TeamSTEPPS : boosting patient safety in French-speaking Switzerland

Anthony Staines, Ph.D.
Patient Safety Program Director, Fédération des hôpitaux vaudois, Switzerland
Professeur associé, IFROSS, University of Lyon 3, France

ZORGEN VOOR TEAMWORK

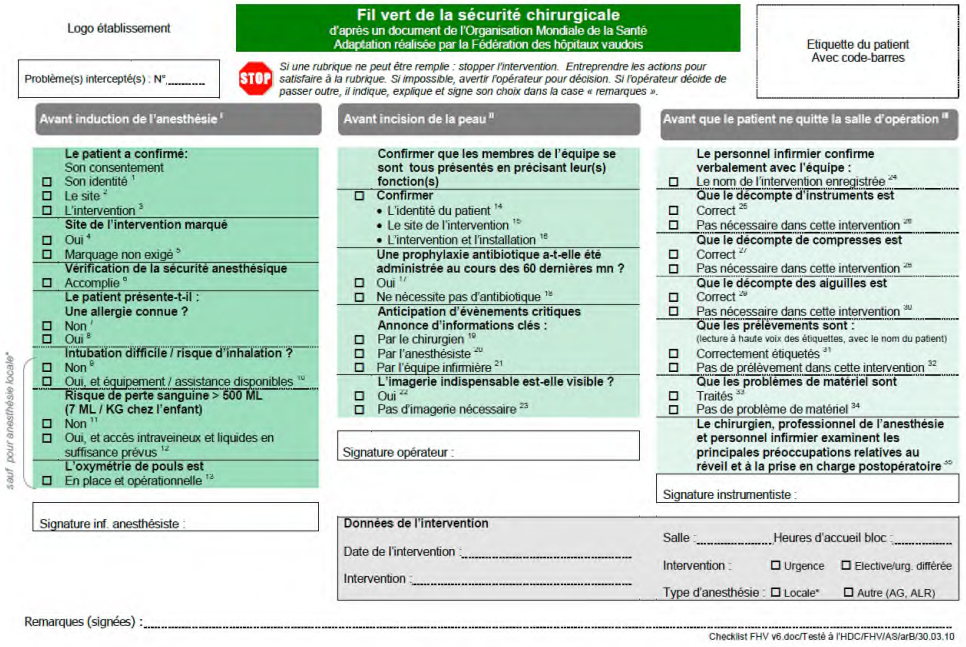
3de Conferentie teamwork in de zorg
Apeldoorn – Netherlands – November 3, 2017

Disclosures

- Anthony Staines is employed by FHV Hospital Federation and by Riviera Chablais Hospital.
- He has nothing else to disclose.

Why Crew Resource Management ?

- Permanent work group about the Surgical Safety Checklist.
- Discussion : too much focus on compliance – ticking boxes. Not enough focus on sharing key information and on teamwork.
- Request form hospitals to the Federation : how can we provide more meaning to the ckecklist ?
- Patient Safety Officers : communication is often found as a contributing factor when analysing serious adverse events.



Logo établissement

Fil vert de la sécurité chirurgicale
d'après un document de l'Organisation Mondiale de la Santé
Adaptation réalisée par la Fédération des hôpitaux vaudois

Etiquette du patient
Avec code-barres

Problème(s) intercepté(s) : N°.....

STOP *Si une rubrique ne peut être remplie : stopper l'intervention. Entreprendre les actions pour satisfaire à la rubrique. Si impossible, avertir l'opérateur pour décision. Si l'opérateur décide de passer outre, il indique, explique et signe son choix dans la case « remarques ».*

Avant induction de l'anesthésie [I]

Le patient a confirmé:
Son consentement
☐ Son identité [1]
☐ Le site [2]
☐ L'intervention [3]

Site de l'intervention marqué
☐ Oui [4]
☐ Marquage non exigé [5]

Vérification de la sécurité anesthésique
☐ Accomplie [6]

Le patient présente-t-il :
Une allergie connue ?
☐ Non [7]
☐ Oui [8]

Intubation difficile / risque d'inhalation ?
☐ Non [9]
☐ Oui, et équipement / assistance disponibles [10]

Risque de perte sanguine > 500 ML (7 ML / KG chez l'enfant)
☐ Non [11]
☐ Oui, et accès intraveineux et liquides en suffisance prévus [12]

L'oxymétrie de pouls est
☐ En place et opérationnelle [13]

Signature inf. anesthésiste :

Avant incision de la peau [II]

Confirmer que les membres de l'équipe se sont tous présentés en précisant leur(s) fonction(s)
☐ **Confirmer**
- L'identité du patient [14]
- Le site de l'intervention [15]
- L'intervention et l'installation [16]

Une prophylaxie antibiotique a-t-elle été administrée au cours des 60 dernières mn ?
☐ Oui [17]
☐ Ne nécessite pas d'antibiotique [18]

Anticipation d'événements critiques
Annonce d'informations clés :
☐ Par le chirurgien [19]
☐ Par l'anesthésiste [20]
☐ Par l'équipe infirmière [21]

