

Teaching TeamSTEPPS to Interprofessional Students or Staff to Promote Teamwork and Patient Safety

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JCIPE Established 2007

http://www.jefferson.edu/university/interprofessional_education.html

Mission- To promote excellence in healthcare through interprofessional education and scholarship

Scope - Dedicated to implementing and evaluating interprofessional education and collaborative practice initiatives throughout Thomas Jefferson University curriculum

Vision Statement- JCIPE will define the future of interprofessional care by creating a culture of collaborative educational practice, setting the standards for patient-centered care, team-based training and becoming a national/international leader in developing evidence-base to support interprofessional education



Thomas Jefferson University

IPE Core Competencies

Adapted from IPEC Core Competencies for Collaborative Practice, 2011

Values/Ethics:

Respect the unique cultures, values, roles/responsibilities and expertise of other health professionals.

Roles/Responsibilities:

Explain the roles and responsibilities of other health/healthcare providers and how the team works together to provide care.

Interprofessional Communication:

Work to ensure common understanding of information, treatment, and health/healthcare decisions by listening actively, communicating effectively, encouraging ideas and opinions of other team members and expressing one's knowledge and opinions with confidence, clarity and respect.

Team and Teamwork:

Reflect on the attributes of highly functioning teams and demonstrate the responsibilities and practices of effective team member(s).



