From Baby STEPPS to Big Leaps: A range of approaches to team training implementation

Providence Health & Services
Moderated by Marly Christenson, PhD, RN, FNP, CPHQ
System Director, Patient Safety

Washington Patient Safety Coalition
May 2014
Objectives

At the end of this session, you will be able to:

1. Discuss a range of options for Team STEPPS implementation
2. Start developing the best fit approach for your organization based on lessons learned at Providence.
3. Prepare for a successful Team STEPPS implementation.
TeamSTEPPS

“an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system.” -http://teamstepps.ahrq.gov/
• A review of 33 studies on implementations to improve safety culture in healthcare settings

• 57% had multi-faceted interventions with the following components
  – 60% included team-training
  – 24% included executive walkrounds
  – 24% included comprehensive unit based safety program

• 72% significantly improved safety culture survey scores
Weaver & Rosen (2013) found moderate to high quality evidence that systematic team-training programs can meaningfully improve care processes and outcomes.
TeamSTEPPS across Providence

• We have a variety of implementation approaches underway across our system
  – Respecting the unique needs and capacity of each organization
• Today’s panelists will present several examples
  – Selecting components of TeamSTEPPS
  – Full implementation in one clinical area
  – Implementation hospital-wide
## Snapshot of Providence

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>56,667</td>
</tr>
<tr>
<td>Employed physicians</td>
<td>2,981</td>
</tr>
<tr>
<td>Physician clinics</td>
<td>400</td>
</tr>
<tr>
<td>Acute care hospitals</td>
<td>32</td>
</tr>
<tr>
<td>Acute care beds (licensed)</td>
<td>7,288</td>
</tr>
<tr>
<td>Hospice and home health programs</td>
<td>19</td>
</tr>
<tr>
<td>Home health visits</td>
<td>580,811</td>
</tr>
<tr>
<td>Hospice days</td>
<td>656,155</td>
</tr>
<tr>
<td>Assisted living and long term care facilities (free standing and co-located)</td>
<td>22</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>Facilities: 14, Units: 693</td>
</tr>
<tr>
<td>Unique Patients Served</td>
<td>2,169,857</td>
</tr>
<tr>
<td>Community benefit and charity care costs</td>
<td>$823 million</td>
</tr>
<tr>
<td>Total net operating revenue</td>
<td>$10.6 billion</td>
</tr>
<tr>
<td>Total net operating income</td>
<td>$204 million</td>
</tr>
<tr>
<td>Total net income</td>
<td>$1.2 billion</td>
</tr>
<tr>
<td>Total net assets</td>
<td>$6.7 billion</td>
</tr>
</tbody>
</table>

**PH&S 2012 Bond ratings**

- Moody’s Aa2
- S&P AA
- Fitch AA
Our panelists

- **Mary Crawford, RN, BSN**, Clinical Educator, Supervisor Organizational Development, Providence St Mary Medical Center, Walla Walla WA

- **Jo K. Quetsch MA, RN, NE-BC**, Senior Director of Perioperative Services-Urban Hospitals, Providence Health Care Region, Spokane WA

- **Bernie Klein, MD**, CEO, Providence Holy Cross Medical Center, Mission Hills, CA
Mary Crawford, RN, Clinical Educator
Supervisor, Organizational Development
Providence St Mary Medical Center
Walla Walla, WA
Our beginning

• First launch misfired
  – Back To the drawing board; then a “re-launch”

• Tools were selected
  – SBAR= Situation, Background, Assessment, Recommendation
  – Cross Check= Get it, Got it
  – Check-back = Get it, Got it, Did it
  – DESC = Describe, Express, Suggest, Consensus
  – CUS = Concerned, Uncomfortable, Safety Issue

• Approach redesigned

• The inevitable challenges were tackled
Assessing progress

Our goal was to achieve 5% improvement in SAQ+ results from 2012 to 2013

SAQ+ Hospital Handoff & Transition Items (from AHRQ's HSOPS)

