Advanced Leadership for Quality
Tentative Schedule

Day 2
Wednesday, August 10, 2011

Time	Objective	Presenter
8:00 – 8:30	Debrief / Review	Karren Kowalski
8:30 – 9:30	Introduction to Team STEPPS	Marianne Horner
9:30 – 10:30	Team STEPPS module 2: Team Structure	Marianne Horner & Karren Kowalski
10:30 – 10:45	Break	
10:45 – 11:45	Team STEPPS module 3: Leadership	Diane Pisanos
11:45 – 12:15	Lunch	
12:15 – 1:15	Team STEPPS module 4: Situation Monitoring	Marianne Horner
1:15 – 2:45	Team STEPPS module 5: Mutual Support	Karren Kowalski
2:45 – 3:00	Break	
3:00 – 4:40	Team STEPPS module 6: Communication	Karren Kowalski
4:40 – 5:00	Wrap up – Homework & Reflection	Karren Kowalski

TeamSTEPPS

Strategies and Tools to Enhance Performance and Patient Safety

The Changing Role of Nursing in Quality and Safety

TeamSTEPPS™

Team STEPPS Overview

TeamSTEPPS
Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS™

TeamSTEPPS™

Team
Strategies & Tools to Enhance Performance & Patient Safety

"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"

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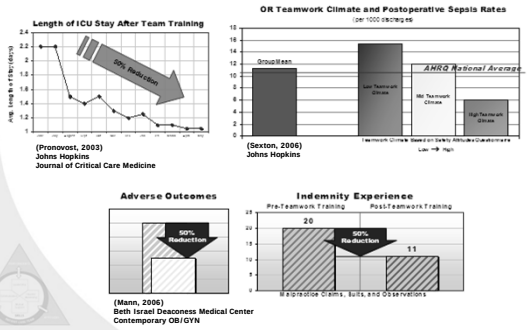

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Team STEPPS

- Team STEPPS is a comprehensive program that was designed for implementation on an agency wide basis
  - Assess the need
  - Planning, Training, Implementation
  - Sustainment
- **For our purposes we will provide an introduction and present a set of tools to begin this journey**

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Team STEPPS

- Which tool would be particularly helpful on your clinical unit?
- Please identify at least one
  - You will report on Day 3 regarding your selection
  - When we make our site visits we will check on the implementation

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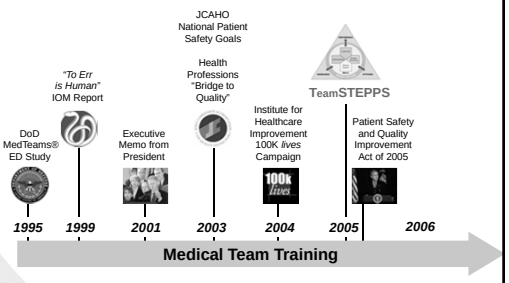
Patient Safety Movement



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Institute of Medicine Report

Impact of Error:

- 44,000–98,000 annual deaths occur as a result of errors
- Medical errors are the leading cause, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS, or car accidents
- 7% of hospital patients experience a serious medication error

Federal Action:

By 5 years;

↓ medical errors by 50%,

↓ nosocomial by 90%; and

eliminate "never-events" (such as wrong-site surgery)

Cost associated with medical errors is $8–29 billion annually.

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How have we done with these challenges?

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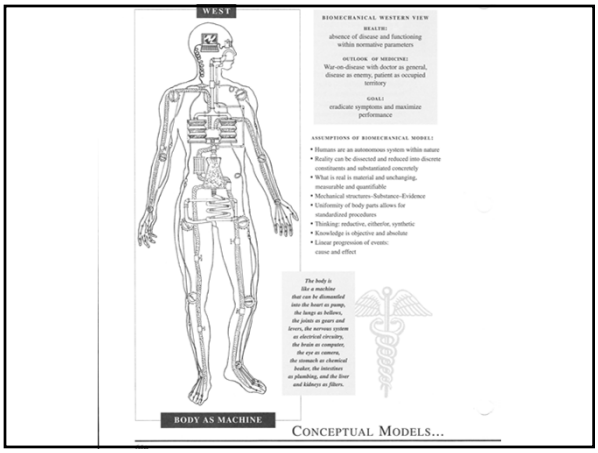
Other complicating factors

- Slicing & dicing the body …..different specialists for
  - Different organs
  - Different systems
  - Different portions of organs
  - Different treatment modalities
    - Medical vs. surgical
    - Chiropractic vs. traditional



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More complications

- Different specialists depending upon your location / setting

- **All of these different parties with the inherent handoffs and necessity of clear, accurate communication creates much increased risk of misunderstanding / error**

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Is nursing a team endeavor?

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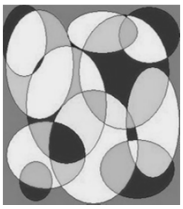
Goal for Nursing's Leadership in Quality and Safety

- It means that we value, possess, and collectively support the development of quality and safety competencies with *rigor* and *passion*



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How can we represent ourselves to patients, to families, and to the public?

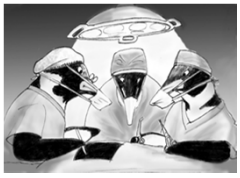
- We can say that we can provide a *team of experts* for care
- We cannot say that we can provide an *expert team* for care

Notes:

Team Structure

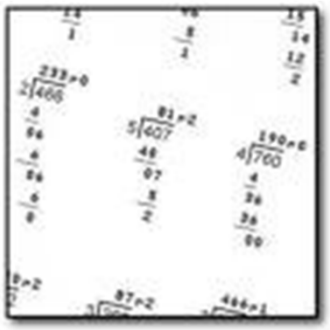
The ratio of We's to I's is the best indicator of the development of a team.

–Lewis B. Ergen



TeamSTEPPS

To err is human…..



What are we taught in our culture about self- sufficiency?

- If you want it done right, do it yourself!
- Stand on your own two feet!
- If everyone else is jumping off a cliff, would you follow?

