



# Patient Safety is the Final Frontier, & TeamSTEPPS™ is the Vehicle



Lumetra

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## Executive Summary

Desired outcomes in healthcare have often not occurred because of communication failures and poor teamwork. This fact is well documented in literature that counts lives lost due to medical errors as well as demonstrating the extraordinary costs associated with treatment of errors.<sup>1</sup> While quality improvement tools, resources, and strategies are abundant in the marketplace, they are ineffective for sustained improvement when multidisciplinary healthcare teams do not function well in the daily practice of patient care. Teamwork training improves the culture for professional collaboration with a shared mental model for excellence in quality and safety.

The Department of Defense (DoD)

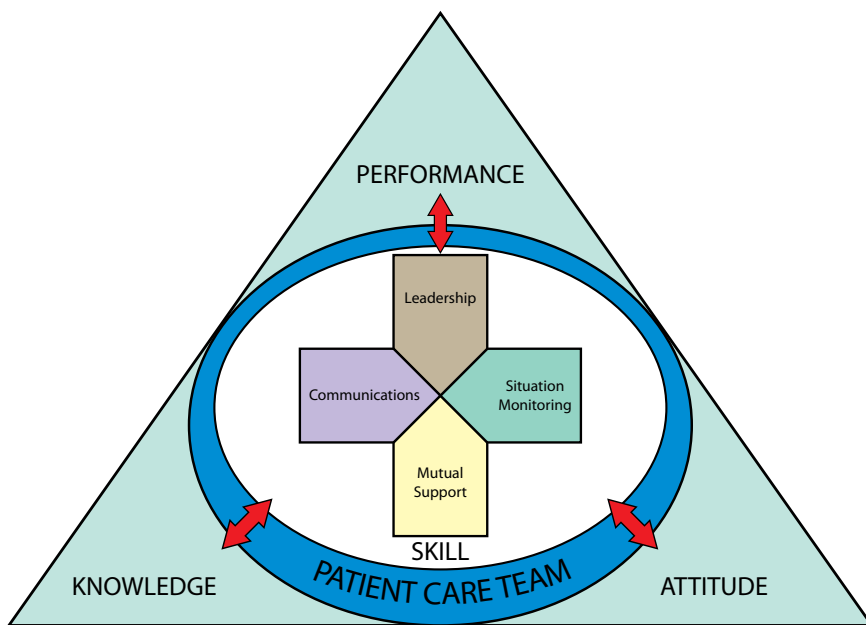
and the Agency for Healthcare Research and Quality (AHRQ) have created, tested, and proven a highly effective teamwork training program called TeamSTEPPS™ - Team Strategies and Tools to Enhance Performance and Patient Safety. Patient safety and healthcare quality are not optional strategic initiatives. They are imperatives - ultimately the responsibility of each organization's Board of Directors. Teamwork training has been the missing component in quality improvement interventions, a fact that is underscored by the Institutes of Medicine in the IOM Reports published in 1999 and 2001.

Patient Safety is the Final Frontier. To reach it, to conquer it, and to inhabit it means quality and efficiency,

with thousands of lives and millions of healthcare dollars saved. The Starship, the vehicle for this journey, is highly effective healthcare teams. The TeamSTEPPS™ teamwork-training program goes where no program has gone before: beyond evaluation and improvement of systems, beyond quality improvement models, and beyond human factors and crew resource management.

## Background

Every healthcare organization today has within its mission statement, language about the provision of safe, high quality care. This is not just the right thing to do; healthcare quality and patient safety saves healthcare dollars as well as lives. According to Leape and Berwick, despite the unprecedented focus on



Using this program, healthcare facilities have demonstrated the following results:

- 40% reduction in adverse drug events<sup>2</sup>
- 50% reduction in adverse outcomes<sup>3</sup>

patient safety that the IOM reports generated, “as many as 98,000 Americans still die each year because of medical errors.”<sup>3</sup> Mortality associated with hospital-acquired bloodstream infections ranges from 23.8% to 50%, and the cost of that care ranges from \$3,061 to \$40,000 per case.<sup>5</sup>

*Why has patient safety and reliable quality been out of our reach?*

*Why is it so hard to achieve?*

Communication is the greatest factor in the occurrence of errors, near misses, and incidents: communication that is poor, hesitant, unwelcome, or absent. Healthcare professionals have been working on quality for several years, using problem and process analysis, QI models for improvement, Organizational Culture Assessment, and collaborative forums with exchange of tools and resources. The ultimate vehicle for all these helpful interventions is a team of healthcare workers with various levels of

professionalism and various agendas.