Questions are negatively worded, scores display percent who disagree or strongly disagree with the statement

- Things fall between the cracks when transferring patients from one unit to another
  - 2012: 30% Disagree, 46% Strongly Disagree
  - 2013: 30% Disagree, 46% Strongly Disagree

- Important patient care information is often lost during shift changes
  - 2012: 20% Disagree, 64% Strongly Disagree
  - 2013: 20% Disagree, 64% Strongly Disagree

- Problems often occur in the exchange of information across hospital units
  - 2012: 17% Disagree, 54% Strongly Disagree
  - 2013: 37% Disagree, 50% Strongly Disagree
Our work continues

2013 Training accomplishments

- 20 sessions (4 hours each)
  - Reaching almost 400 (40%) of our clinical and non-clinical staff
- 3 sessions (2 hours each) for our ambulatory medical group
- 8 sessions (1 hour each) as part of our new employee orientation

2014 Training plans

- More of our Providers
- Broader across our hospital
- Additional sessions for our ambulatory medical group
Jo K. Quetsch MA, RN, NE-BC
Senior Director of Perioperative Services
Urban Hospitals
Providence Health Care Region, Spokane WA
Enhancing team communication in the perioperative care setting

The supporting evidence

• Significant issues raised concerns about team functioning
  – Confirmed in patient safety reporting, safety culture surveys, and other comments from staff
    • “I feel ostracized in that many of my co-workers do not want to work with me, surgeons, tech, other nurses”.
    • “People talk about me and describe my actions to adhere to our safety standards as a negative thing, I just wonder why the other providers let things slide!”
    • “There is an enormous amount of social pressure to NOT get on anyone's bad side. Very unsafe environment for patient safety”
Our goal

- To improve team communication in the perioperative care setting to maximize patient safety, as measured by:
  - Effectiveness of physician and nurse care coordination
  - Ability to speak up
  - Resolution of disagreements, not who is right but what is right for the patient
Launched September 2012

- Established a change team with a multidisciplinary approach
- Utilized Kotter's change model
- Used train the trainer model with small audiences
- Reduced OR volume on designated training days
- Conducted follow up sessions in conflict simulation
- Reinforced at weekly huddles
- Coached at unit level by leadership
Assessing progress

1. The physicians and nurses here work together as a well-coordinated team.
   - 2012: 33%
   - 2013: 73%
   - Goal Zone: 80%

2. *In this work setting, it is difficult to speak up if I perceive a problem with patient care. (*negatively worded)
   - 2012: 10%
   - 2013: 13%
   - Danger Zone: 50%

3. Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient).
   - 2012: 27%
   - 2013: 50%
   - Goal Zone: 80%
Our future

• Up next
  – Ongoing training sessions
  – Site-specific targeted plans (i.e. “improving ability to speak up”)

• Sustainability
  – Yearly competencies via on-line training module
  – Customization for team specific needs
  – Monthly phone calls with other TeamSTEPPS sites

• Adoption
  – Spokane organizational wide adoption at urban campuses
Patient Safety Toolkit

Communication is a vital component of patient safety. The purpose of the PHCMC Patient Safety Toolkit is to ensure excellent communication for every patient, every time, whether it concerns a “hand-off”, a need to inform others of an escalation in a patient’s condition or when one needs to ask a clarifying question… And always make sure to have a Wingman!

A. The 5Ps of hand-off communication:
   - Patient (identify)
   - Plan (plan of care: fluids, intake, output, intravenous access)
   - Purpose of plan (clinical findings, supporting plan of care, goals to be achieved)
   - Problem (abnormal findings, pain scale, vital signs, assessment)
   - Precaution (isolation, allergies, etc.)

A “hand-off” communication is real time, interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for ensuring the continuity and safety of the patient’s care.