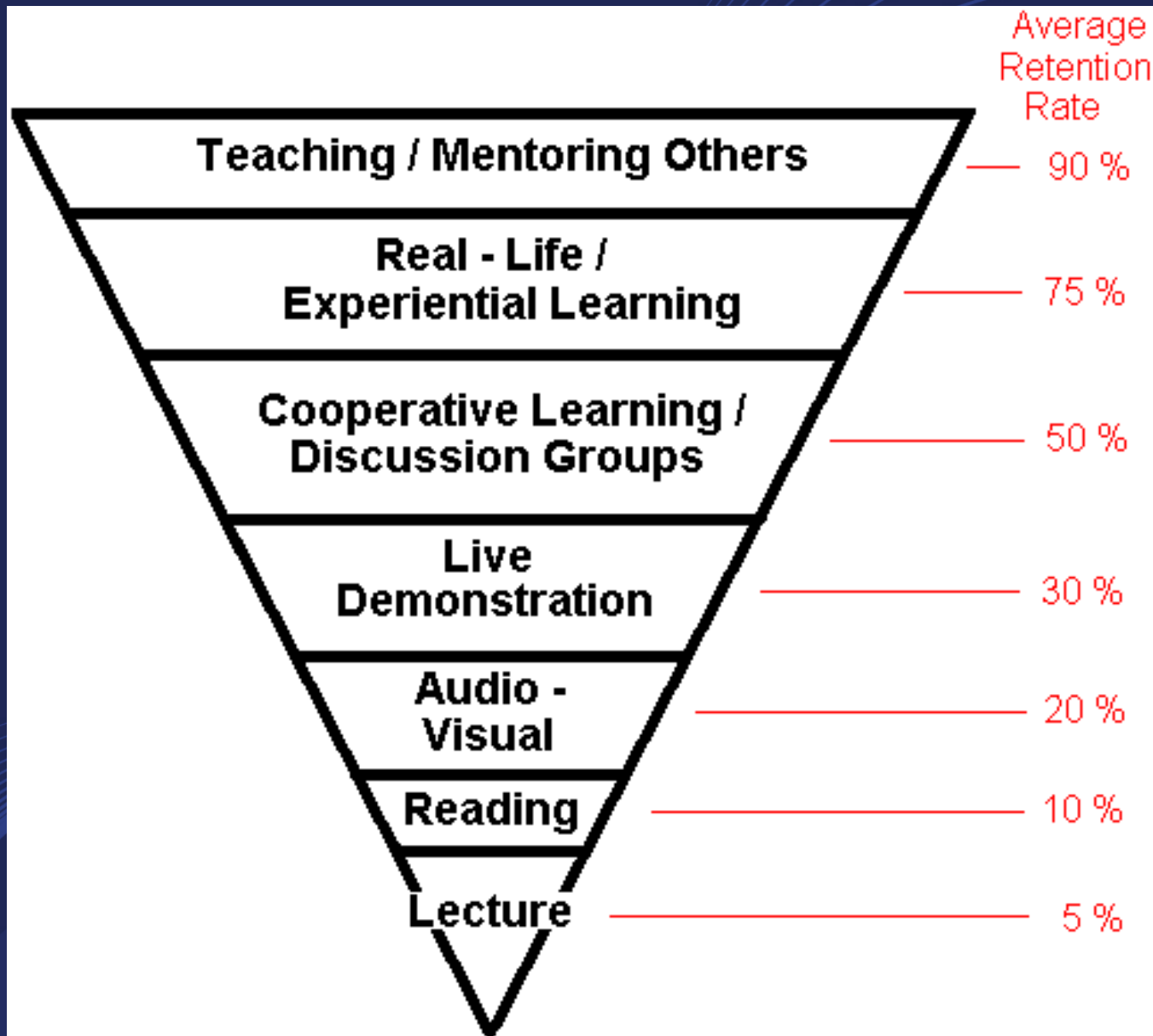
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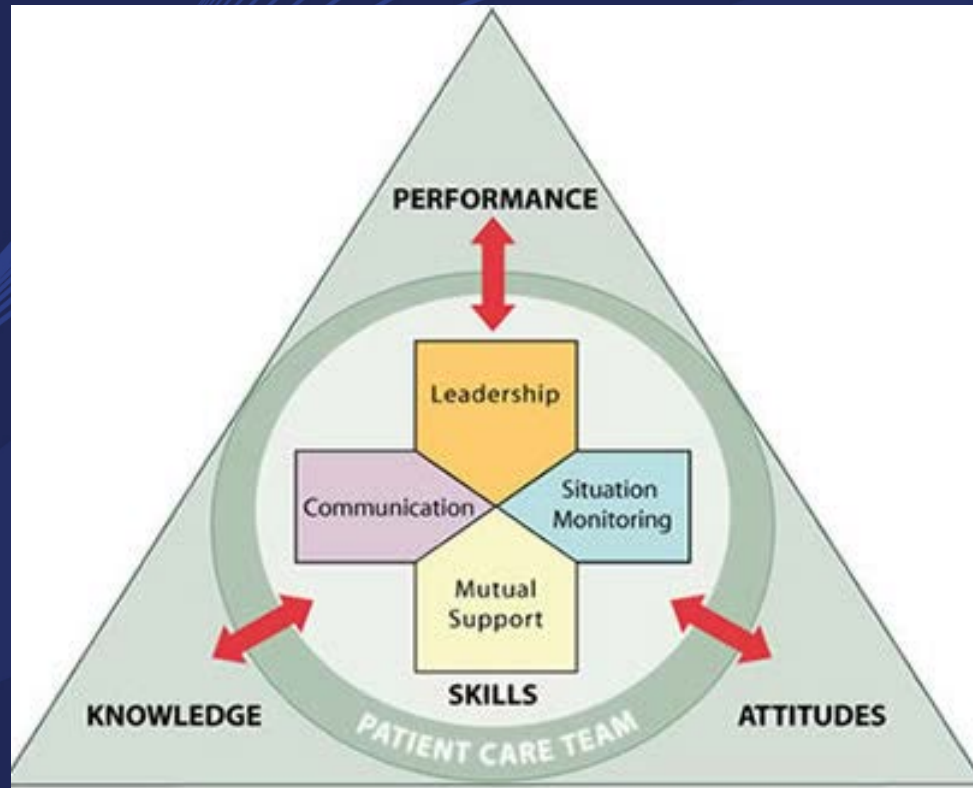
“Simulation-based learning strategies... can aid healthcare professionals in meeting... core competencies”