Multidisciplinary clinical professionals have functioned for many years in an unspoken hierarchy and often with dysfunctional communications that hinder safe and effective operations.

Continuous Quality Improvement efforts with well-designed interventions, change packages, proven strategies, education, campaigns, and collaboratives have not brought the quality of the healthcare industry to the desired level of safety and reliability. Physicians are not taught teamwork in medical school; nursing education lacks assertiveness training; and executives are primarily concerned with the bottom line. Patients and families are sometimes not regarded as members of the patient care team, and few healthcare workers listen to them.

### Teamwork Training

A proven method for combating these

issues is the TeamSTEPPS™ program.

Its premise is that effective teamwork requires four teachable, learnable skills: leadership, situation monitoring, mutual support, and communication. One might prematurely conclude that clinical professionals already know how to practice all of these skills, until each of the four areas is explored for learning opportunities.

Effective team leaders must direct and coordinate team efforts, assign tasks, motivate team members, keep the “aim” alive in everyone’s mind, and facilitate optimal performance. Team leaders must have superior coaching skills, inspiring continuous hard work and the belief that the goal is achievable - indeed must be achieved. This is a requisite to success. Situation monitoring involves a common understanding of the team environment that must be dynamic. It includes ongoing monitoring of teammates to maintain a shared

mental model. Mutual support requires that teammates anticipate each other's needs and are ready to help one another, especially in periods of high workload or stress. Specific communication techniques can be learned so that information is more effectively delivered and more willingly received. TeamSTEPPS™ teaches all these skills.

The TeamSTEPPS™ program includes several hundred pages of training materials, broken down into eight modules, accompanied by very effective video clips and group exercises. The video scenarios that accompany the printed program modules are key to helping individual professionals recognize what a sub-optimal team looks and sounds like (and here they often see themselves unexpectedly), in contrast to what an effective, high quality team looks and sounds like. In this way the goals are set not only didactically, but also visually.

### **TeamSTEPPS™ Benefits—Why It Works**

The TeamSTEPPS™ program was developed by a panel of experts and is evidence-based, with over 25 years of scientific research conducted on team performance. This program has delivered statistically proven results, reducing medical errors and saving healthcare dollars.<sup>1,2</sup> Through formal teamwork training, one organization demonstrated the reduction of adverse drug events from 30 to 18 per 1000 patient days.<sup>6</sup> After implementation of multiple teamwork strategies and tools, another facility demonstrated a 50% reduction

in the Weighted Adverse Outcome Score (WAOS) and a 50% decrease in the Severity index in their Labor and Delivery Unit.<sup>7</sup> After implementation of a “Patient Daily Goals” form to facilitate staff communication, a third facility demonstrated a 50% decrease in mean ICU length of stay from 2.2 days to 1.1 days.<sup>8</sup>

We talk a lot about “Culture Change” in healthcare, but, in truth, it is hard to know what that feels like, what it sounds like, and what it looks like. It's hard to know what we are shooting for. The TeamSTEPPS™ program is not another package of process change strategies, checklists, and alert tools. It is a systematic presentation of essential strategies that change the organizational culture into one that practices effective teamwork in everyday activities and champions patient safety. One of the TeamSTEPPS™ techniques called “cross monitoring” encourages staff to communicate to their peers: “I've got your back,” and “If you think it - say it.” This tool brings about a paradigm shift, changing the punitive and defensive posture from “I'm watching you,” to one that is ready to help and can expect to receive help in return, to prevent medical errors. The healthcare environment is extremely complicated, and every facet is made up of many moving parts. We must acknowledge this fact, acknowledge that it will not change, and work together.

