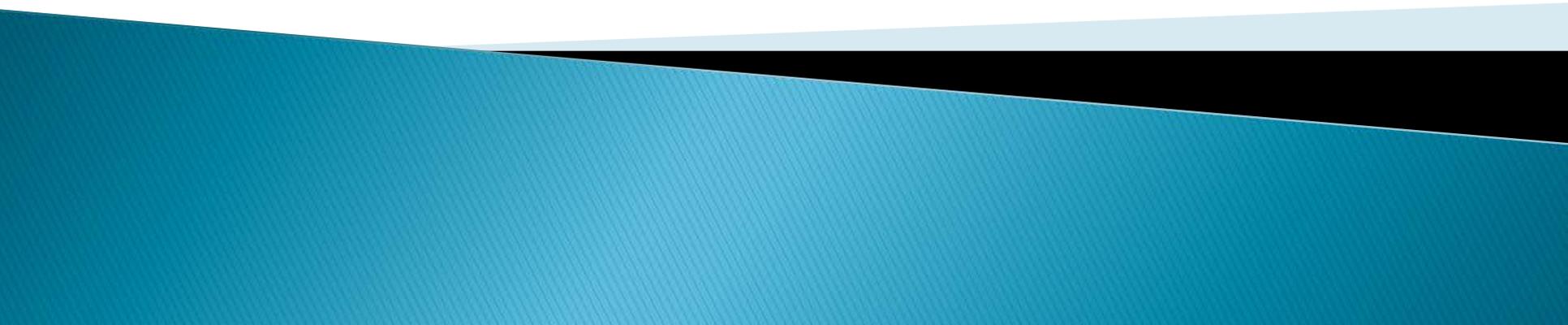


# Guttenberg Municipal Hospital

Our Team STEPPS Journey



# Who are we?



- ▶ **Critical Access Hospital**
  - Rural Hospital Partner with UnityPoint Health
  - Ambulance
  - Family Resource Center
  - Community Fitness Center
  - Clinic Integration Dec 2011
    - Cornerstone Family Practice / Provider Based Rural Health Clinics
  - 28E Agreement with Kids' Kampus (Child Care)
  
- ▶ **Services Include OB, Surgery, ED, Med-Surg, ATC Clinic, Rehab Services, Lab, Imaging with In-House CT and MRI, Specialty Clinics**
  
