TeamSTEPPS Implementation at Central Maine Healthcare

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Central Maine Healthcare

- An integrated healthcare delivery system serving those individuals living in central, western, and mid-coast Maine.

Central Maine Medical Center
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Bridgton Hospital
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Rumford Hospital
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Member of Central Maine Medical Group
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Introduced to High Reliability

Institute *for* Healthcare Improvement

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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

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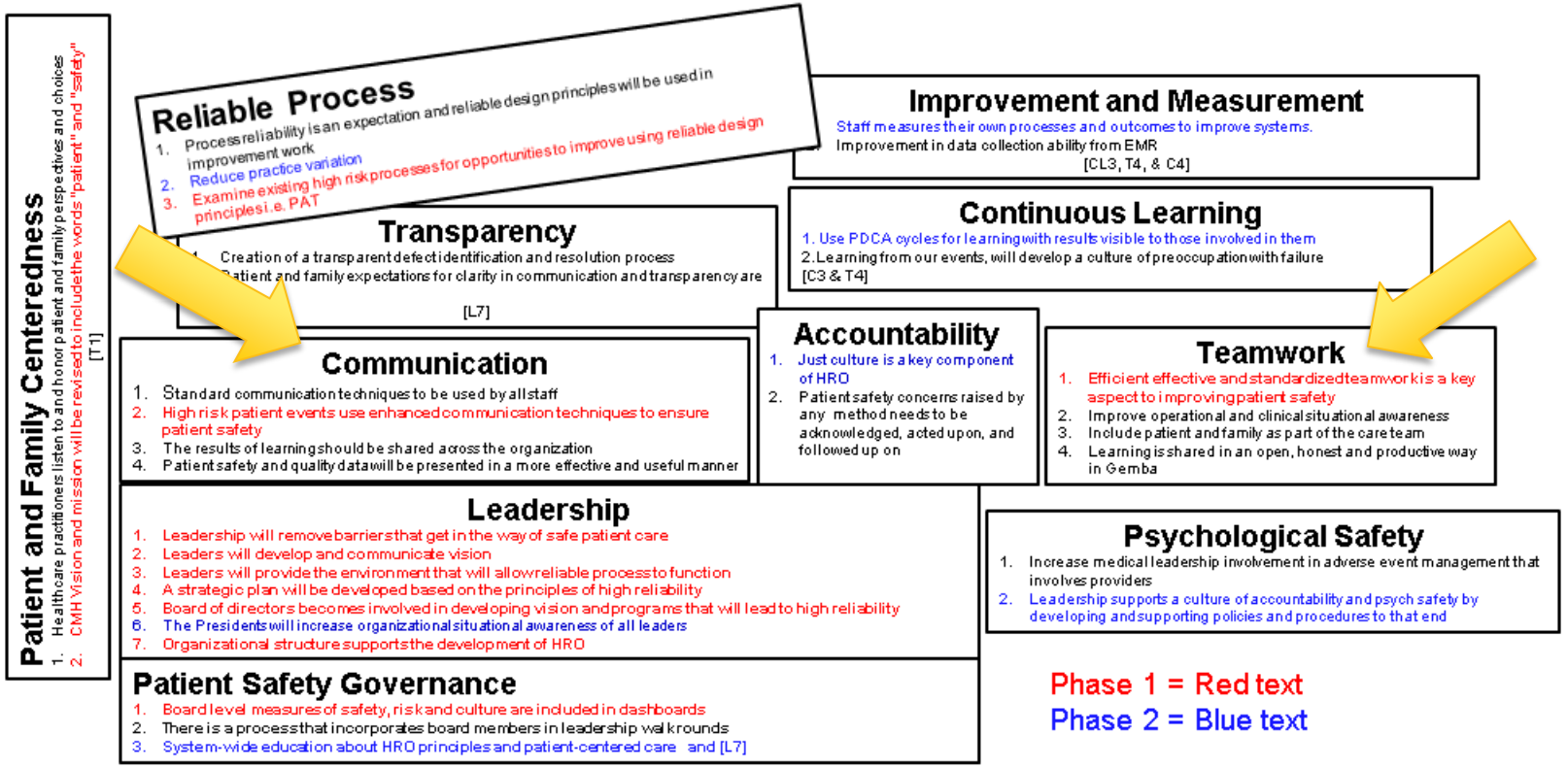
Journey towards High Reliability

CMH High Reliability Strategic Plan



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Improving Communication & Teamwork using TeamSTEPPS

- Evidence-based curriculum aimed at optimizing patient outcomes by improving communication and teamwork skills
- Free program available from the Agency for Healthcare Research and Quality (AHRQ) https://www.ahrq.gov/teamstepps/about-teamstepps/index.html
- Customizable to all care settings/audiences

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TeamSTEPPS 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!!*

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

Session Date	# attendees
10/3/2014	44
10/4/2014	20
10/10/2014	42
10/11/2014	18
TOTAL	124
Make-up session 12/12/2014	16
New TOTAL	140

SUSTAIN PLAN

Course is offered twice per year for new staff

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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

Safe. Reliable. High Quality Care for Every Patient ... Every Day

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 ...