- What happens when we try to "multi-task"?

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Team Structure

The human brain cannot have multiple simultaneous foci of interest. This lack of cognitive resource is the single limiting factor of human activity.

Francois Clergue

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Team Structure

- What happens when we are rushed or have too much to do?

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Team Structure

- What happens when our environment is incredibly complex?

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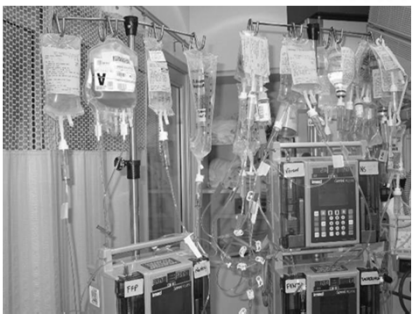
Team Structure



Would you agree that we work in complex environments?

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Team Structure

- What happens when we are tired?

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Team Structure

- What happens when our own amazing human brains let us down?

TeamSTEPPS

Team Structure

- **Olny srmat poelpe can raed tihs. I cdnuolt blveiee taht I cluod aulaclty uesdnatnrd waht I was rdanieg. The phaonmneal pweor of the hmuan mnid, aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe. Amzanig huh? yaeh and I awlyas tghuhot slpeling was ipmorantt!**

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Team Structure

EPInephrine
EPHEDrine

DOPamine
DoBUTamine

TeamSTEPPS

Team Structure

Human beings who *will* make errors

+

Faulty systems

=

Harm

TeamSTEPPS

Team Structure

- What happens if we fundamentally change our paradigm….

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Team Structure

- We accept and in fact **actively anticipate** that we *will* make mistakes

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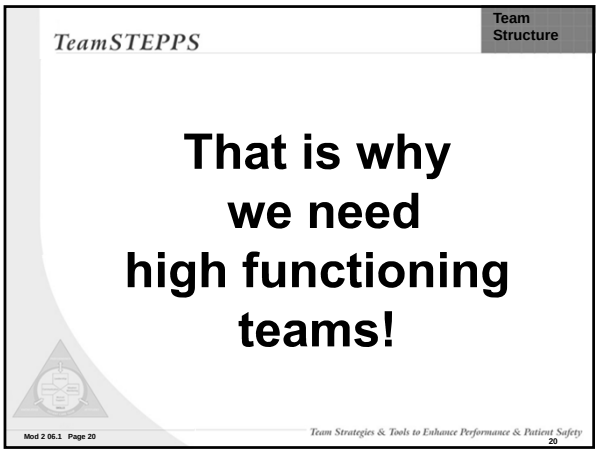
Team Structure

- We build in systems to CATCH those mistakes before a patient is harmed


TeamSTEPPS
Team Structure
That is why we need high functioning teams!
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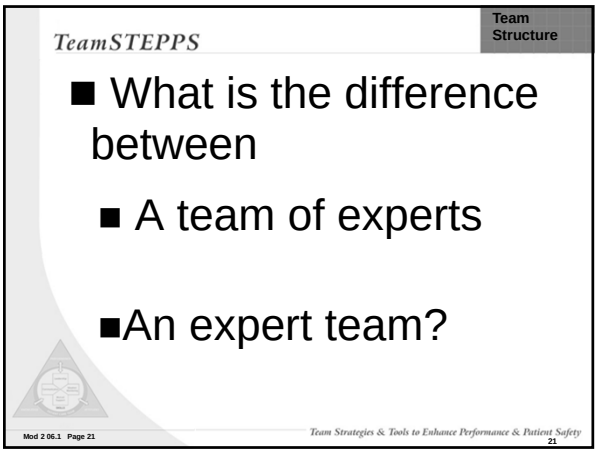
TeamSTEPPS
Team Structure
■ What is the difference between
■ A team of experts
■An expert team?
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Condition H

At UPMC Shadyside Hospital, we are building the hospital of the future with the help of patients and families we care for. We believe in teamwork and ask that you be a part of our team when visiting your loved ones.

UPMC Shadyside
Part of UPMC Presbyterian Shadyside
5230 Centre Avenue
Pittsburgh, PA 15232

For questions regarding Condition H:
Beth Kuzminsky – 412-623-3954

Condition H

(Condition HELP)

Josie King Call Line
 # 3-3131

UPMC Shadyside
Part of UPMC Presbyterian Shadyside

The Josie King Story

Josie King, an 18 month old little girl, died from medical errors at John's Hopkins Children Center in 2001. Josie was the sister of Jack, Relly, and Eva and beloved daughter of Tony and Sorrel. She died as a result of a series of hospital errors and poor communication.

"Listening to Sorrel King tell her tragic story left a lasting impression with me-- 'if I would have been able to call a Rapid Response Team, I can't help but think Josie would be here today.'—providing the highest quality care for patients and their families is UPMC Shadyside's history. I knew that we had to bring a family life line (Condition H) to our patients."

Tami Merryman
Vice President
Patient Care Services
UPMC Shadyside

Condition H

At UPMC Shadyside, we are leading the national focus on eliminating system problems that affect delivery of care. As a response to providing the best care to our patients, we created a Josie King Call Line -- ***Condition H***. Josie's mother, Sorrel King, worked with UPMC Shadyside to design how this valuable resource will work in health care

UPMC is dedicated to making the hospital a safe place for patient care to happen.

Condition H was created to address the needs of the patient in case of an emergency or when the patient is unable to get the attention of a healthcare provider. This call will provide our patients and families an avenue to call for immediate help when they feel they are not receiving adequate medical attention.

When to call

1.If a noticeable medical change in the patient occurs and the health care team is not recognizing the concern.

2. If after speaking with a member of the healthcare team (i.e. nurses, physicians), you continue to have serious concerns on how care is being given, managed, or planned.

To access Condition H, please call 3-3131 and place your call light on. The operator will ask for caller ID, room number, patient name and patient concern. The operator will immediately activate a "Condition H" where a team of medical professionals are alerted and will arrive in the room to assess the situation. Additional clinical supports will be called in as needed.