- ▶ **New Hospital Construction January 2012**
  
- ▶ **Guttenberg Population of 2500**
  
- ▶ **Service Area 9000 – Lower Clayton County**





# Team STEPPS Implementation



Kettle

# Why TeamSTEPPS?

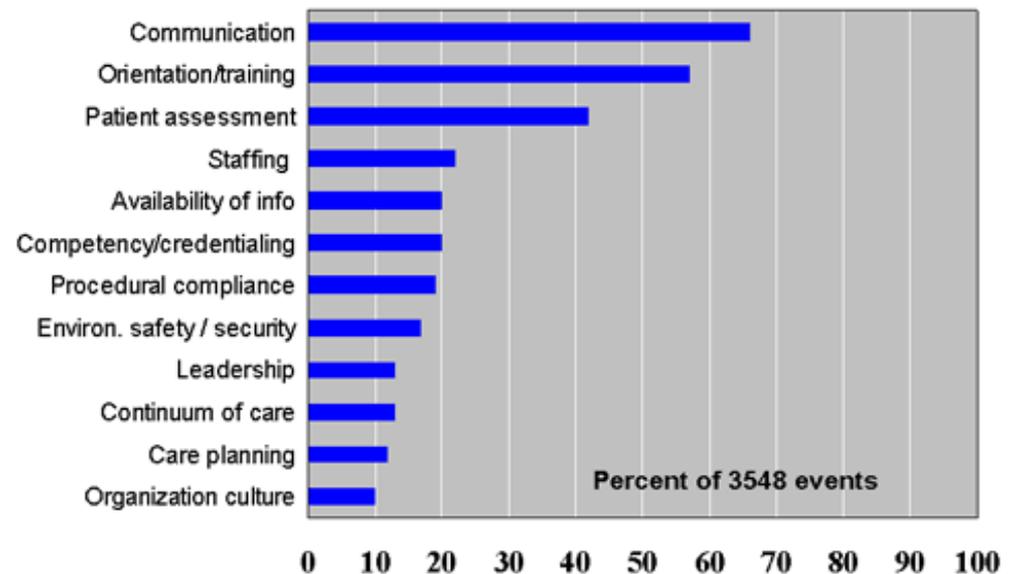
## Institute of Medicine Report

### 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

## Root Causes of Sentinel Events

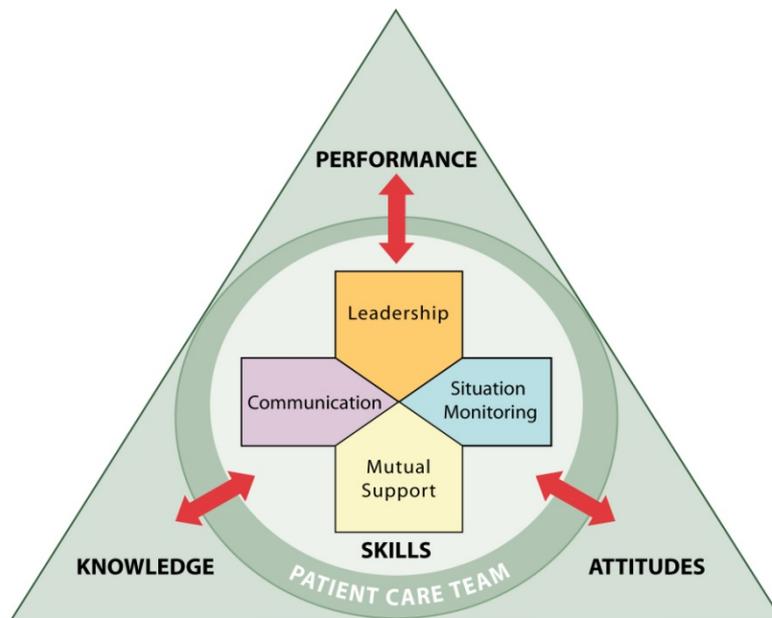
(All categories; 1995-2005)



*Cost associated with medical errors is \$8-29 billion annually.*

# Why Team STEPPS?

- ▶ Based on the concept of teamwork



## Key Principles

### Team Structure

Delineates fundamentals such as team size, membership, leadership, composition, identification and distribution

### Leadership

Ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and that team members have the necessary resources

### Situation Monitoring

Process of actively scanning and assessing situational elements to gain information, understanding, or maintain awareness to support functioning of the team

### Mutual Support

Ability to anticipate and support other team members' needs through accurate knowledge about their responsibilities and workload

### Communication

Process by which information is clearly and accurately exchanged among team members

# Why Team STEPPS?

- ▶ Strategies and Tools:
    - Reduce clinical errors
    - Improve patient outcomes
    - Improve process outcomes
    - Increase patient satisfaction
    - Increase staff satisfaction
    - Reduce malpractice claims
- 

# Why TeamSTEPPS?

## 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 Follow-Up with Co-Workers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

## TOOLS and STRATEGIES

- Brief
- Huddle
- Debrief
- STEP
- Cross Monitoring
- Feedback
- Advocacy and Assertion
- Two-Challenge Rule
- CUS
- DESC Script
- Collaboration
- SBAR
- Call-Out
- Check-Back
- Handoff

## OUTCOMES

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

# Our Team STEPPS Master Trainers

- ▶ Robin Esmann, RN, Quality and Safety Manager
  - ▶ Deb Preston, RN, OR Manager
  - ▶ Mary Aulwes, RN, Staff Nurse
  - ▶ Kayleen Schmelzer, MLT (Lab Tech)
  - ▶ Michele Sadler, Physician
- 

