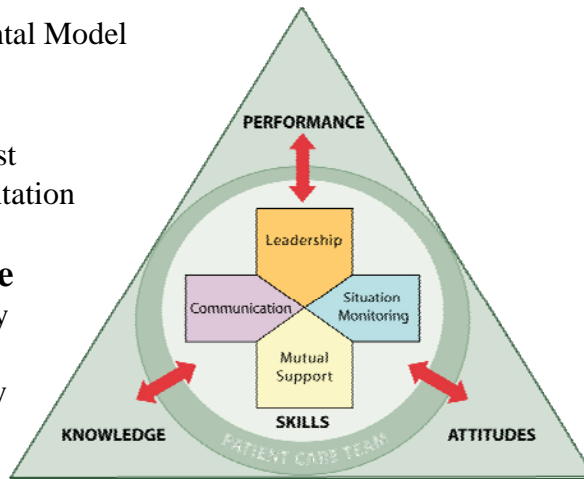
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## What Comprises Team Performance?



## Outcomes of Team Competencies

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



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## Errors to Avoid

- Allowance for complacency
- Failure to create a sufficiently powerful Change Team
- Not truly integrating the vision
- Not allowing for barriers and obstacles
- Not celebrating “short-term wins”
- Declaring victory too soon
- Neglecting to anchor changes firmly in the culture

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## **TeamSTEPPS Leadership and Culture**

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## **Leadership**

Leaders are judged not by  
their personal successes  
but by the successes of  
those they lead.”  
— Pam Bilbrey



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## ***Team Leadership***

- Organize the team
- Articulate clear goals
- Make decisions through collective input of members
- Empower members to speak up and challenge, when appropriate
- Actively promote and facilitate good teamwork
- Skillful at conflict resolution

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## ***Culture***

Integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm.

*Patient Safety, Achieving a New Standard for Care*  
Institute of Medicine

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## ***Developing a Culture***

- Time
- Commitment
- Leadership
- Vision
- Sense of urgency
- Skills, knowledge, and attitude

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## ***Urgency***

- Get people's attention!
- Sell the need for change . . . sell the pain and the consequences of not changing.
- Immerse people in information about the change.
- Discuss ways to solve the problems people identify with the change.
  - Empower people to solve the “problem.”

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## Change Management



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## Transforming Culture

- Establishes names for behaviors and a common language for talking about “communication failures”
- Bridges the professional divide and levels the hierarchy
- Provides “actions” to practice
- Enlists the patient as a valued team member

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## ***Vision and Strategy***

Senior Leadership is responsible for:

- Establishing the definition of a “culture of safety” aligned with expectations, core values, and shared beliefs.
- Informing the organization of these values and evaluating the culture.
- Leading the process of:
  - *Translating values into expected behaviors.*
  - Establishing trust and accountability.
- Communicating a commitment to shaping the culture.
- Modeling the expected behaviors.

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## ***Create a New Culture!***

- Develop action steps for stabilizing, reinforcing, and sustaining the change.
- Continually monitor the results from the change and identify opportunities for further improvements.
- Make adjustments to the change vision and strategy to reflect new learning and insights.
- Encourage people to be open to new challenges, forces, and pressures for the change.

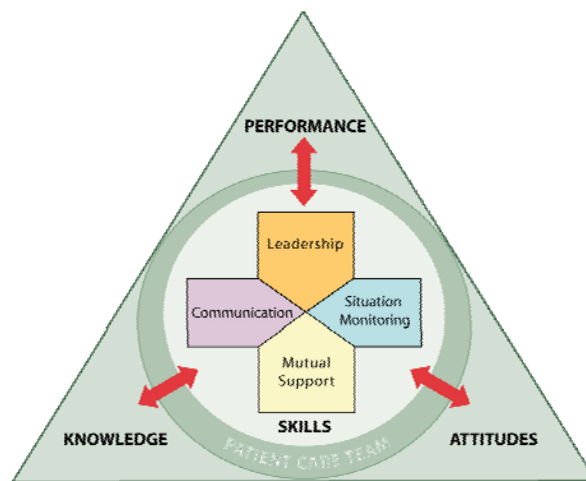
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# TeamSTEPPS