In offering our families the Condition H option, we want you to know that you are our partners in care. If you have any questions, please discuss them with one of our healthcare providers.

Notes:

Leadership

TeamSTEPPS

2 reasons why people make mistakes

- Poor technical expertise
- Breakdown in teamwork

We can limit an individual's or team's propensity to make a mistake only if they recognize and understand where *they* tend to commit errors.

Team Leader

Two types of leaders:

- **Designated** – The person assigned to lead and organize a designated core 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

- 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

Resource Management is…

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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Leadership

Resource Management

Core Team Leader	Coordinating Team Leader
• Information – Patient & Family – Plan of care – Facilities • Time • Equipment	• Information – Administrative – Facilities • Time • Equipment • Patient flow • Other departments

FOCUS Team & Your Unit	FOCUS Support Units

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Leadership

Delegation

- Method of re-distributing tasks or assignments
- Process includes 4 steps:
  - Decide what to delegate
  - Decide to whom to delegate
  - Communicate clear expectations
  - Request feedback

Management Time: Who's Got the Monkey?
William Oncken, Jr., and Donald L. Wass
Harvard Business Review, HBR.ORG, Nov-Dec 1999

Learning about delegation and it's challenges

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Leadership

Promoting & Modeling Teamwork

Effective leaders cultivate desired team behaviors and skills through:

- Open sharing of information
- Role modeling and effectively cueing team members to employ prescribed teamwork behaviors and skills
- Constructive and timely feedback
- Facilitation of briefs, huddles, debriefs, and conflict resolution

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Leadership

Team Events

- Briefs – planning
- Huddles – problem solving
- Debriefs – process improvement

Leaders are responsible to assemble the team and facilitate team events

But remember…

Anyone can request a brief, huddle, or debrief

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Leadership

Briefs

Planning

- Form the team
- Designate team roles and responsibilities
- Establish climate and goals
- Engage team in short and long-term planning

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Leadership

Planning Essentials for Teams

- Leader usually initiates the planning process
- Team members are included in the planning process
- Team members have a common understanding of the problem and their roles

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Leadership

Briefing Checklist

TOPIC	
Who is on core team?	☑
All members understand and agree upon goals?	☑
Roles and responsibilities understood?	☑
Plan of care?	☑
Staff availability?	☑
Workload?	☑
Available resources?	☑

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Leadership

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

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Leadership

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 reconstruction of key events
  - Analysis of why the event occurred
  - What should be done differently next time

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Leadership

Debrief Checklist

TOPIC	
Communication clear?	☑
Roles and responsibilities understood?	☑
Situation awareness maintained?	☑
Workload distribution?	☑
Did we ask for or offer assistance?	☑
Were errors made or avoided?	☑
What went well, what should change, what can improve?	☑

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Leadership

Debrief

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Leadership

Successful debriefings

- Avoid outcome-based debriefings
- Confidential
- Non-threatening
- Structured
- Timely

Effective debriefing is the key to long-term sustainable improvements in patient safety and care.

Debriefing for PATIENT SAFETY "If only I could do it all over again…."

Patient Safety & Quality Healthcare
Nov/Dec 2008
www.psqh.com

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Leadership

2 great examples

MediCorp Health System (Virginia)

- Focus: situation awareness & frontline staff debriefing
- Trained > 2,000 clinical & nonclinical staff
- 4 hour customized training
- Goal: ingrain the concept & practice of these skills into the daily culture of our healthcare system

Georgetown University Medical Center

- Initially trained > 1,000 frontline staff & doctors
- Initially skeptical of applying military & aviation principles to healthcare
- Involved leadership of astute physicians, VP of medical affairs, chief medical officer
- Outcome: "What we initially thought was a patient safety focus also became a mechanism to eliminate inefficiency."

Those who fail to learn from the mistakes of the past are doomed to repeat them.

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Leadership

Team Formation Video

TeamSTEPPS

Leadership

Leadership

BARRIERS	TOOLS and STRATEGIES	OUTCOMES
■ Hierarchical Culture ■ Lack of Resources or Information ■ Ineffective Communication ■ Conflict	Brief Huddle Debrief	■ Shared Mental Model ■ Adaptability ■ Team Orientation ■ Mutual Trust

Leadership is no longer defined as having the right answers, but as an ability to engage others to find the best solutions. (and of course, ourselves)

Most of leadership (once you have your foundation) is about making a "communication message"

Successful Teams

CLARITY

Team members work toward a common purpose and goals that they commit to and live by. There are clear defined roles with shared participation amongst the team. Empowerment and accountability are proactively designed.

HOW WE BEHAVE

Team members hold themselves accountable for adhering to some set of agreed upon values/behaviors how team members act and treat each other. A common value of mutual respect guides the team's interactions and behavior. People speak their truth and are heard while holding other's self-regard.

HANDLING OF CONTROVERSY

Team members handle controversy in a straightforward way. There is an established mechanism to deal with conflict between members and with those outside the team, regardless of position with the team. Conflicts are dealt with creatively and respectfully while acknowledging the learning.

CONSCIOUS LEADERSHIP

Leadership models the team ideals and serves to elevate these ideals through embracing, embodying, and facilitating them. Leadership is a function of competence and effectiveness, not title or authority. The "talk is walked". (Integrity) People refine themselves through personal growth, service, and partnership.

A SAFE AND SUPPORTIVE ENVIRONMENT

An effective team feels free to express ideas, take risks, seek or offer help. There is a total absence of abuse, shame and threat. Deviations and errors are opportunity for learning and growth. The environment is an invitation to develop people's physical, emotional, mental, and spiritual spheres. Renewal and celebration are intentionally created on a regular basis for the human spirit.

D.Pisanos ♦ dpisanos1@aol.com ♦ Integral Healthcare Consulting

Notes:

Situation Monitoring

"Attention to detail is one of the most important details ..."