L'imagerie indispensable est-elle visible ?
☐ Oui [22]
☐ Pas d'imagerie nécessaire [23]

Signature opérateur :

Avant que le patient ne quitte la salle d'opération [III]

Le personnel infirmier confirme verbalement avec l'équipe :
☐ Le nom de l'intervention enregistrée [24]

Que le décompte d'instruments est
☐ Correct [25]
☐ Pas nécessaire dans cette intervention [26]

Que le décompte de compresses est
☐ Correct [27]
☐ Pas nécessaire dans cette intervention [28]

Que le décompte des aiguilles est
☐ Correct [29]
☐ Pas nécessaire dans cette intervention [30]

Que les prélèvements sont :
(lecture à haute voix des étiquettes, avec le nom du patient)
☐ Correctement étiquetés [31]
☐ Pas de prélèvement dans cette intervention [32]

Que les problèmes de matériel sont
☐ Traités [33]
☐ Pas de problème de matériel [34]

Le chirurgien, professionnel de l'anesthésie et personnel infirmier examinent les principales préoccupations relatives au réveil et à la prise en charge postopératoire [35]

Signature instrumentiste :

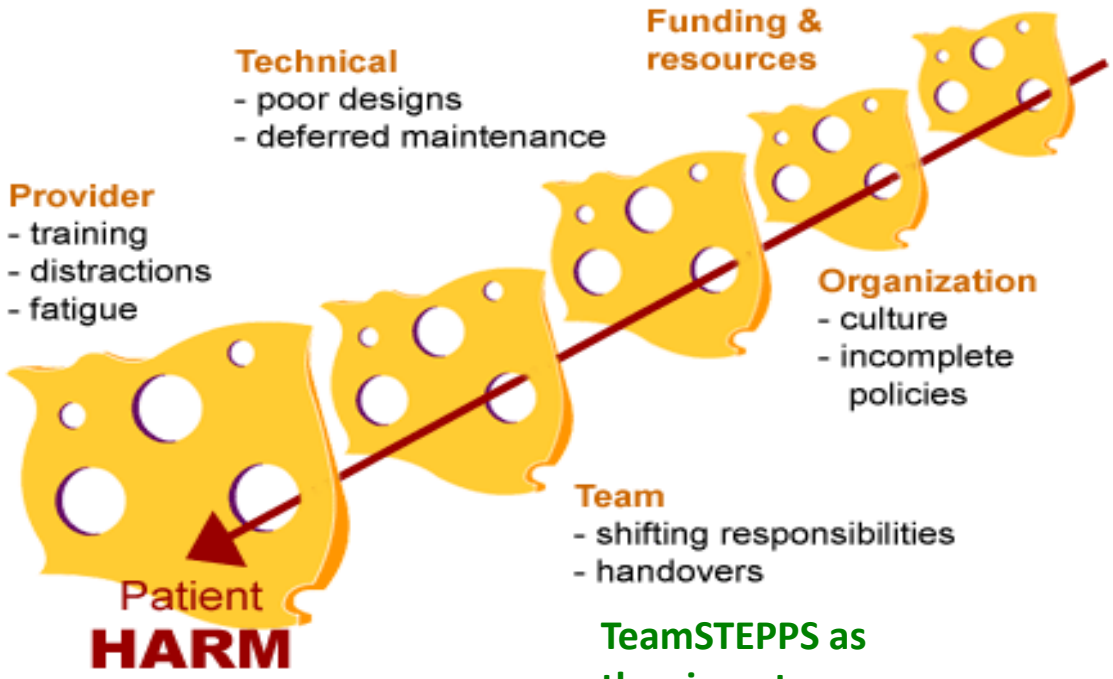
*sauf pour anesthésie locale**

Données de l'intervention
Date de l'intervention :.....
Intervention :.....
Salle :..... Heures d'accueil bloc :.....
Intervention : ☐ Urgence ☐ Elective/urg. différée
Type d'anesthésie : ☐ Locale* ☐ Autre (AG, ALR)

Remarques (signées) :.....

Checklist FHV v6.doc/Testé à l'HDC/FHV/AS/arB/30.03.10

The Swiss Cheese model



TeamSTEPPS as the ciment

The Swiss Cheese model
Adapted from J. Reason, 2000 by www.cmpa-acpm.ca/

Two views of safety management
Moving to Patient Safety 2

Safety 1

Classical safety management uses trivial (structural) models. The aim is to reduce the number of adverse events (the visible). Efforts focus on avoiding that something happens again ("fixing weaknesses," prevention, protection).

Dr Erik Hollnagel

Safety 2

Resilience management uses non-trivial (functional) models. The aim is to improve the ability to succeed under varying conditions. Efforts focus on enhancing the organization's ability to respond, monitor, anticipate, and learn (the visible and invisible).

Erik Hollnagel, Safety Culture, Safety Management, and Resilience Engineering 2009

Why TeamSTEPPS ?

- Search for Crew Resource Management concepts.
- Invited presentations from various hospitals that had experience with CRM.
- Searched literature.
- Feedback from hospitals was constantly the same : great concept, but cannot free up staff for 2-3 days for training. Find something that is teachable in 1 day.
- Found TeamSTEPPS. Team of 3 attended Master Training in NY Long Island.