# Our Journey

- ▶ “Just Culture” training done many years ago but safety culture didn’t change
  - ▶ Determined the need to improve our Safety Culture – high importance due to the many hats worn in small hospitals
  - ▶ TeamSTEPPS discussed during strategic planning; added to the 3 year plan, year 3
  - ▶ Opportunity for TeamSTEPPS Master Trainer Training came from Telligen and decided to participate
  - ▶ Complete AHRQ Safety Culture Survey June 2011
  - ▶ Attend TeamSTEPPS Master Trainer Training June 2011
  - ▶ Develop TeamSTEPPS staff and manager education Nov 2011
  - ▶ Train managers to “coach” staff on TeamSTEPPS Dec 2011
  - ▶ Train all hospital staff on TeamSTEPPS Dec 2011 – Jan 2012
- 

- ▶ Focus Team STEPPS tools according to Safety Culture Survey results
  - ▶ Implement one Team STEPPS tool at a time– small “wins”
  - ▶ Measure success of each tool implemented
  - ▶ 1<sup>st</sup> Tool: Briefs, Huddles and Debriefs – 2 depts at a time Jan 2012
  - ▶ Repeat AHRQ Safety Culture Survey Aug 2012
  - ▶ Develop Safety Culture Survey Improvement Teams comprised of staff to suggest improvements Mar 2013
  - ▶ Quality and Safety Committee review of Teams’ suggestions & develop improvement action plan; add to Hospital Operations Plan and monitor progress quarterly – April 2013
  - ▶ EHR build and implementation Oct 2012 to June 2013 go-live – halted implementation of more TeamSTEPPS tools
  - ▶ 2<sup>nd</sup> Tool: Hospital-Wide Briefs Dec 2013
  - ▶ Train new hospital employees and clinic staff on TeamSTEPPS Mar/Apr 2014
- 

# Safety Culture Assessment

- ▶ AHRQ Safety Culture Survey – June 2011 baseline prior to Team STEPPS implementation; repeat survey Aug 2012
- ▶ 12 Survey Categories:
  - Non-Punitive Response to Error
  - Handoffs and Transitions
  - Communication Openness
  - Frequency of Events Reported
  - Staffing
  - Teamwork Across Units
  - Overall Perception of Patient Safety
  - Feedback and Communication About Error
  - Teamwork Within Units
  - Supervisor/Manager Expectations and Actions Promoting Patient Safety
  - Management Support for Patient Safety
  - Organizational Learning – Continuous Learning

# Safety Culture Improvement Plan

## 2012 AHRQ Safety Culture Survey

### Improvement Plan

#### Composites and Scores (lowest to highest):

1. **Nonpunitive Response to Error – 54%**
2. **Handoffs and Transitions – 54%**
3. **Communication Openness – 56%**
4. Frequency of Events Reported – 62%
5. Staffing – 65%
6. Teamwork Across Units - 72%
7. Overall Perception of Patient Safety - 78%
8. Feedback and Communication About Error – 79%
9. Teamwork Within Units – 82%
10. Supervisor/Manager Expectations and Actions Promoting Patient Safety – 83%
11. Management Support for Patient Safety – 85%
12. Organizational Learning—Continuous Improvement – 85%

#### Plan:

- Assigned Team Leader will pull team together, lead discussions, document recommendations and forward to Robin Esmann
- Each team will develop 3 suggestions (related to the Composite assigned) for our organization that could help to improve our scores

#### **Quarter 1 (March 2013): Teams 1, 2 and 3**

Quarter 2 (May 2014): Teams 4, 5 and 6

Quarter 3 (Nov 2014): Teams 7, 8 and 9

Quarter 4 (May 2015): Teams 10, 11 and 12

## 2012 AHRQ Safety Culture Survey

### Improvement Teams

#### Team One: Nonpunitive Response to Error

Composite Score: 54%

Team Leader: Terri Koopmann, Radiology

#### Team Members:

1. Jen Radl, Nursing
2. Danielle Bockenstedt, Nursing
3. Sam Moser, HR/HIM/Nursing/Rehab Services
4. Linda Ihm, Env. Services
5. Heidi Bolsinger, Pt Accounts
6. Linda Bockenstedt, Cornerstone