–Author Unknown

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Situation Monitoring (Individual Skill)

Process of *actively scanning* behaviors and actions to assess elements of the situation or environment

Take a minute to imagine yourself on the dance floor…

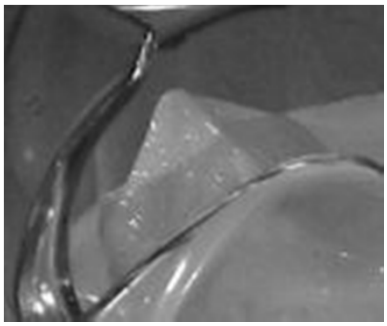
What are your thoughts?

Describe your sensations

What do you see?

Situation Monitoring

- Has to do with "Getting on the Balcony"
- Is the view / your perspective different from here?



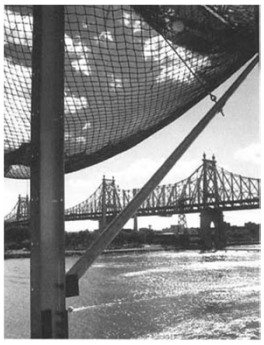
Cross Monitoring is…

Process of monitoring the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors

- Mechanism to help maintain accurate situation awareness
- Way of "watching each other's back"
- Ability of team members to monitor each other's task execution and give feedback during task execution

Mutual performance monitoring has been shown to be an important team competency.
(McIntyre and Salas 1995)

- Cross Monitoring is a *safety net*



Cross Monitoring

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Situation Monitoring

I'M SAFE Checklist

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

An individual team member's responsibility …

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Situation Monitoring

Situation Awareness is…

The state of knowing the current conditions affecting the *team's* work

- Knowing the status of a particular event
- Knowing the status of the team's patients
- Understanding the operational issues affecting the team
- Maintaining mindfulness

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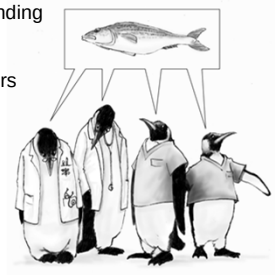
Situation Monitoring

A Shared Mental Model is…

The perception of, understanding of, or knowledge about a situation or process that is shared among team members through communication.

"Teams that perform well hold shared mental models."
(Rouse, Cannon-Bowers, and Salas 1992)



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Situation Monitoring

Shared Mental Model?

Handoff-Checklist for Home Care →to →Another Health Care Setting

The intention of this document is to help you – the home care nurse – ensure a safe transition for your patient when they discharge from your care. Having the following items* at the time of discharge will reduce delays in care, avoid duplication of services and ensure safe and effective transitions of care.**

Demographics:

_____**Home Care Face Sheet/Demographics** - Name, Address, Phone, Date of Birth, Social Security #, Payment Source/Insurance
_____**Diagnosis(es) for Home Care**. Include primary and secondary diagnoses that relate to the plan of care.
____**Emergency LOCAL contact**.

History and Chart Items:

_____ **Verbal/Telephonic Report – Handoff**
_____**Summary of Home Care provided/Current Orders** Include Start of Care date, last visit date, and progress during care. This includes an updated care plan for all disciplines providing care.
_____Complete **Updated Medication** List
_____**Copy of History and Physical-** include any recent height/weight
_____**Any Surgical Procedure and date(s)**
_____**Any laboratory results** during care
_____**Date of last catheter change**
_____**IV Access Information**– when it was inserted, length of the catheter used; # of lumens, last does of drug given; duration of therapy; orders for line care protocols.)
_____**Record of influenza & pneumococcal immunizations**.

Quality & Safety Alerts:

____ **Allergies**
____**Safety Alert** – this includes safety issues for the patient, caregivers or staff. This includes any functional limitations for vision, hearing, weight bearing, fall risk, issues of violence, family conflict, etc..
____**Infection Alert** – this is any specific infection or precaution to be considered beyond universal precautions.
____If being readmitted to acute care, include any requirements for safe discharge that must be considered ***prior*** to future discharge.
____**Functional Limits** – as known.
____**Diet** with information on tolerance and swallowing.
____Any **future appointments** for health care scheduled.

* Included due to regulatory requirements; payment/reimbursement; to avoid duplication of services, delays in care and ensure continuity of care or are best practice recommendations for quality.

** The Joint Commission Patient Safety Goal 2; Requirement 2E recommends the following: 1.) Include up-to-date patient information; 2.) Use "read-back" techniques; 3.) Limit or minimize interruptions; 4.) Allow time for questions and answers.

Handoff-Checklist for Home Care to Physician Office

The intention of this document is to help you – the home care nurse – ensure a safe transition for your patient when they discharge from your care. Having the following items* at the time of discharge will reduce delays in care, avoid duplication of services and ensure safe and effective transitions of care.**

Demographics:

_____**Home Care Face Sheet/Demographics** - Name, Address, Phone, Date of Birth, Social Security #, Payment Source/Insurance
_____**Diagnosis(es) for Home Care**. Include primary and secondary diagnoses that relate to the plan of care.

History and Chart Items:

_____**Verbal Handoff – Report**
_____**Summary of Home Care provided**. Include Start of Care date, last visit date, and progress during care. Includes Care Plan update from all disciplines providing care in the home.
_____Complete Updated **Medication List**
_____**Any laboratory results** during care
_____**Any future appointments for health care scheduled.**

If the patient is being discharged to a Physician that did not participate with patient care while receiving home health care services, please provide them with a *COPY of the 485 Physician Orders* **and** ***COPY of the Plan of Care*****.**

* Included due to regulatory requirements; payment/reimbursement; to avoid duplication of services, delays in care and ensure continuity of care or are best practice recommendations for quality.
** The Joint Commission Patient Safety Goal 2; Requirement 2E recommends the following: 1.) Include up-to-date patient information; 2.) Use "read-back" techniques; 3.) Limit or minimize interruptions; 4.) Allow time for questions and answers.