Northwell Health – New York – Long Island - USA
TeamSTEPPS Master Training

Team Strategies and Tools to Enhance Performance and Patient Safety

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Defense Health Agency

TeamSTEPPS® 2.0

Acknowlegement

- Many thanks to the Agency for Healthcare Research and Quality (AHRQ) and to the US Department of Defense (DoD), who have developed TeamSTEPPS and who allow its free spread internationally.
- The following slides are all from the original TeamSTEPPS curriculum : TeamSTEPPS® 2.0. Content last reviewed July 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/teamstepps/instructor/index.html

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

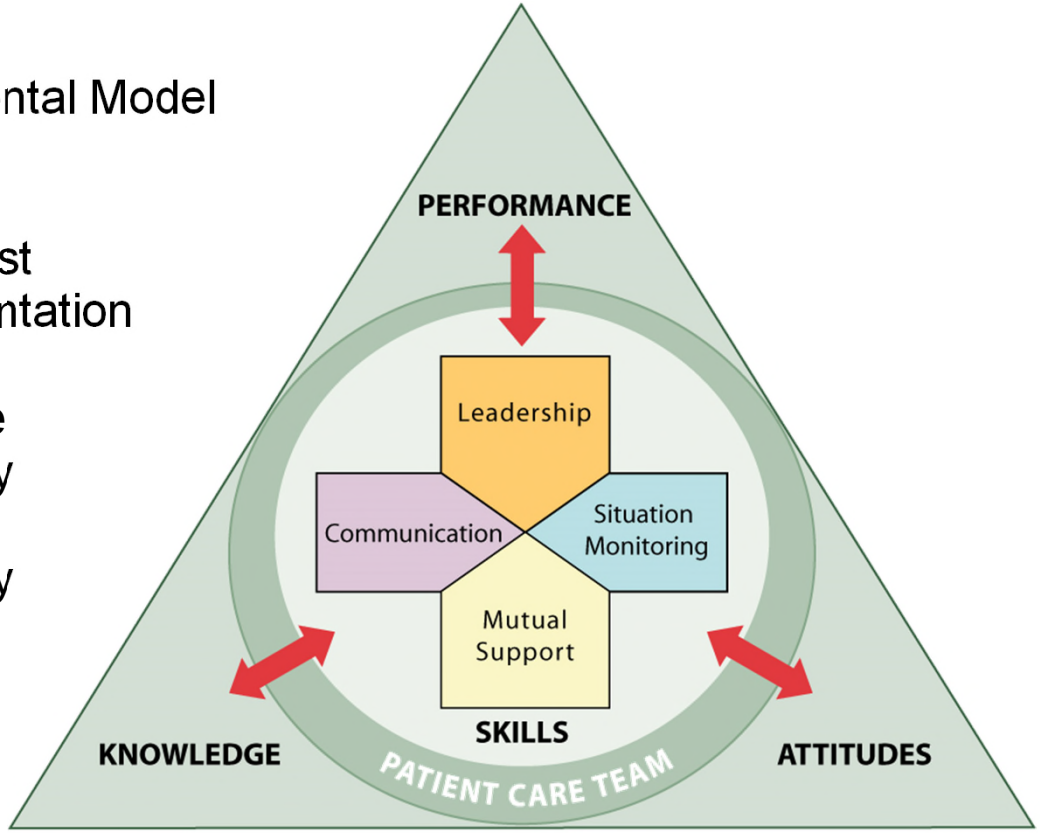
Mutual Support
- Task Assistance
- Feedback
- Assertive Statement
- Two-Challenge Rule
- CUS
- DESC Script

OUTCOMES

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

Outcomes of Team Competencies

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



SBAR Provides…

A framework for team members to effectively communicate information to one another

Communicate the following information:

- **S**ituation—What is going on with the patient?
- **B**ackground—What is the clinical background or context?
- **A**ssessment—What do I think the problem is?
- **R**ecommendation—What would I recommend?

