# Physician Leadership with TeamSTEPPS

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

*SCIP Learning Session 3*
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## TeamSTEPPS

- *To Err is Human*: There is a need for "interdisciplinary team training programs that incorporate proven methods for team management."
- Developed by the Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense
- Evidence-based team training and techniques of effective communication and other teamwork

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## TeamSTEPPS Alignment

- National Patient Safety Goals
- IHI 5 Million Lives Campaign
- NQF Safe Practices
- SCIP Measures
- Joint Commission Leadership Standards
- Universal Protocol

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## Teamwork Targets Root Causes



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## What Comprises Team Performance?



*...team performance is a science...consequences of errors are great...*

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## Outcomes of Team Competencies

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



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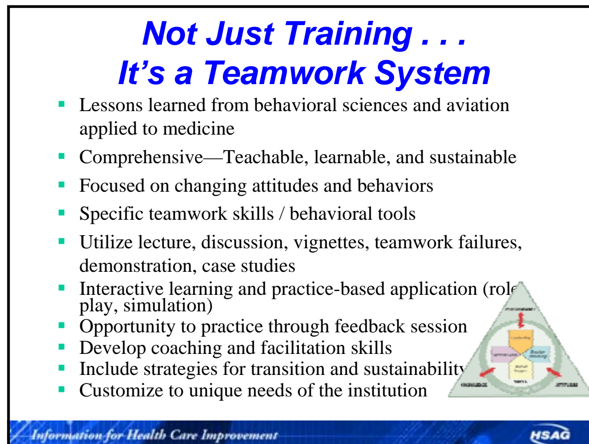


## Transforming Culture

- 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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## Situation Monitoring

The team:

- Assesses the patient—establishes a situation awareness (SA).
  - *Assess patient history, current data*
- Maintains their SA.
  - *Update information with new, emerging, data*
- Creates and maintains a shared mental model.
  - *Share/exchange information*
- Establishes and communicates the plan.
- Cross-monitors all actions against the plan.
  - *Advocate and assert a position, Two-Challenge Rule, when actions conflict with the established plan*

Individual Skill

Individual Skill

Team Skill

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## Mutual Support

Team members:

- Offer back-up help.
- Anticipate the needs of the team.
  - *Assemble and present all information possible—e.g., chart, EMR, new lab results, etc.*
- Obtain resources as necessary.
  - *Do or delegate tasks*
  - *Cover or reassign other patients*
  - *Handoff care*
- Use appropriate strategies for resolving conflicts or barriers to care.
  - *DESC Script*

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## Key Discussion Points

- *We hear a lot:* Leadership questions
  - What is TeamSTEPPS?
  - What are the phases to a successful implementation?
  - How will I measure effectiveness of training?
  - What resources are available?
  - How can you support the effort?
  - What are the tools that can be integrated into daily practice to enhance quality, performance, and patient safety?
- *We listen a lot:* Provider and Staff questions
  - What is this change? What is wrong with what we are doing now?
  - Why is it necessary? What will happen if we don't change? ***…but we already work as a team!***
- *We learn even more:* Transferring training to outcomes – Change Model

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## Leadership

- The team leader is established and
  - Introduces him- or herself to the team and patient.
  - Assumes the authority of leader.
  - Conducts a quick team brief.
    - Ensures a shared mental model
    - Establishes a plan
  - Facilitates the plan.
    - Identifies and addresses barriers to team outcomes
  - Ensures on-going communication – planning and problem solving.
  - Ensures workload and resource distribution.
- Team members
  - Identify themselves and assume roles.
  - Engage the behaviors and perform as a team—plan, problem solve, deliver, handoff, and improve over time.

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## Barriers to Team Effectiveness

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



## Resource Requirements

- Strategic planning expertise
- Trainers: physician and others
- Coaches: practicing clinicians, human factors or patient safety experts
- Flexibility for in-situ training and coaching
- Observation team
- Data analysis support
- Project management action planning skills



## Team Training Yields Proven Results

Length of ICU Stay After Team Training

50% Reduction

(Pronovost, 2003)
Johns Hopkins
Journal of Critical Care Medicine

OR Teamwork Climate and Postoperative Sepsis Rates

(Sexton, 2006)
Johns Hopkins

Adverse Outcomes

50% Reduction

(Mann, 2006)
Beth Israel Deaconess Medical Center
Contemporary OB/GYN

Indemnity Experience

Pre-Teamwork Training | Post-Teamwork Training

50% Reduction

Malpractice Claims, Suits, and Observations



## Team Events

- Briefs – planning
- Debriefs – process improvement

***Leaders are responsible for assembling the team and facilitating team events***



## Supporting Evidence

- Gawande—communication breakdowns are contributing factors in 43% of adverse events in surgical cases
- Carthey—reported that more favorable patient outcomes were associated with effective collaborative teamwork in the operating room