Situation Monitoring  
Mutual Support  
Communications

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# Situation Monitoring



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## Situation Monitoring



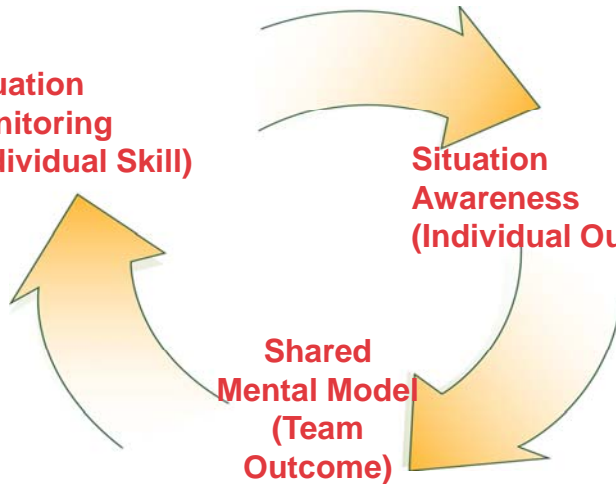
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## Situation Monitoring

**Situation  
Monitoring  
(Individual Skill)**

**Situation  
Awareness  
(Individual Outcome)**

**Shared  
Mental Model  
(Team  
Outcome)**



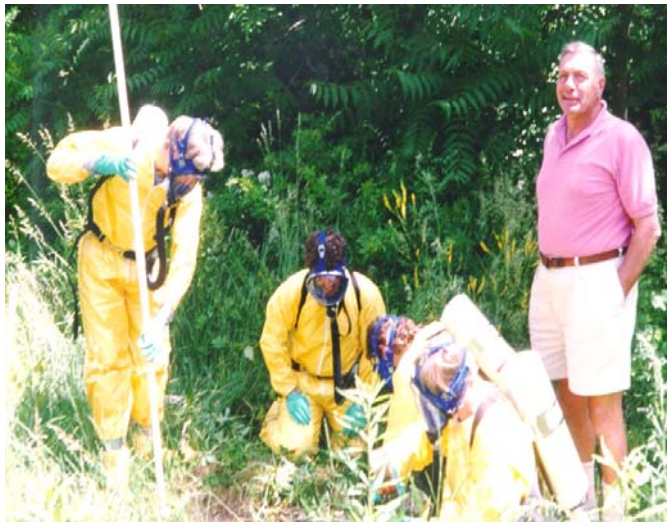
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## ***Situation Monitoring***

- Situation Monitoring: actively scanning behaviors and actions to assess elements of the situation or environment
- Cross Monitoring: monitoring the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors
- Situation Awareness: knowing the current conditions affecting the team's work

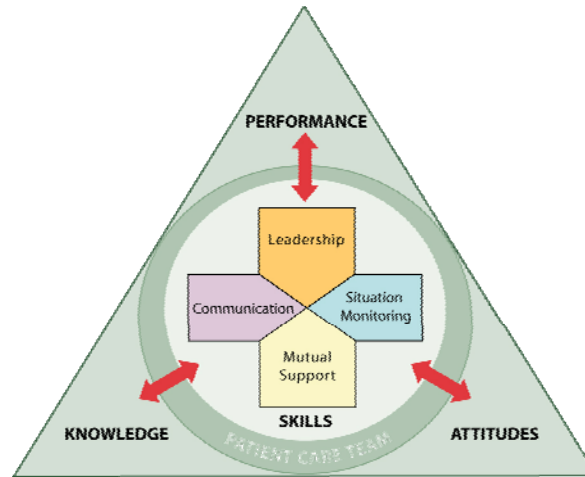
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## ***Shared Mental Model***



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## Mutual Support



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## Mutual Support

- Mutual Support is the essence of teamwork
- Protects team members from work overload that may reduce effectiveness and increase the risk of error.

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## **Mutual Support Task Assistance**



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## **Task Assistance**

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

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## **Advocacy, Assertion, and Conflict Resolution**

- Advocate for the patient
  - Invoked when team members' viewpoints don't coincide with that of a decision maker
- Assert a corrective action in a *firm* and *respectful* manner



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## **Assertion**

- Respect and support authority
- Clearly assert concerns and suggestions
- Use an assertive statement (**nonthreatening and ensures that critical information is addressed**)
  - Make an opening
  - State the concern
  - State the problem
  - Offer a solution
  - Reach an agreement