Handoff-Checklist for Referrals to Home Care

The intention of this document is to help you – the healthcare provider – ensure a safe transition for your patient into the home care setting. Having the following items* at the time of referral will reduce delays in care, avoid duplication of services and ensure safe and effective transitions of care.**

Demographic Information:

_____**Name, Address, Phone, Date of Birth, Social Security #, Payment Source/Insurance** (*Please include any temporary residence the patient use for their recovery if it is not their actual residence*.)
_____**Date of Referral**
_____**Referral Source** – *includes the Referring Physician and the name and contact information for Case Manager or the referring contact in the organization.*
_____**Date of Specified or Start of Care (SOC)**
_____**Diagnosis(es) for Home Care**. *Include primary & secondary diagnoses related to plan of care*.

History & Chart Items:

_____**Verbal/Telephonic Report** called to Home Care
_____The type of **setting** the patient is being admitted from
any recent hospitalizations admit/discharge dates
_____**Date last seen by Physician (Face-to-Face)**
Name of the Physician _____
_____**Surgical Procedure and date(s)**
_____Record of influenza & pneumococcal **immunizations**.
_____**Discharge Summary** - discharge planning and teaching "***community care-plan***" given to the patient at the time of discharge for all disciplines.
_____Copy of the last **History and Physical**, *include Height/Weight*

Referring Physician & Orders:

_____**Primary/Admitting Physician** – *This is the Physician who **has agreed** to sign the 485/Orders **and** this Physician must be enrolled in the PECOS System (per regulation July, 2010 – Provider Enrollment Chain and Ownership System)*
_____**Other Physicians/Providers who may provide care and write orders**. *Identify the specific area (i.e. Dr. X for wound care only.)*
_____**Provider Orders.** These should include:

- **Parameters for when the Physician should be called**
- **Laboratory Data - testing**
- **Wound care**
- **Complete medication list** *(discharge medication list or a current complete list of medications)*
- **Respiratory/Oxygen**
- **Catheter change orders**
- **Diet** *(with information on tolerance and swallowing as available)*
- **Other discipline to care for the patient** (PT, OT, Speech etc.)
- **IV's (Please include: information on the access – when it was inserted, length of the catheter used; # of lumens, last does of drug given; duration of therapy; orders for line care protocols.)**

_____**Next appointment** for FACE-to-FACE encounter by Physician **especially** if within 30 days.

Quality & Safety Needs:

_____**Emergency Correct LOCAL contact**. *The Home Care Agency will verify this*.
_____**Allergies**
_____**Safety Alert** – *Please include any safety issues for the patient, caregivers or the home care employee. This includes and is not limited to any functional limitations for vision, hearing, weight bearing, fall risk, issues of violence, family conflict, etc.*
_____**Infection Alert** – *this is any specific infection or precaution considered beyond universal precautions.*
_____**Information about any previous home care agency providing care.** Please verify by asking the patient – *is there anyone else helping you at home? If another home care is identified, the original home care should be referred unless there is a specific request by the patient to change agencies.*
_____**Functional Limits** – as known.

* Included due to regulatory requirements; payment/reimbursement; to avoid duplication of services, delays in care and ensure continuity of care or are best practice recommendations for quality.
** The Joint Commission Patient Safety Goal 2; Requirement 2E recommends the following: 1.) Include up-to-date patient information; 2.) Use "read-back" techniques; 3.) Limit or minimize interruptions; 4.) Allow time for questions and answers.

Notes:

Mutual Support

"A chain is only as strong as its weakest link."

–Author Unknown

TeamSTEPPS

TeamSTEPPS

Mutual Support

Objectives

- Describe Just Culture
- Define mutual support
- Discuss task assistance and the types of feedback
- Describe advocacy, assertion, and the Two-Challenge rule
- Discuss "CUS"" techniques
- Discuss common approaches to conflict resolution
- List barriers, tools, strategies, and outcomes of mutual support

TeamSTEPPS

Mutual Support

How do we respond to errors?

TeamSTEPPS

Mutual Support

Because – to error is human

TeamSTEPPS

Mutual Support

Harvard Business School

- Amy Edmondson's Research on Errors:
  Nursing units with the BEST leadership and BEST co-worker relationships

  Had TEN TIMES more errors than

  Nursing units with the WORST Leadership and co-worker relationships

TeamSTEPPS

Mutual Support

Edmondson's Research (cont)

- **Better units reported more errors because nurses felt psychologically safe to do so**
- "Mistakes are natural and normal to document"

TeamSTEPPS

Mutual Support

Edmondson's Research (cont)

- **On units where errors were rarely reported….**
- **"The environment is unforgiving, heads will roll."**

TeamSTEPPS

Mutual Support

Must encourage our People:

- 1. Tell everyone about problems you have fixed
- 2. Point out errors (by anyone) so all can learn from them
- 3. Admit your own errors
- 4. Never stop questioning what is done and how to do it better.
- Pfeffer & Sutton (2002)

TeamSTEPPS

Mutual Support

MLE'S

- **NO FAILURE/MISTAKES**
- **MAJOR**
  - **LEARNING**
    - **EXPERIENCES**

TeamSTEPPS

Mutual Support

The Behaviors We Can Expect

- **Human error** - inadvertent action; inadvertently doing other that what should have been done; slip, lapse, mistake.
- **At-risk behavior** - behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified.
- **Reckless behavior** - behavioral choice to consciously disregard a substantial and unjustifiable risk.