#1 - Communicate Clearly

1. **Listen**
   - Focus on what is being said
   - Listen without interrupting, disagreeing, or offering explanations.
   - Observe non-verbal communication cues
   - Ask clarifying questions:
     - In all high risk situations
     - When information is incomplete
     - When Information is not clear

Asking clarifying questions can reduce the risk of making an error by 2½ times!

2. **Don't Assume -** Seek to understand
3. **Phonetic & Numeric Clarifications**

For sound alike words and letters, say the letter followed by a word that begins with the letter.

A	Alpha	J	Juliet	S	Sierra
B	Bravo	K	Kilo	T	Tango
C	Charlie	L	Lima	U	Uniform
D	Delta	M	Mike	V	Victor
E	Echo	N	November	W	Whiskey
F	Foxtrot	O	Oscar	X	X-Ray
G	Golf	P	Papa	Y	Yankee
H	Hotel	Q	Quebec	Z	Zulu
I	India	R	Romeo		

When communication involves sound alike numbers, say the number and then the digits.

For Example:

15 ... that's one-five

50 ... that's five-zero

0.9 ... that's zero-point-nine

4. **SBAR** provides a framework for team members to effectively communicate information to one another.
   - **Situation:** What is the problem or patient or project?
   - **Background:** What is the relevant information?
   - **Assessment:** What is your read of the problem or patient?
   - **Recommendation:** What is your request or recommendation?

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Patient Safety Education

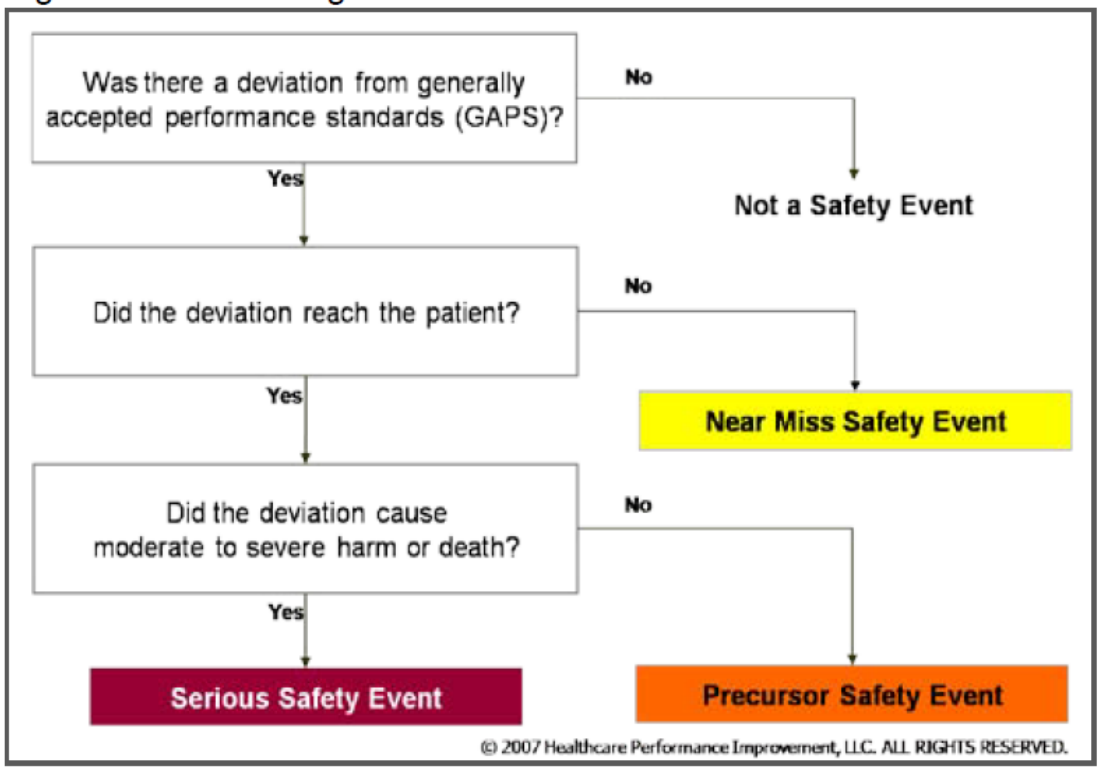
- Developed an education program to teach the Safety Behaviors
- Pilot with new hires in 2016
- Required leadership to attend the pilot sessions in 2016
- Incorporated into New Employee Orientation March 2017