When healthcare professionals are given such effective tools, and when leadership supports organization-wide implementation, the end result is

increased patient safety, highly motivated and satisfied staff, and healthcare dollars saved. This is a win – win – win proposition. Every healthcare professional would prefer to work in an environment where they can count on interdisciplinary professionalism, respect, and mutual support - one that reliably delivers high quality patient care. Decreased staff turnover is the icing on this cake, maintaining quality in the workforce and decreasing dollars spent on new-hire orientation and training.

### **Conclusion**

Ineffective teams keep healthcare organizations from the goals boldly promised in their mission statements: superior quality and patient safety. Medical errors are costly, causing unintentional harm and requiring expensive treatment and risk management. Optimum risk management is achieved through prevention. Improved teamwork and communication will result in the prevention of medical errors (errors of commission as well as omission), prevention of infections, and prevention of adverse events.

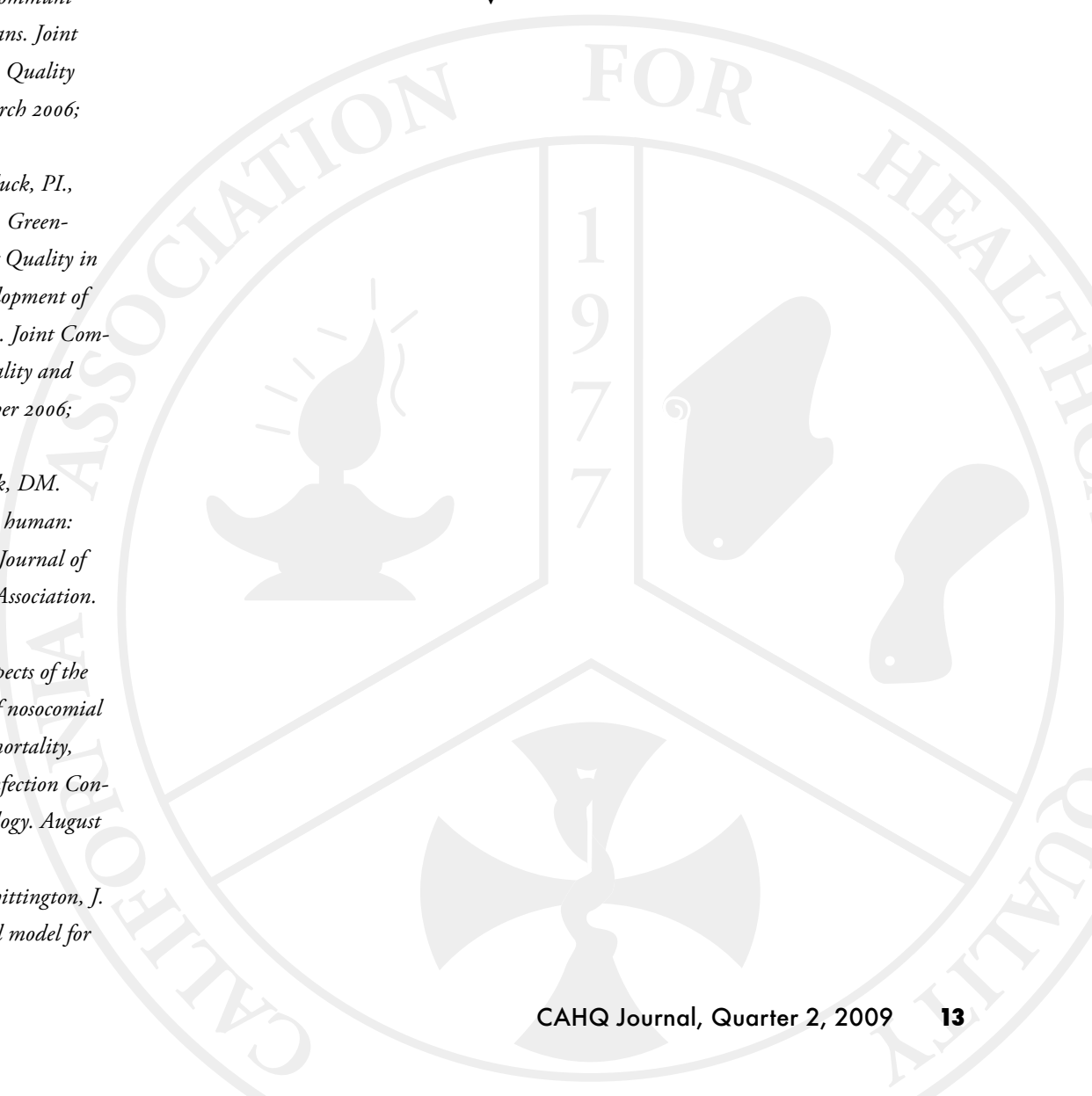
When your healthcare team has implemented the Team Strategies and Tools to Enhance Performance and Patient Safety from the DoD and AHRQ, you will have all the skills and resources needed to break through the barriers to organizational excellence, and you will use these strategies to enhance performance and patient safety for years to come.