## Training & Education

- Historically focused on individual technical skills for proficiency of specific tasks
- Team work skills are not taught
- OR team members should be educated about TeamSTEPPS, patient safety, and the processes of brief and debrief

## Your Role as a Physician Leader

- Participate in the development of the process
- Actively participate in Brief and Debrief
- Remember that this is about patient safety and protecting everyone



## We Know That . . .

- At least half of all surgical complications are avoidable.
- Processes designed to reduce surgical-site infections or anesthesia-related mishaps have been shown to significantly reduce complications.
- Evidence also links teamwork in surgery to improved outcomes, with high-functioning teams achieving significantly reduced rates of adverse events.



## Briefing/Debriefing Is Proven to . . .

- Reduce “undesirable events” in surgical patients, such as:
  - Untimely or failed preoperative antibiotic administration.
  - Failure to provide necessary surgical instruments.
  - Failure to provide necessary blood products.
  - Inappropriate or absent surgical consent.



## Rules of Conduct

- Respect each person.
- Share responsibility.
- Criticize only ideas, not people.
- Keep an open mind.
- Question and participate.
- Attend all meetings on time.
- Listen constructively.
- EVERYONE PARTICIPATES.



## Operative Briefing

- Introductions (first-name basis)
- Case discussion (5 minutes)
  - Patient identification (nursing)
  - Review planned surgical procedure, including positioning. (surgery)
  - Anything usual about this case? (surgery)
  - Estimated length of procedure (surgery)
  - Anticipated challenges or problems (surgery, anesth., nursing)
  - Contingency plans (surgery, anesth., nursing)
  - Does everyone understand the planned procedure?
  - Special equipment needs (surgery, anesth., nursing)
  - Special issues: fatigue, stress, anticipated staff turnover during procedure (surgery, anesth., nursing)
  - Consent (nursing)
  - Questions? (surgery, anesth., nursing)



## Operative Briefing

- Patient Considerations
  - NPO appropriate? (nursing)
  - Allergies (anesthesia)
  - Laterality (if appropriate) (surgery, anesth, nursing)
  - Site marked? (nursing)
  - Anesthesia technique and anticipated issues (anesthesia)
  - Any precautions (e.g., HIV, C Diff, HCV, MRSA) (surgery, anesth, nursing)
  - **Antibiotics (surgery, anesth)**
  - Medication issues (**B-Blocker**, “bleeding”meds (e.g., ASA, coumadin) (surgery, anesth, nursing)
  - **DVT prophylaxis: SCDs, heparin (surgery, nursing)**
  - Lab issues (e.g., hct) (anesth)
  - Blood product availability/likelihood (nursing, surgery, anesthesia
  - Radiology (surgery) films available, reviewed
  - Intraoperative x-ray needed?
  - Postopdisposition—has bed been reserved? (surgery, nursing)
  - Pathology specimen (surgery, nursing)

## Results of Implementing a Surgical Checklist

- The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward ($p = 0.003$). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist ($p < 0.001$).

*N Engl J Med* 2009;360:491–9
A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

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## Debriefing

- Name of the procedure as recorded
- Counts
- SCIP (Inf 3, Card 2, DVT)
- Specimens
- Unanticipated events
- Suggestions for improvement
- Systems assurance (the surgeon, nurse, and anesthesia professional review aloud the key concerns for the recovery and care of the patient)

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## Debrief

**Process Improvement**

- Brief, informal information exchange and feedback session
  - An accurate reconstruction of key events
  - Analysis of why the event occurred
  - What should be done differently next time
- Designed to:
  - Improve teamwork skills
  - Improve outcomes

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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.

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## IHI Video

- http://www.ihi.org/IHI/Programs/ImprovementMap/WHOSurgicalSafetyChecklist.htm

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## What is Needed for Sustained Improvement?

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## Creating Iterative Quality Improvement In Your Institution

1. Define the issue and create the sense of urgency.
2. Vertical buy-in /understanding /ownership to improvement (administrators, managers, front-line providers).
3. Pull the working team together (make up is important with ownership and accountability).
4. For broader issues: take the time necessary (e.g., RPIW 5 day vs. Kai Zen 1–2 day).
5. Collect initial (starting) data.
6. Have everyone on the team examine the process together.
7. Develop the change vision and strategy—stay focused.
8. Immediate change (with ad hoc personnel, if necessary).
9. Iterative–don't wait for perfection. Fail forward fast (PDSA).
10. Produce short-term wins.
11. Don't let up, don't be too satisfied.
12. Create the culture for iterative improvement . . . it can exist.

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**"I lift, you grab. Was the concept of collaboration a little too complex, Carl?"**

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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

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