Board Level Measure of Safety

Serious Safety Event (SSE)

- Patient safety measurement system
- Distinguishes harm from bad outcomes
- GAPS (Generally accepted performance standards)

Figure 2. HPI SEC Algorithm



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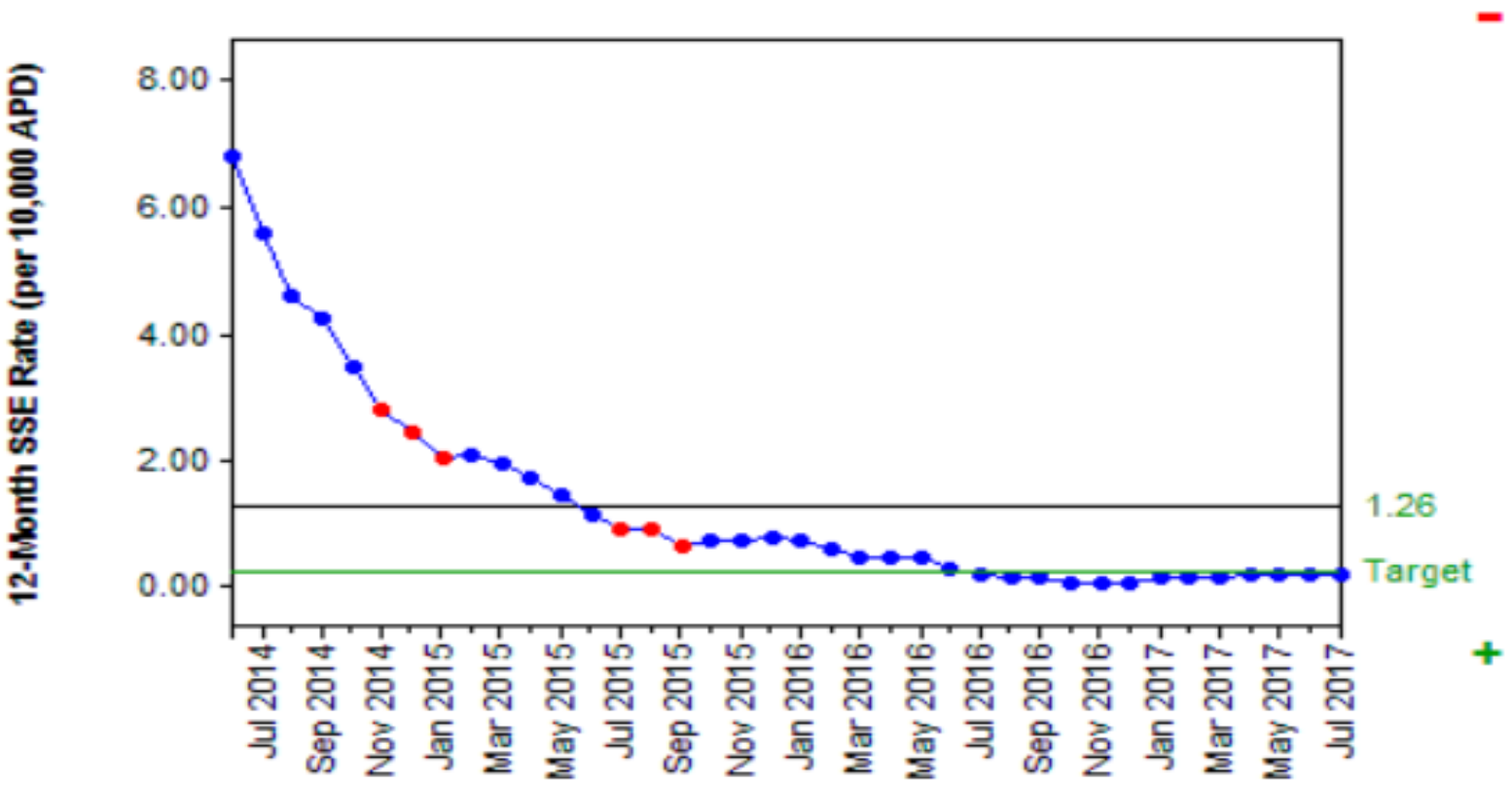
Serious Safety Event Classification

Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	**SSE 1**	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	**PSE 1**	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	**NME 1**	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch

CMH Serious Safety Event Rate



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?