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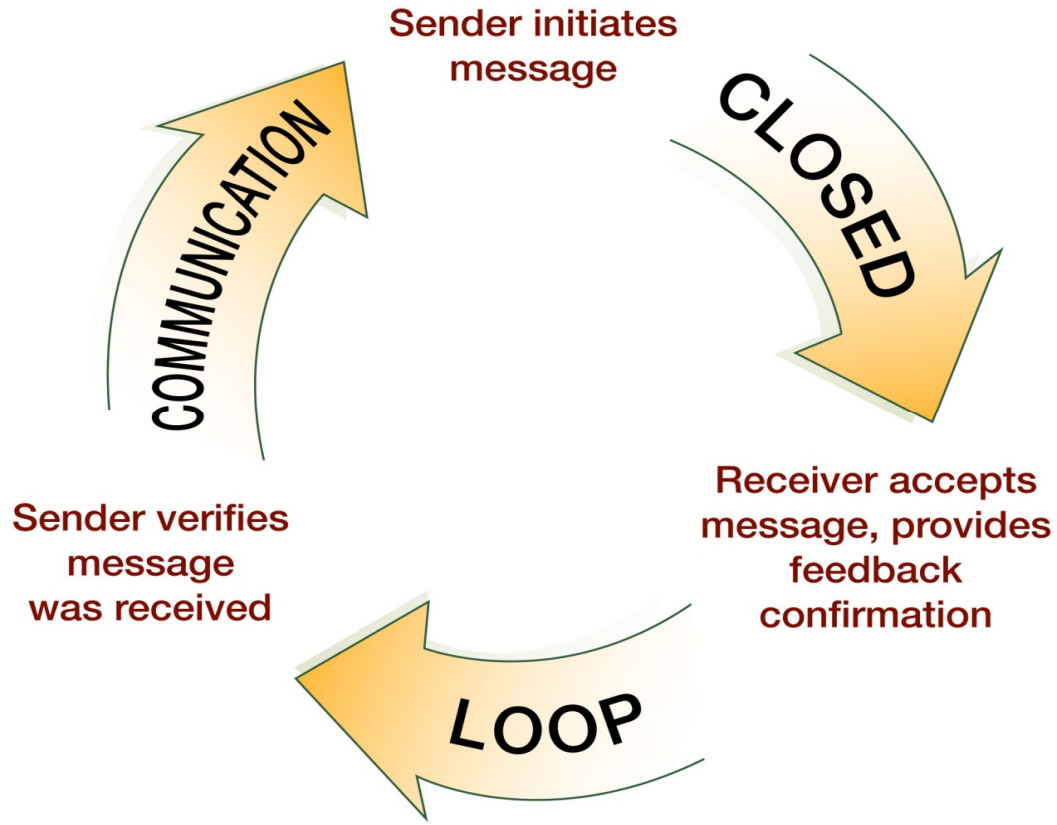
Check-Back is…



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Handoff is…

- The transfer of information during transitions in care across the continuum
  - Includes an opportunity to ask questions, clarify, and confirm

The I-PASS Mnemonic

I Illness Severity
Stable, "Watcher," Unstable

P Patient Summary
Summary statement; events leading up to admission; hospital course; ongoing assessment; plan

A Action List
To do list; timeline and ownership

S Situation Awareness & Contingency Planning
Know what's going on; plan for what might happen

S Synthesis by Receiver
Receiver summarizes what was heard; asks questions; restates key action/to do items

Starmer, A. J., Spector, N. D., Srivastava, *et al*. (2014). Changes in medical errors after implementation of a handoff program. *New England Journal of Medicine*, *371*(19), 1803-1812.

Sharing the Plan: Briefs

- **A team briefing is an effective strategy for sharing the plan**
- **Briefs should help:**
  - Form the team
  - Designate team roles and responsibilities
  - Establish climate and goals
  - Engage team in short- and long-term planning

Monitoring & Modifying the Plan: Huddle

Problem Solving

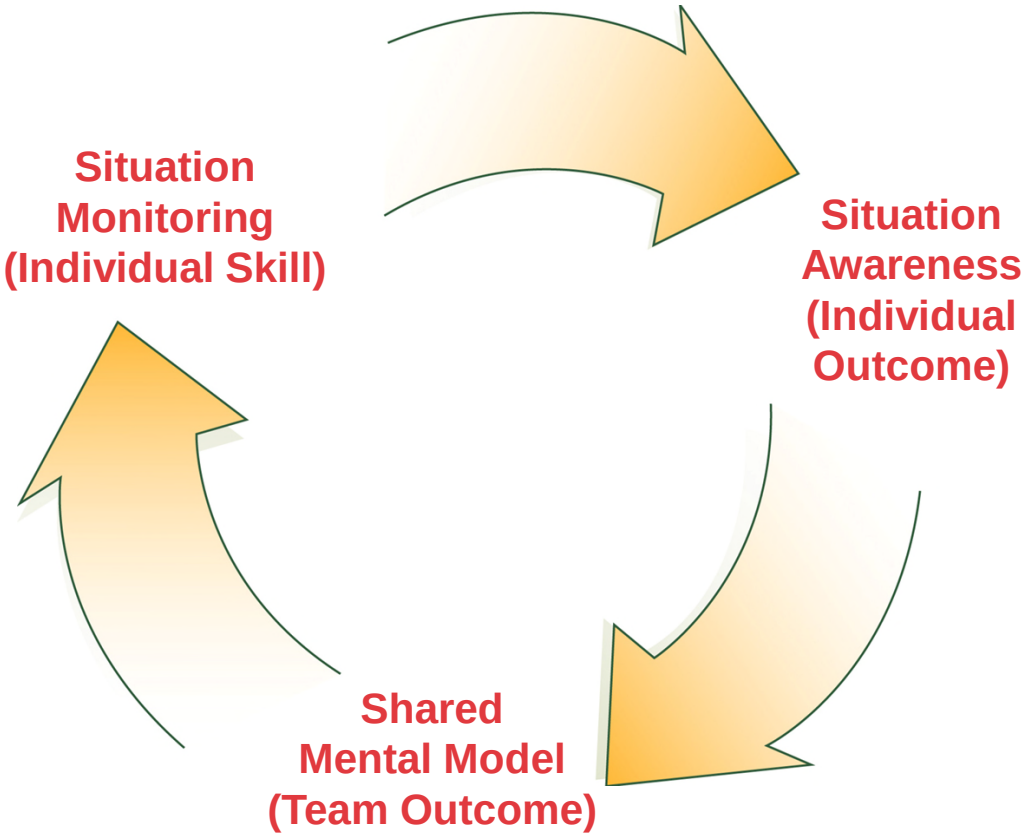
- Hold ad hoc, “touch base” meetings to regain situation awareness
- Discuss critical issues and emerging events
- Anticipate outcomes and likely contingencies
- Assign resources
- Express concerns