TeamSTEPPS™ program materials can be ordered from the Web site [www.](http://www.)

[ahrq.gov/teamSTEPPS](http://ahrq.gov/teamSTEPPS). The multimedia resource kit (CD/DVD package) is free of charge, and the full instructor guide, including printed materials, is also available for a fee. If you would like more information, please contact Lumetra.

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## Author Bios

**Mary Kay Bader** has been a nurse for 30 years with an emphasis in neuroscience/critical care nurse for 26 years. She has been CCRN certified since 1982 and CNRN since 1983 and received her CCNS in 2006. Practicing in a variety of hospitals (teaching/community) across the country, Ms. Bader has functioned in roles such as ICU staff nurse, trauma nurse responder, clinical educator, clinical faculty, and clinical nurse specialist. She has held clinical and joint faculty positions at Georgetown University and Loyola University of Chicago. Currently, Ms. Bader is employed as a neuroscience/critical care clinical nurse specialist working collaboratively with neurosurgeons, trauma surgeons, nurses, therapists, and pharmacists. Ms. Bader has lectured locally, regionally, nationally and internationally on subjects such as traumatic brain injury, spinal cord injury, increased intracranial pressure, stroke, neurointerventional therapy and aneurysms. She has published in the following journals: Journal of Neuroscience Nursing, Critical Care Nursing Clinics of North America, AACN Clinical Issues, Journal of Cardiovascular Nursing, Heart and Lung, Critical Care Nurse, Dimensions in Critical care, Journal of Trauma, and Neurocritical Care. Ms. Bader is the co-editor for the 2004 AANN Core Curriculum for Neuroscience Nursing and serves as a consulting editor for Critical Care Nurse. She is co-editor of 2008 AACN AANN Protocols for Practice in Neuro

Critical Care. Ms. Bader is on the Medical Advisory Board for the Brain Trauma Foundation and on the Neurocritical Care Society Board of Directors. She is the recipient of AACN Circle of Excellence Awards: Outstanding CNS and Mentor along with the SICU's Multidisciplinary Team Award for Collaboration and Innovation Awards. In May 2009, she will receive the Flame of Excellence award from AACN. Badermk@aol.com

**Mary L. Jordan, CPHQ** is the Regional Safety Manager and Emergency Preparedness Coordinator for St. Joseph and Redwood Memorial Hospitals in Humboldt County. A southern California native, Mary graduated from Humboldt State University and remained in Humboldt County to work and raise her family. Mary is a member of the Humboldt County Public Health Branch Hospital Preparedness Program, the Humboldt-Del Norte Medical Society Disaster Preparedness Committee and the North Coast Emergency Medical Care Committee. Her email address is MaryL.Jordan@stjoe.org

**Tricia Kassab** is currently the Asst. Vice President of Quality/Patient Safety at SJHS, and has accepted the Vice President of Quality/Patient Safety position at the City of Hope. She is the Past President of CAHQ; the chair of the Accreditation and Licensing Committee at the Hospital Association of Southern California; and a Baldrige California Award for Performance Excellence examiner. She has her CPHQ and received the Healthcare Accreditation of Certified Professionals (HACP)

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Julia Slininger is a senior healthcare consultant at Lumetra. She recently led the Surgical Care Improvement Project (SCIP) during Lumetra's contract with the Centers for Medicare & Medicaid Services.

She is a TeamSTEPPS Master Trainer. She earned a bachelor of science in healthcare management from the University of La Verne in La Verne, California.