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## Conflict Resolution

- Two-challenge rule
  - 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



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## CUS

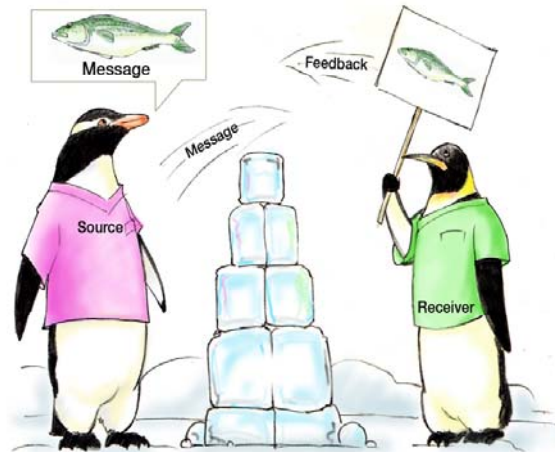


**A constructive approach for managing and resolving conflict**

- D—Describe** the specific situation
- E—Express** your concerns about the action
- S—Suggest** other alternatives
- C—Consequences** should be stated

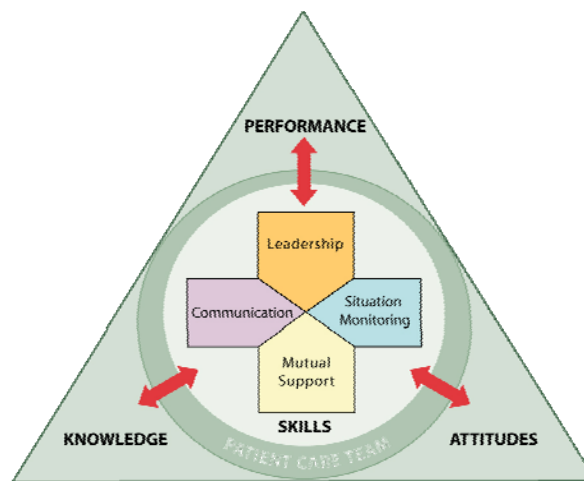
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## Communication



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## TeamSTEPPS Communication



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## ***Communications is . . .***

- Information exchange between individuals, departments, or organizations
- The lifeline of the Core Team
- Effective when it permeates every level of an organization

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## ***Resource Management***

A strategy for achieving workload balance within and across teams in a unit

- Refers to people, knowledge or information, materials, and time that can be drawn upon to accomplish a task
- Goal is to prevent work overload situations that compromise situation awareness and increase the risk of error

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## Strategies for Resource Management

**Delegate**



**Huddle**

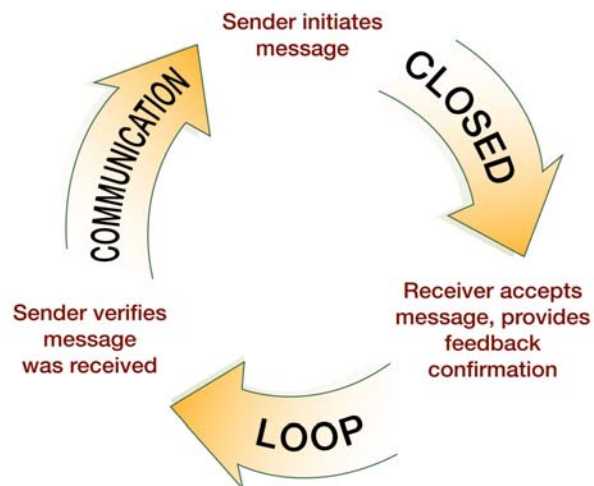


**Debrief**



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## Information Exchange Strategies



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## Barriers to Team Effectiveness

### 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 Follow-Up with Co-Workers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

### TOOLS and STRATEGIES

Brief  
Huddle  
Debrief  
STEP  
Cross Monitoring  
Feedback  
Advocacy and Assertion  
Two-Challenge Rule  
CUS  
DESC Script  
Collaboration  
SBAR  
Call-Out  
Check-Back  
Handoff

### OUTCOMES

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

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## Teamwork Actions

- Communicate with team members in a brief, clear, and timely format
- Seek information from all sources
- Verify and share information
- Practice communication tools and strategies

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## ***Remember the Long-Term Goal***

- Effective team members:
  - Are better able to predict the needs of other team members
  - Provide quality information and feedback
  - Engage in higher level decision-making
  - Manage conflict skillfully
  - Understand their roles and responsibilities
  - Reduce stress on the team as a whole through better performance
  - Communicate

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## ***Questions***

- Thank you for participating today.



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## Contact Information

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*Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.*

**To find out how to prevent medication errors, go to <http://www.hsag.com/drugsafety/>.**



[www.hsag.com](http://www.hsag.com)

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