Reviewing the Team's Performance: Debrief

Process Improvement

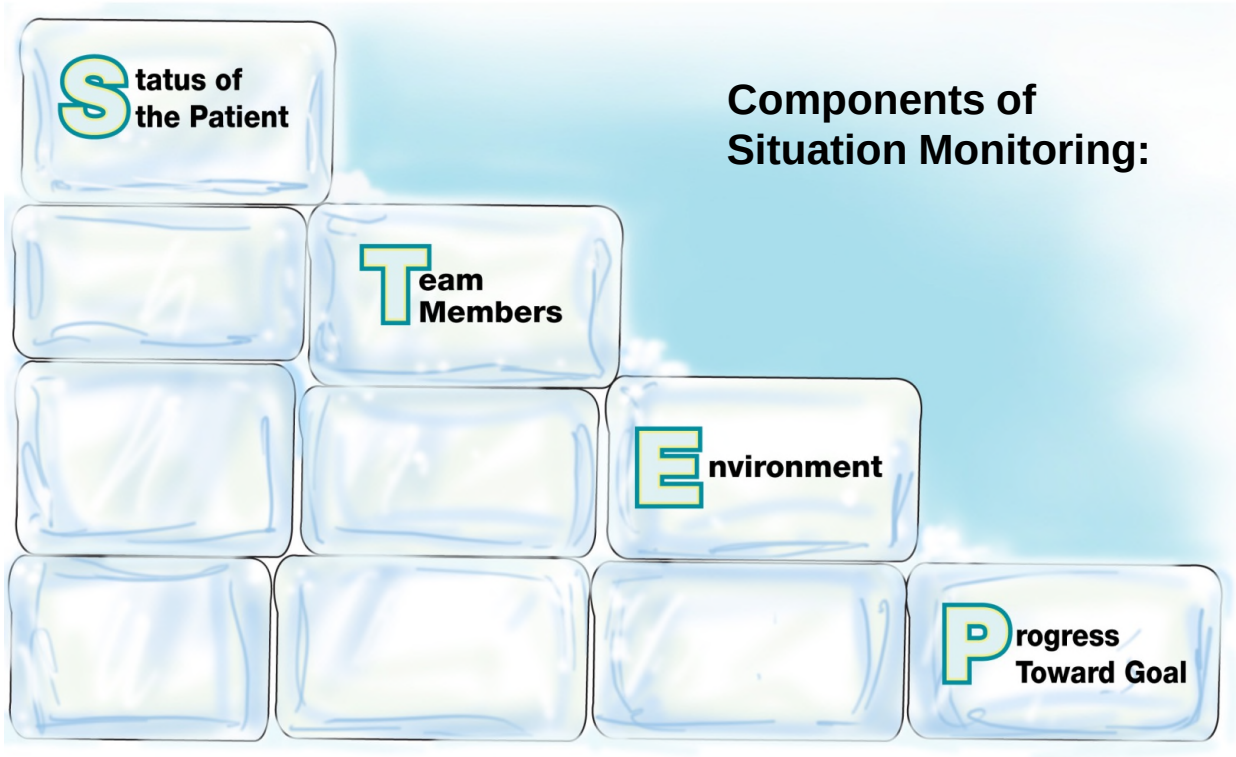
- Brief, informal information exchange and feedback sessions
- Occur after an event or shift
- Designed to improve teamwork skills
- Designed to improve outcomes
  - An accurate recounting of key events
  - Analysis of why the event occurred
  - Discussion of lessons learned and reinforcement of successes
  - Revised plan to incorporate lessons learned

A Continuous Process



Shared Mental Model?