TeamSTEPPS

Mutual Support

Lessons from Human Factors Research

- Errors are common
- The causes of errors are known
- Errors are byproducts of useful cognitive functions

TeamSTEPPS

Mutual Support

Lessons from Human Factors Research

- Many errors are caused by activities that rely on weak aspects of cognition
  - short-term memory
  - attention span
- Errors can be prevented by designing tasks and processes that minimize dependency on weak cognitive functions

TeamSTEPPS

Mutual Support

Lessons from Human Factors Research

- Many errors are caused by activities that rely on weak aspects of cognition
  - short-term memory
  - attention span
- Errors can be prevented by designing tasks and processes that minimize dependency on weak cognitive functions

TeamSTEPPS

Mutual Support

Human Factors Principles & Systems Design

- Avoid reliance on memory and vigilance
  - Use protocols and checklists
- Simplify
- Standardize

TeamSTEPPS

Mutual Support

Human Factors Principles & Systems Design

- Improve access to information
  - Make potential errors obvious
  - Increase feedback
- Reduce hand-offs
- Decrease look-alikes
- Automate very carefully

TeamSTEPPS

Mutual Support

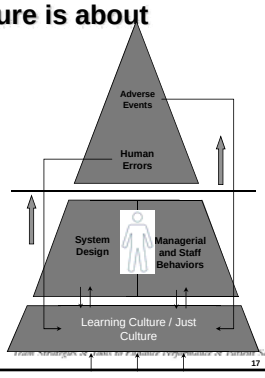
- "We can't change the human condition, but we can change the conditions under which humans work"
  - James Reason

TeamSTEPPS

Mutual Support

Just Culture is about

- Creating an open, fair, and just culture
- Creating a learning culture
- Designing safe systems
- Managing behavioral choices



TeamSTEPPS

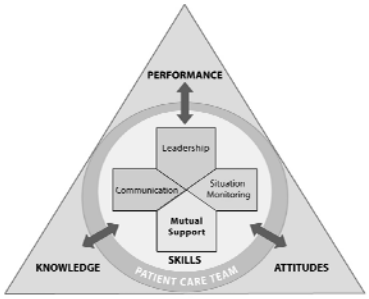
Mutual Support

- However….

  Humans **are** accountable for their behavioral choices

TeamSTEPPS

Mutual Support



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Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS

Mutual Support

Mutual Support

Mutual support is the essence of teamwork

- Protects team members from work overload situations that may reduce effectiveness and increase the risk of error

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Team Strategies & Tools to Enhance Performance & Patient Safety

20

TeamSTEPPS

Mutual Support

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.

"In support of patient safety, it's expected!"

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Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS

Mutual Support

Task Assistance

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Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS

Mutual Support

Discussion: Task Assistance

- In which situations can task assistance be used?
- How can you make this a daily practice on your unit?
- How can you build it into your system to achieve cultural change?

"Ask for help…Offer help"

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Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS

Mutual Support

What Is Feedback?

"Feedback is the giving, seeking, and receiving of performance-related information among the members of a team."

(Dickinson and McIntyre 1997)

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Team Strategies & Tools to Enhance Performance & Patient Safety

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TeamSTEPPS

Mutual Support

Types of Feedback

- Can be formal or informal
- Constructive feedback
  - Is considerate, task-specific, and focuses attention on performance and away from the individual *(Baron 1988)*
  - Is provided by all team members
- Evaluative feedback
  - Helps the individual by comparing behavior to standards or to the individual's own past performance *(London, Larson, and Thisted 1999)*
  - Most often used by an individual in a coaching or mentoring role

TeamSTEPPS

Mutual Support

Characteristics of Effective Feedback

Good Feedback is—

- TIMELY
- RESPECTFUL
- SPECIFIC
- DIRECTED toward improvement
  - Helps prevent the same problem from occurring in the future
- CONSIDERATE

"Feedback is where the learning occurs."

TeamSTEPPS

Mutual Support

ARC STATEMENT Example

- (1) "When I observe…"(Action – person has/has not taken)
- (2) "I feel…"(Identify feelings) (See list of feelings)
- (3) "Because…"(Identify what behavior means to coach, to unit, to facility)
- (4) "Can you see how…"(Seek agreement from coachee concerning outcomes or consequences of behavior)

TeamSTEPPS

Mutual Support

Providing Feedback Effectively

■PRACTICE

Advocacy, Assertion, and Conflict Resolution

AHRQ Agency for Healthcare Research and Quality

TeamSTEPPS

TeamSTEPPS

Mutual Support

An Advocacy and Assertion Scenario

A medical floor nurse is assigned to a patient following a myocardial infarction. The attending physician provides the final treatment, reviews the clinical situation, and determines that the patient is well enough to be discharged.

Before the patient is discharged, the nurse checks the patient's vitals one last time. The nurse finds it unusual that the blood pressure and heart rate are substantially elevated. Despite these concerns, the nurse discharges the patient because the physician made it clear that the patient was well enough to go home. Besides, the physician is a well-respected authority at the hospital.

TeamSTEPPS

Mutual Support

Advocacy and Assertion

- 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

TeamSTEPPS

Mutual Support

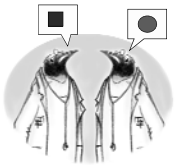
The Assertive Statement

- 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

TeamSTEPPS

Mutual Support

Conflict Resolution Options



Information Conflict
(We have different information!)

Two-Challenge rule

Personal Conflict
(Hostile and harassing behavior)

I Feel, I Think, I Want

TeamSTEPPS

Mutual Support

Two-Challenge Rule

TeamSTEPPS

Mutual Support

Two-Challenge Rule

Invoked when an initial assertion is ignored…

- 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
- If the outcome is still not acceptable
  - Take a stronger course of action
  - Use supervisor or chain of command

TeamSTEPPS

Mutual Support

Two-Challenge Rule

"Empower any member of the team to "stop the line" if he or she senses or discovers an essential safety breach."

This is an action never to be taken lightly, but it requires immediate cessation of the process and resolution of the safety issue.

TeamSTEPPS

Mutual Support

Please Use CUS Words

but *only* when appropriate!

TeamSTEPPS

Mutual Support

- I Feel
- I Think
- I Want

TeamSTEPPS

Mutual Support

Common Approaches to Conflict Resolution

Often used to manage conflict; however, typically do not result in the best outcome—

- Compromise—Both parties settle for less
- Avoidance—Issues are ignored or sidestepped
- Accommodation—Focus is on preserving relationships
- Dominance—Conflicts are managed through directives for change

TeamSTEPPS

Mutual Support

Collaboration

- Achieves a mutually satisfying solution resulting in the best outcome
  - All Win!: Patient Care Team (team members, the team, and the patient)
  - Includes commitment to a common mission
- Meet goals without compromising relationships

"True collaboration is a process, not an event."