#### Survey Items Scored by Staff - to Consider During Session:

1. Staff feel like their mistakes are held against them.
2. When an event is reported, it feels like the person is being written up, not the problem.
3. Staff worry that mistakes they make are kept in their personnel file.

#### **WHAT CAN WE DO TO IMPROVE?**

- 1.
- 2.
- 3.

# 1<sup>st</sup> TeamSTEPPS Tools Implemented

## Planning



- ***Brief:*** a short session prior to start to discuss team formation; assign essential roles; establish expectations and climate; anticipate outcomes and likely contingencies



## Problem Solving

- ***Huddle:*** Ad hoc planning to re-establish situation awareness; reinforcing plans already in place; and assessing the need to adjust the plan



## Process Improvement

- ***Debrief:*** Informal information exchange session designed to improve team performance and effectiveness; after action review

# Brief

## Planning

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

Required for each dept each day



## Brief Checklist

During the brief, the team should address the following questions:

- Who is on the team?
- All members understand and agree upon goals?
- Roles and responsibilities are understood?
- What is our plan of care?
- Staff and provider's availability throughout the shift?
- Workload among team members?
- Availability of resources?

# GMH Brief



# 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

GMH Huddle Story



## Huddle Checklist

- ❑ Who is on the team
- ❑ What is reason for “Huddle”
- ❑ Do roles and responsibilities change
- ❑ Does our plan of care change
- ❑ Need to adjust workload among team members
- ❑ Team understands and agrees with new plan

# 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
- GMH Debrief Story



# Debrief Checklist



TOPIC	
Communication clear?	<input checked="" type="checkbox"/>
Roles and responsibilities understood?	<input checked="" type="checkbox"/>
Situation awareness maintained?	<input checked="" type="checkbox"/>
Workload distribution?	<input checked="" type="checkbox"/>
Did we ask for or offer assistance?	<input checked="" type="checkbox"/>
Were errors made or avoided?	<input checked="" type="checkbox"/>
What went well, what should change, what can improve?	<input checked="" type="checkbox"/>

# Visual Cues

## Brief Checklist : (Planning)

- Who is on the team?
  - All members understand and agree upon goals?
  - Roles and responsibilities understood?
  - What is our plan of care?
  - Staff and provider's availability throughout the shift?
  - Workload among team members?
  - Availability of resources?
- 



***Brief:*** a short session prior to start to discuss team formation; assign essential roles; establish expectations and climate; anticipate outcomes and likely contingencies

## Huddle Checklist: (Problem Solving)

- Who is on the team?
  - What is reason for huddle?
  - Do roles and responsibilities change?
  - Does our plan of care change? How?
  - Need to adjust workload among team members?
  - Team understands & agrees with new plan?
- 



***Huddle:*** Ad hoc planning to re-establish situation awareness; reinforcing plans already in place; and assessing the need to adjust the plan

## Debrief Checklist : (Process Improvement)

- Communication clear?
- Roles and responsibilities understood?
- Situation awareness maintained?
- Workload distribution equitable?
- Task assistance requested or offered?
- Were errors made or avoided?
- Availability of resources?
- What went well what should



***Debrief:*** Informal information exchange session designed to improve team performance and effectiveness; after action review

# Monitor Compliance

## Team STEPPS Monitoring

### Briefs, Huddles and Debriefs

Department: \_\_\_\_\_

Month/Year \_\_\_\_\_

Place an X in the appropriate box:

Day	Brief Performed	Huddle Performed	Debrief Performed	Reason for Huddle or Debrief
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