STEP

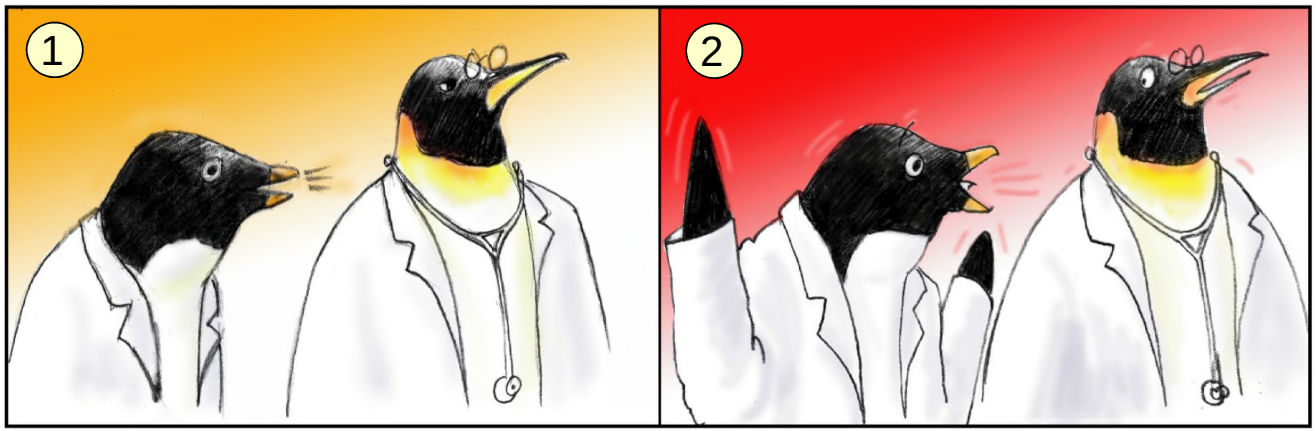

Components of
Situation Monitoring:
Status of the Patient
Team Members
Environment
Progress Toward Goal

Mutual Support

Mutual support involves members:

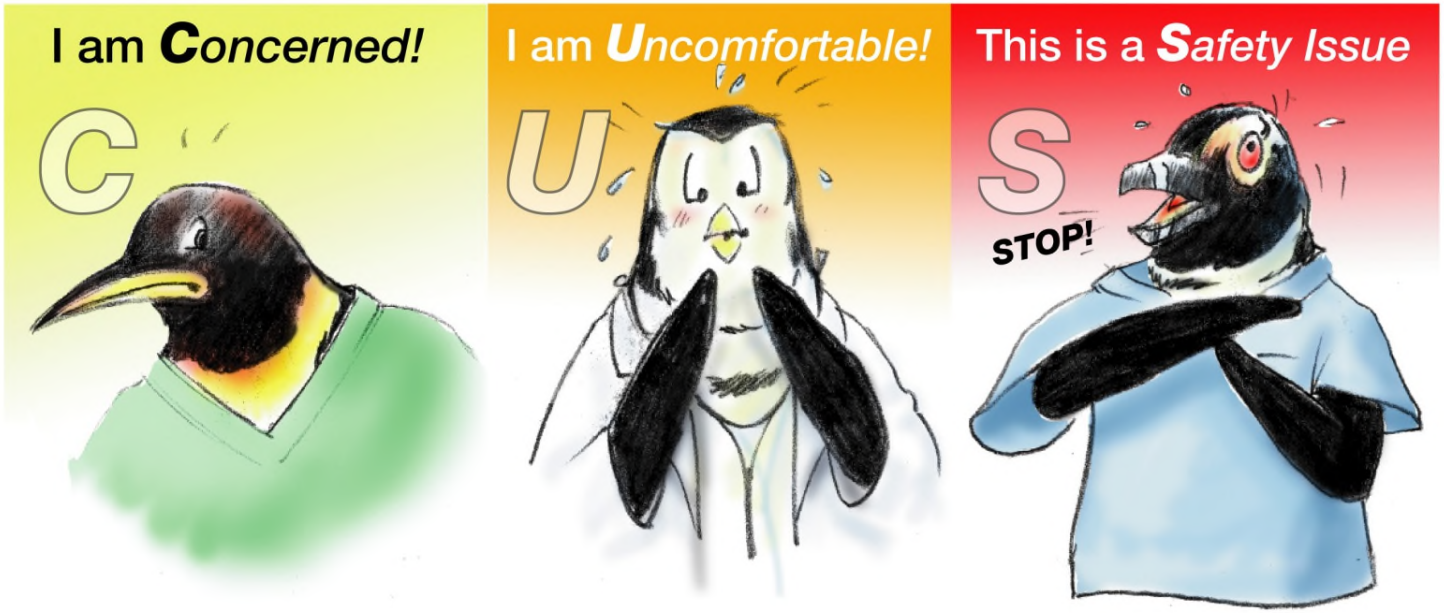
1. Assisting each other
2. Providing and receiving feedback
3. Exerting assertive and advocacy behaviors when patient safety is threatened

Two-Challenge Rule



Please Use CUS Words

but *only* when appropriate!