TeamSTEPPS

Mutual Support

Teamwork Actions

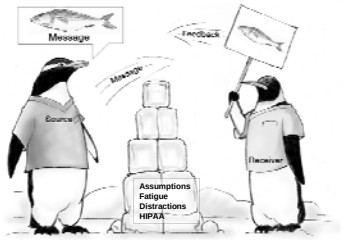
- Foster a climate supportive of task assistance
- Provide timely and constructive feedback
- Be assertive and advocate for the patient
- Use the Two-Challenge rule and CUS, to resolve conflict
- Resolve conflict through collaboration—Create a "Win-Win-Win" situation

"Those whom we support hold us up in life."

–Marie von Ebner-Eschenbauch

Notes:

Communication



TeamSTEPPS

TeamSTEPPS

Communication

Objectives

- Describe the importance of communication
- Recognize the connection between communication and medical error
- Discuss the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) national patient safety goals
- Define communication and discuss the standards of effective communication
- Describe strategies for information exchange
- Identify barriers, tools, strategies, and outcomes to communication

---

TeamSTEPPS

Communication

TeamSTEPPS

Communication

JCAHO: Importance of Communication

Ineffective communication is a root cause for nearly 66 percent of all sentinel events reported*

* *(JCAHO Root Causes and Percentages for Sentinel Events (All Categories) January 1995–December 2005)*

TeamSTEPPS

Communication

JCAHO Goals That Relate To Communication

National Patient Safety Goals (NPSGs) related to communication:

- Improve the effectiveness of communication among caregivers
  - Read-Back
  - Handoff
- Accurately and completely reconcile medications and other treatments across the continuum of care
  - Address specifically during handoff
- Encourage the active involvement of patients and their families in the patient's care, as a patient safety strategy

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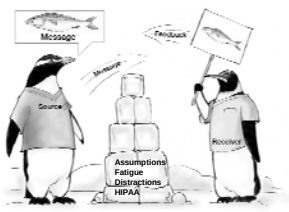
TeamSTEPPS

Communication

Communication is…

- The process by which information is exchanged between individuals, departments, or organizations
- The lifeline of the Core Team
- Effective when it permeates every aspect of an organization



TeamSTEPPS

Communication

Standards of Effective Communication

- Complete
  - Communicate all relevant information
- Clear
  - Convey information that is plainly understood
- Brief
  - Communicate the information in a concise manner
- Timely
  - Offer and request information in an appropriate timeframe
  - Verify authenticity
  - Validate or acknowledge information

TeamSTEPPS

Communication

Brief

Clear

Timely

TeamSTEPPS

Communication

Information Exchange Strategies

- Situation–Background– Assessment–Recommendation (SBAR)
- Call-Out
- Check-Back
- Handoff

TeamSTEPPS

Communication

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?

Remember to introduce yourself…

TeamSTEPPS

Communication

SBAR Example

TeamSTEPPS

Communication

SBAR Exercise

Create an SBAR example based on your role.

TeamSTEPPS

Communication

Call-Out is…

A strategy used to communicate important or critical information

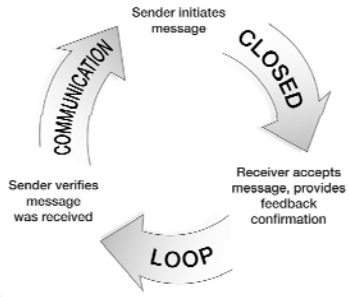
- It informs all team members simultaneously during emergency situations
- It helps team members anticipate next steps

…On your unit, what information would you want called out?

TeamSTEPPS

Communication

Check-Back is…



TeamSTEPPS

Communication

Handoff

The transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include an opportunity to ask questions, clarify, and confirm

TeamSTEPPS

Communication

Handoff

- Optimized Information
- Responsibility– Accountability
- Uncertainty
- Verbal Structure
- Checklists
- IT Support
- Acknowledgement

Great opportunity for quality and safety

TeamSTEPPS

Communication

Communication Challenges

- Language barrier
- Distractions
- Physical proximity
- Personalities
- Workload
- Varying communication styles
- Conflict
- Lack of information verification
- Shift change

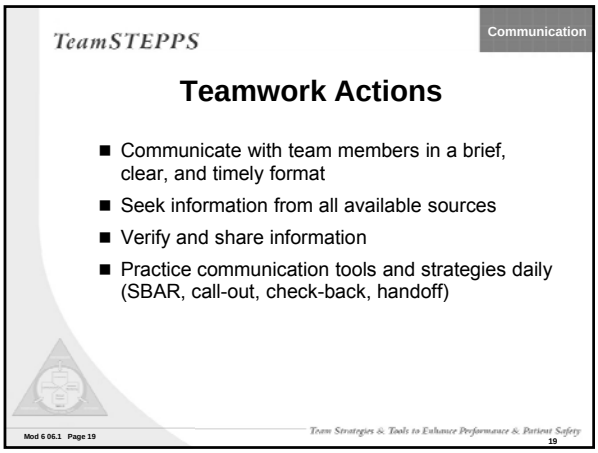
Great Opportunity for Quality and Safety

TeamSTEPPS

Communication

Barriers to Team Effectiveness

BARRIERS	TOOLS and STRATEGIES	OUTCOMES
■ 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	Brief Huddle Debrief STEP Cross Monitoring Feedback Advocacy and Assertion Two-Challenge Rule CUS DESC Script Collaboration SBAR Call-Out Check-Back Handoff	■ Shared Mental Model ■ Adaptability ■ Team Orientation ■ Mutual Trust ■ Team Performance ■ *Patient Safety!!*