**\*\*Return completed form to Robin at the end of each month**

# 2012 Compliance Results

## Team STEPPS Briefs

### 2012 Compliance by Department

Goal >80%

Department	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Lab	95%	95%	91%	86%	86%	90%	100%	100%	100%	100%	100%	100%
Radiology	78%	87%	86%	90%	86%	81%	82%	96%	100%	100%	100%	100%
Nursing 5A	----	74%	52%	77%	68%	77%	77%	68%	81%	90%	100%	100%
Nursing 5P	----	----	----	----	----	----	----	----	----	----	100%	100%
Rehab Services	----	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgery	----	----	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dietary	----	----	----	----	93%	97%	100%	100%	100%	100%	100%	100%
Health Info	----	----	----	----	100%	90%	100%	100%	100%	100%	100%	95%
Admin/HR/Finance	----	----	----	----	100%	100%	100%	100%	100%	100%	100%	100%
Materials Mgmt/CS	----	----	----	----	----	100%	100%	100%	100%	100%	100%	100%
Pt Accounts	----	----	----	----	----	100%	100%	100%	100%	100%	100%	100%
Env Services	----	----	----	----	----	89%	95%	100%	100%	100%	100%	100%

# 2013 Compliance Results

## Team STEPPS Briefs

### 2013 Compliance by Department

Goal >80%

Department	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Lab	100%	100%	100%	100%	95%	100%	91%	95%	100%	100%	100%	100%
Radiology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nursing 5A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nursing 5P	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Rehab Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgery	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%
Dietary	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Info	100%	100%	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%
Admin/HR/Finance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Materials Mgmt/CS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pt Accounts	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%	100%
Env Services	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%	100%

EssWordsafetyTeamSTEPPS/TeamSTEPPSCompliance

# 2<sup>nd</sup> TeamSTEPPS Tool Implemented

## Hospital-Wide Brief



TEAM STEPPS

HOSPITAL-WIDE BRIEF

Monday-Friday at 10am SHARP in the Employee Break Area

Each department needs to send a representative

10 minute session to discuss pertinent information about the day:

1. What is our workload and staffing?
2. Any barriers or challenges?
3. Any planned events?
4. What could we use help with?

# Monitor Compliance

Hospital-Wide Brief									
Attendance Log									
Date									
Team STEPPS Leader									
Nursing									
ER									
OR/GSP									
Pharmacy									
HK/PO									
Lab									
Radiology									
Pt Accts									
MM									
Rehab Serv									
IT									
Health Info									
Admin/HR									
Cornerstone									

Common/Team STEPPS/Hospital-Wide Brief Attendance Log

# GMH Hospital-Wide Brief



# Staff Satisfaction

## Comments from Staff Regarding Hospital-Wide Briefs

### ▶ Lab

- “Staff finds it helpful to know how the clinic is staffed, what meetings are scheduled, who is short staffed, and what the patient census is. Also a good reminder of events going on within the organization”

### ▶ Business Office

- “Good to know when there are issues and concerns in other departments. We can better respond to patients and callers, explain ahead why there might be a delay”

### ▶ Human Resources

- “More connected as a hospital – it makes us more of a team”

### ▶ Patient Care Unit

- “Appreciation of the fact that others are busy too”

### ▶ Radiology

- “At first the staff was hesitant and didn’t really think it would work, however after starting in the departments and then moving to hospital wide, everyone thinks they are great and very beneficial. There have even been times when staff has called a second brief or huddle during the day when they think it’s needed”

# Next Steps

- ▶ Train physicians and mid-level providers
  - ▶ Implement next Team STEPPS tools
    - *Handoff Communication*
    - *Two Challenge Rule*
    - *CUS*
  - ▶ Measure success – Repeat AHRQ Safety Culture Survey Aug 2014
  - ▶ Study results of survey and determine course of action
  - ▶ Continue with remaining Safety Culture Survey Improvement Teams and develop improvement action plans
- 