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Conflict Resolution
DESC Script

A constructive approach for managing and resolving conflict

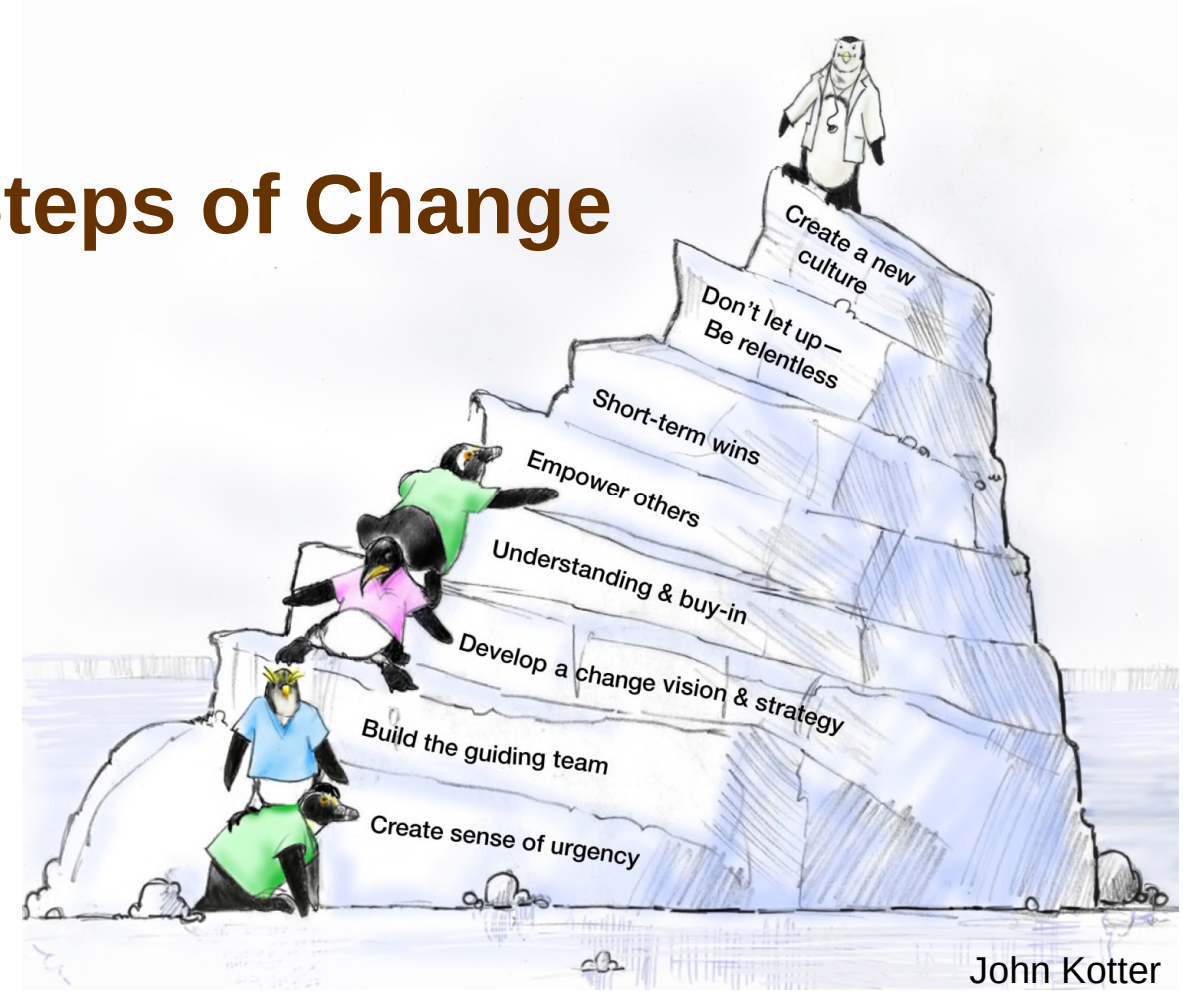
D—**Describe** the specific situation

E—**Express** your concerns about the action

S—**Suggest** other alternatives

C—**Consequences** should be stated

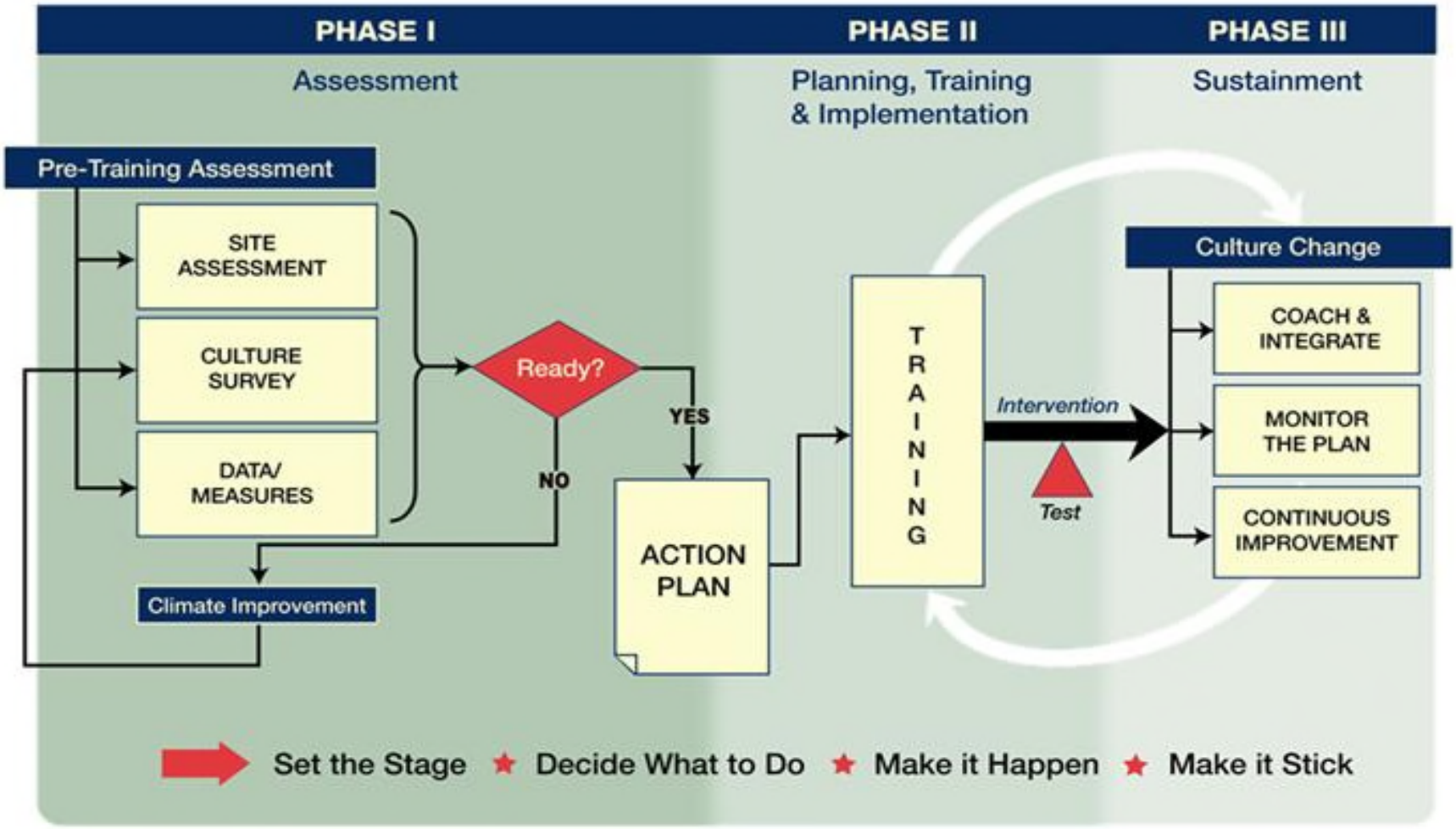
8 Steps of Change



John Kotter

The Role of a TeamSTEPPS Coach

- Role model behavior
- Observe performance and provide feedback
- Motivate team members
- Provide opportunities to practice and improve


PHASE I
Assessment
PHASE II
Planning, Training & Implementation
PHASE III
Sustainment
Pre-Training Assessment
SITE ASSESSMENT
CULTURE SURVEY
DATA/ MEASURES
Ready?
YES
NO
Climate Improvement
ACTION PLAN
TRAINING
Intervention
Test
Culture Change
COACH & INTEGRATE
MONITOR THE PLAN
CONTINUOUS IMPROVEMENT
Set the Stage
Decide What to Do
Make it Happen
Make it Stick

Lessons from the pilot site

HÔPITAL RIVIERA-CHABLAIS
VAUD-VALAIS

- Attendees like the TeamSTEPPS concept, tools and strategies. Enthusiasm.
- Nothing changes the next day, when attendees go back to their ward.
- Change Team has to be in place.
- Coaches have to be trained and in place. (1/10 recommended)
- Important change in culture. The concept must be negotiated with leaders before implementation.
- No official kick-off before >60% of staff trained.
- Champions are needed.
- The TeamSTEPPS training provides the tools and strategies, not the diagnosis. The change team must work on the diagnosis.

5 current locations