TeamSTEPPS
Communication
Teamwork Actions
Communicate with team members in a brief, clear, and timely format
Seek information from all available sources
Verify and share information
Practice communication tools and strategies daily (SBAR, call-out, check-back, handoff)
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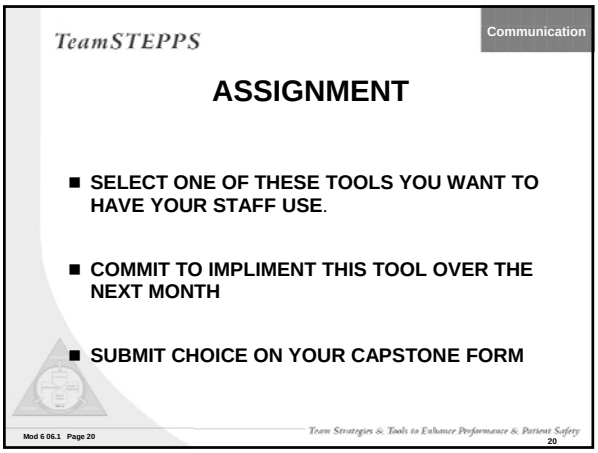
TeamSTEPPS
Communication
ASSIGNMENT
SELECT ONE OF THESE TOOLS YOU WANT TO HAVE YOUR STAFF USE.
COMMIT TO IMPLIMENT THIS TOOL OVER THE NEXT MONTH
SUBMIT CHOICE ON YOUR CAPSTONE FORM
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Notes:

Quality Improvement Models

Plan – Do – Study – Act (PDSA) or Plan – Do – Check – Act (PDCA)

- http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act%20(PDSA)%20Worksheet
- Product of Institute for Healthcare Improvement (IHI)
- This model is cyclical in nature to address and impact change
- Most effective with small, frequent PDSAs rather than large, slower ones

F: Find a process to improve

O: Organize a team that knows the process

C: Clarify the current knowledge of the process

U: Understand the sources/causes of process variation; select those causes most likely to be contributing to the problem, collect and analyze data to validate the root causes.

S: Start the improvement cycle, determine ways to change the process to eliminate the root causes, evaluate each choice in terms of cost, risks, benefits, and likelihood that changes will eliminate the causes.

Plan: Select the most desirable action plan. Define criteria by which the action plan will be judged. Define what data are needed to substantiate that improvement has occurred.

Do: Implement an action plan.

Check: Collect data to measure the effectiveness of the action. Report and analyze the results. Observe the effects of the change or test. Define if the action plan achieved the desired results.

Act: Act to hold gain and continue improvement. Define a schedule for collecting and analyzing future results.

Six Sigma

- http://www.isixsigma.com/index.php?option=com_content&view=article&id=201&Itemid=27
- Originally designed as a business strategy to improve, design and monitor processing to reduce or eliminate waste
- Reported to be useful in decreasing variations, cost and improving outcomes
- 5-phase process (DMAIC):
    - Define
    - Measure
    - Analyze
    - Improve
    - Control

Lean Production System

- http://www.lean.org/whatslean/
- This model originated in the manufacturing process of Toyota
- Overlaps with Six Sigma but Lean is driven by the identification of customer needs and removal of activities that are not value-added (eliminating waste)
- Steps include using root-cause analysis to investigate errors to improve quality and prevent similar errors
- Reported to be useful in decreasing variations, cost and improving outcomes

Root Cause Analysis (RCA)

- http://www.ahrq.gov/clinic/ptsafety/chap5.htm
- Formal investigation into the cause of an event or potential event
- Reactive assessment, after an event
- Problem-solving to understand the cause(s)
- Required by the Joint Commission in response to all sentinel events
- Useful in identifying trends or risk associated with human error, knowing that system errors are usually the root cause of problems

Failure Modes and Effects Analysis (FMEA)

- http://www.ihi.org/ihi/workspace/tools/fmea/
- Evaluation technique used to identify and eliminate known failures or potential failures
- Developed for use by the U.S. military and NASA to predict potential failures
- Used to avoid events and improve or maintain quality of care

Quality and Safety Education for Nurses (QSEN)

- http://www.qsen.org/
- Goal is to prepare new nurses with the knowledge, skills and attitudes (KSAs) to improve the quality and safety of the environments in which they work
- The established competencies are in alignment with the Institute of Medicine (IOM) report and Essentials for Baccalaureate Education
- All BSN programs will be implementing these competencies and the major categories include:
    - Patient-centered care
    - Teamwork and collaboration
    - Evidence-based practice
    - Quality improvement
    - Safety
    - Informatics

Notes:

Evaluation of Program For Quality Workshop

Course: ***Advanced Leadership for Quality Workshop***	**Date: August 10, 2011**

Regarding the Overall Course:	**Scale**					
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**No Opinion / N/A**
1. The presentations promoted active learning.	○	○	○	○	○	○
2. Appropriate reference materials were provided.	○	○	○	○	○	○
3. The presenters were responsive to questions from the audience.	○	○	○	○	○	○
4. The content was presented in an understandable way.	○	○	○	○	○	○
5. The content was presented in a logical sequence.	○	○	○	○	○	○
6. Handouts and other materials were clear.	○	○	○	○	○	○
7. I learned new skills that will be useful to me as a leader / coach.	○	○	○	○	○	○

Regarding the Objectives of the Course: Did the following presenters meet your expectations based on the stated objectives for their content?	**Scale**				
	Exceeded Expectations	**Met Expectations**	**Partially Met Expectations**	**Did Not Meet Expectations**	**No Opinion/ N/A**
1. Karren Kowalski – *Introduction to Team STEPPS; Team Structure; Mutual Support; Communication*	○	○	○	○	○
2. Marianne Horner – *Team Structure; Situation Monitoring*	○	○	○	○	○
3. Diane Pisanos – *Leadership*	○	○	○	○	○

Please explain any responses of partially met or did not meet expectations:

_____

_____

_____

_____

What did you find to be the most worthwhile content?

_____

_____

_____

_____

Thank you for your responses to our evaluation. We appreciate your participation in this work for the last three days. We look forward to working with you over the next six months on your capstones and coaching! Safe travels home!