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TeamSTEPPS

MOVING A TEAM OF EXPERTS TO AN EXPERT TEAM

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TEAMSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety

- Based on more than 30 years of research and evidence
- Team training programs have been shown to improve attitudes, increase knowledge, and improve behavioral skills
- Salas, et al. (2008) meta-analysis provided evidence that team training had a moderate, positive effect on team outcomes (ρ = .38)

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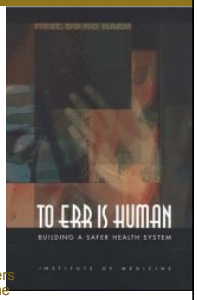
November, 1999
Approximately 100,000 patients die in the hospital each year from medical errors and 72% resulted from communication errors



This report lays out a comprehensive strategy by which government, health care providers, industry, and consumers can reduce preventable medical errors. Concluding that the know-how already exists to prevent many of these mistakes, the report sets as a minimum goal a 50 percent reduction in errors over the next five years.

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14 YEARS LATER…

Now comes a study in the current issue of the Journal of Patient Safety that says the numbers may be much higher – between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death.

The study says this would make medical errors the third-leading cause of death in America, behind heart disease, which is the first, and cancer which is the second

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Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2013 (N=887)		2014 (N=764)		2015 (N=936)	
Human Factors	635	Human Factors	547	Human Factors	699
Communication	563	Leadership	517	Leadership	849
Leadership	547	Communication	489	Communication	744
Assessment	505	Assessment	392	Assessment	545
Information Management	155	Physical Environment	115	Physical Environment	202
Physical Environment	138	Information Management	72	Health information technology-related	125
Care Planning	103	Care Planning	72	Care Planning	75
Continuum of Care	97	Health Information Technology-related	59	Operative Care	62
Medication Use	77	Operative Care	58	Medication Use	60
Operative Care	76	Continuum of Care	57	Information Management	52

67% of adverse events

The reporting of root sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

The Joint Commission

Office of Quality and Patient Safety - 8

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BARRIERS TO TEAM PERFORMANCE

- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Varying communication styles
- Conflict
- Lack of coordination and followup
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity

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CULTURE CHANGE

Leadership

vs

Teamanship

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CULTURE CHANGE

Team of Experts

Expert Team

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HIGH-PERFORMING TEAMS

Teams that perform well:

- Hold shared mental models
- Have clear roles and responsibilities
- Have clear, valued, and shared vision
- Optimize resources
- Have strong team leadership
- Engage in a regular discipline of feedback
- Develop a strong sense of collective trust and confidence
- Create mechanisms to cooperate and coordinate
- Manage and optimize performance outcomes

(Salas, et al., 2004)

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TeamSTEPPS Concepts

Concept	*Definition*	
Call-Out	To Request or Provide Information	
Cross-Check	Parroting Requests for Confirmation of Understanding	
Check-Back	Closing the loop of communication.	
SBAR	**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation	SBAR
Brief	Short planning session prior to start	
Huddle	Team Regroup to Reestablish awareness and planning	
Hand-Off	Transfer of information during transitions	
CUS	I'm **C**oncerned, I'm **U**ncomfortable, This is a **S**afety Issue	CUS
Two-Challenge	It is your responsibility to assertively voice a concern at least two times to ensure it had been heard.	

REVIEW OF SKILLS

100 Level Skills	*200 Level Skills*	*300 Level Skills*
Request	**Huddle**	**CUS**
Call-Out	Debrief	**Two-Challenge Rule**
Cross-Check	Handoff	DESC
Check-Back	Cross- Monitoring	I' M SAFE
SBAR	STEP	
Brief	Task Assistance	
	Shared Mental Model	

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THANK YOU!

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