One future location (under construction)

Role of the Federation (in cooperation with the pilot site)

- TeamSTEPPS selected as the teamwork method for FHV.
- Promotion of TeamSTEPPS through Patient Safety Officers.
- Presentation in congresses, education programs.
- Short presentations for Executive Boards that are considering TeamSTEPPS.
- Translation of TeamSTEPPS trainer manual, slides.
- Subtitles for videos.
- Organization of the Master Training program.
- Forum to share experience.
- Cooperation with simulation center.

Deployment

- Hospitals sign in on a voluntary basis.
- 1/12 has decided full scale implementation (2000 people to train over 1 day)
- 2/12 have pilot projects
- 5/12 have trained trainers
- The CHUV University Hospital (not member of the Federation) has chosen TeamSTEPPS as the institutional method for Teamwork and communication.
- Interest from several hospitals outside FHV, and from pregraduate training institutions.

Next steps for teamwork training - anticipated

- Increase in pilot sites (mainly high complexity environment).
- Spread to nonacute facilities.
- Major organizations will set up their own teamwork training program. Smaller organizations will pool resources.
- Coupling with simulation.
- Progressive inclusion of CRM in pregraduate education (under way).
- Multi-professional education.
- Standard training in education centers, customized simulation scenarios inhouse.
- Must be part of a global quality/safety improvement plan. Dependent on a Just Culture.
- Must be supported by a learning culture, research and measurement, leadership support.