B. SBARR (Situation, Background, Assessment, Request, Read Back):
   - S = Situation (a concise statement of the problem)
   - B = Background (pertinent and brief information related to the situation)
   - A = Assessment (analysis and considerations of options—what you found/think)
   - R = Request (action requested/recommended—what you want)
   - R = Read back

SBARR is an effective and efficient way to communicate important information to physicians. SBARR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

C. If you have a concern, ask a “Clarifying Question”:
   - Ask (for more information/clarification about an order or intervention)
   - Request (an intervention if the MD has not ordered something)
   - Concern (state concern if the MD dismisses the collaboration)
   - Chain of Command (elevate the concern through the chain of command)

AND ALWAYS have a “Wingman,” a co-worker you trust and respect to:
   - Provide you with support, including checking your work to prevent an error.
   - Provide you with peer coaching, encouragement and praise for performing correct behaviors and discouraging incorrect behaviors.
   - Be a mutually supportive team member, creating a safe environment to identify and correct safety risks.

Mutual support implies “You are not alone – I’ve got your back!”
Team STEPPS

Overview

TeamSTEPPS is an evidence-based teamwork approach used to improve communication among health care professionals and ensure patient safety. TeamSTEPPS looks at how we optimize performance and enable caregivers to respond quickly and effectively to changes in the patient care environment.

Goal:

To understand how to leverage teamwork to standardize communication, improve patient care and prevent medical errors.

Background:

Staff indicated through the Culture of Safety Survey that the communication and teamwork climate at Providence Holy Cross had a great opportunity for improvement, specifically in the areas of handoff and transition.

Plan:

This year, we plan to implement TeamSTEPPS in 5 Clinical Areas: Acute Rehab, PACU, Cath Lab, Tele, and GI. To ensure multi-disciplinary collaboration, the Ancillary and Support Services staff will be integrated into the clinical area training.

Patient Safety Toolkit

- SP Handoff
- SBAR + Communication
- Timeout (step the line)
- 2-way Communication
- Debrief
- Wingsman

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Culture of Safety at Providence Holy Cross Medical Center

Our patient safety toolkit

- 5P Handoff
- SBARR Communication
- Timeout (stop the line)
- 2-way Communication
- Debrief
- Wingman

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>OR/PACU</td>
</tr>
<tr>
<td>Rehab</td>
<td>Women’s Health</td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Short Stay</td>
<td></td>
</tr>
<tr>
<td>Cath Lab/Specials</td>
<td></td>
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Assessing progress

How Healthy Is Our Culture?
Safety Attitudes Questionnaire Domain Scores

Goal Zone
Danger Zone

Teamwork Climate
Safety Climate

2010 2012 2013

*Facility and System scores may differ based on the facility and work setting permissions that have been granted to the user that is downloading the reports.
**See Sources Appendix
Pascal Metrics Patient Safety Organization #0047 – Privileged and Confidential Patient Safety Work Product: Not Subject to Discovery and Cannot be Used as Evidence.
How Healthy Is Our Culture?

Safety Attitudes Questionnaire Plus Domain Scores

Scores for: PHS PHCMC-Cardiology (1/1 Work Settings)*

- **Goal Zone**
- **Risk Zone**

Average Percent Positive

- Teamwork Climate
  - 2010: 25
  - 2012: 46
  - 2013: 62

- Safety Climate
  - 2010: 38
  - 2012: 62
  - 2013: 100

- Job Satisfaction
  - 2010: 31
  - 2012: 67
  - 2013: 77

- Stress Recognition
  - 2010: 26
  - 2012: 50
  - 2013: 92

- Working Conditions
  - 2010: 14
  - 2012: 38
  - 2013: 38

- Perceptions Of Senior Management
  - 2010: 26
  - 2012: 67
  - 2013: 77

- Perceptions Of Local Management
  - 2010: 25
  - 2012: 38
  - 2013: 54

- Hospital Handoffs & Transitions
  - 2010: 12
  - 2012: 24
  - 2013: 47

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Questions & Discussion