TeamSTEPPS stands for

**Team Strategies and Tools to Enhance
Performance and Patient Safety**

Team STEPPs Interprofessional Education Simulation



Glossary of Terms

Concept	Definition
Brief:	Short planning session prior to start to discuss team formation; assign essential roles; establish expectations and climate; anticipate outcomes and likely contingencies.
Huddle:	Ad hoc problem solving planning to reestablish situation awareness; reinforcing plans already in place; and assessing the need to adjust the plan.
Debrief:	Informational information exchange session designed to improve team performance and effectiveness; after action review.
Step Process:	<p>A tool for monitoring situations in the delivery of health care. Components of STEP situation monitoring include:</p> <ol style="list-style-type: none"> 1) Status of the patient (S): Patient history, vital signs, medications, physical exam, plan of care 2) Team members (T): Fatigue, workload, task performance, skill, stress 3) Environment (E): Faculty information, administrative information, human resources, triage acuity, equipment 4) Progress Toward Goal (P): Status of teams patients, established goals of team, tasks/actions of team, plan still appropriate.
Two-Challenge Rule:	When an initial assertion is ignored it is your responsibility to assertively voice the concern at least two times to ensure it has been heard. The team member being challenged must acknowledge. If outcome is still not acceptable, take a stronger course of action or use a chain of command.
CUS:	Statement of: I am <u>C</u> oncerned, I am <u>U</u> ncomfortable, This is a <u>S</u> afety Issue!
DESC Script:	<p>Approach to managing and resolving conflict.</p> <ol style="list-style-type: none"> 1) <u>D</u>escribe the specific situation or behavior; provide concrete data 2) <u>E</u>xpress how the situation makes you feel/what your concerns are 3) <u>S</u>uggest other alternatives and seek agreement 4) <u>C</u>onsequences should be stated in terms of impact on established team goals; strive for consensus
SBAR:	Technique for communicating critical information that requires immediate attention and action concerning a patient's condition: 1.) Situation (what is going on with the patient?) 2.) Background (What is the clinical background or context?) 3.) Assessment (What do you think the problem is?) 4.) Recommendation and request (What would I do to correct it?)
Call-Out:	Strategy used to communicate important or critical information. E.g. Team leader calls out = "Airway status? Assessing clinician response = "Airway status clear"
Check Back:	Process of employing closed loop communication to ensure that information conveyed by the sender is understood by the receiver as intended. E.g. Team Leader: "Give me 25 mg Benadryl IV push", Clinician: "25 mg Benadryl push", Team Leader: "That's correct"
Hand-Off Technique:	Transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include an opportunity to ask questions, clarify and confirm.

**Jefferson Hospital prioritized
TeamSTEPPS Speak-Up
language as the focus of
TeamSTEPPS training.**

TeamSTEPPS video:



TeamSTEPPS video: Cross Monitoring

TeamSTEPPS video:

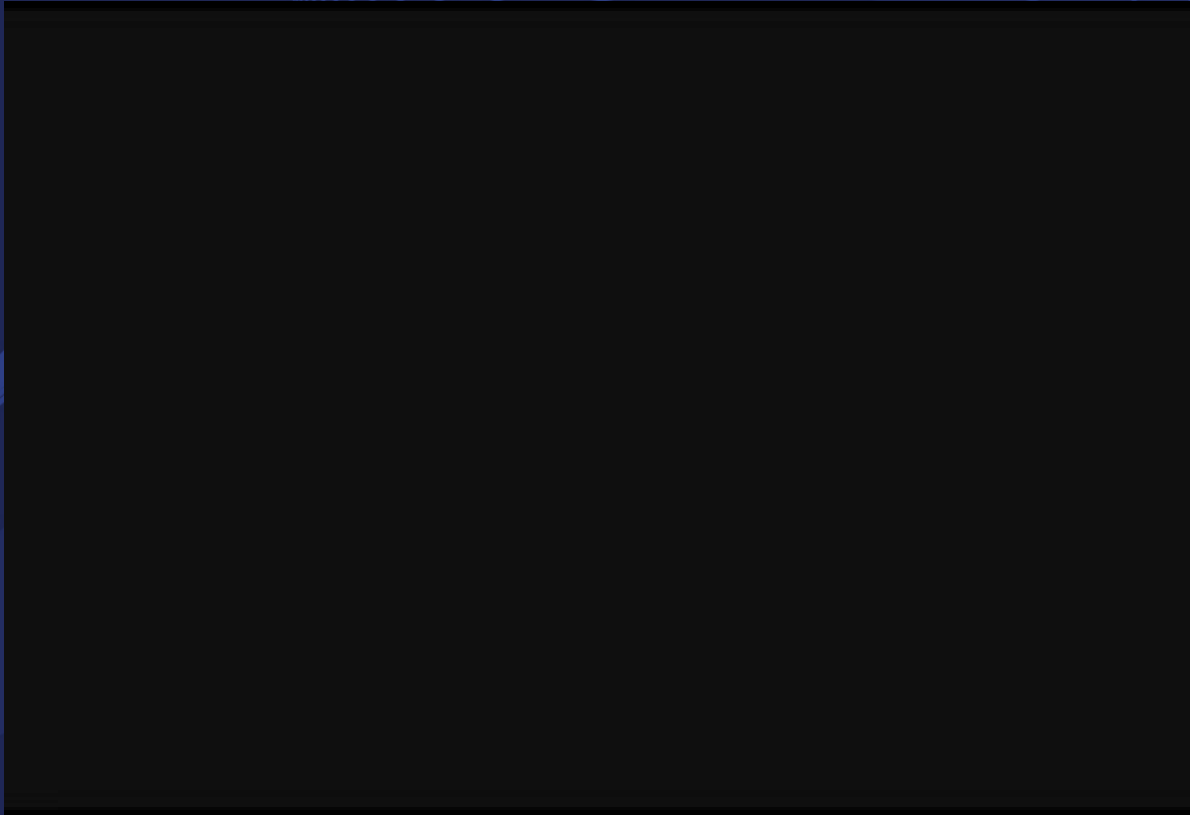


TeamSTEPPS video: CUS

- I'm **Concerned**
- I'm **Uncomfortable**
- Patient **Safety** Issue

- **Similar to 2 Challenge**

TeamSTEPPS video:



TeamSTEPPS video: Brief

TeamSTEPPS video:



TeamSTEPPS video: Check Back

SPEAK-UP at Jefferson

- **2 Challenge Rule:** When a safety concern is expressed but ignored, assertively voice the concern at least two times to ensure it has been heard.
- **CUS:** I am Concerned, I am Uncomfortable, This is a Safety Issue!

Give Permission to Speak-Up

Leader says:

- **“ Please speak up if I make a mistake or you notice a safety concern.”**

borrowed from Crew Resource Management

TeamSTEPPS Teaching @ Jefferson

- **TeamSTEPPS Speak-Up language was introduced as part of a JCIPE sponsored Patient Safety Course in 2012**
- **The following year JCIPE organized the first TeamSTEPPS Simulation-based Course at Jefferson**

TeamSTEPPS Teaching @ Jefferson

Here's Johnny

TeamSTEPPS: *Team Strategies and Tools to Enhance Performance and Patient Safety*

Feasibility Pilot Spring 2013

Faculty/Students: Medicine, Nursing, Pharmacy, PT, OT, Radiologic sciences with clinical experience.

Scenario #1 A patient experiencing a medical incident in the MRI suite

Scenario # 2 A patient falls while being ambulated by PT/OT

Purpose of the Pilot

- Educational opportunity for students to:
 - practice team behaviors (clarify roles, resolve conflict, communication to eliminate barriers to quality and safety) in a simulated and safe setting
 - gain new skills (i.e. leadership, situation monitoring, mutual support)



How can we include all the disciplines in each scenario?





The Debrief





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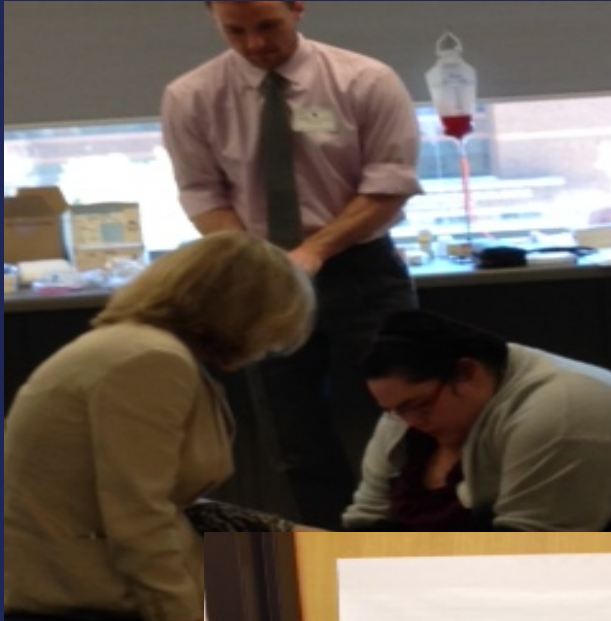
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Pilot Spring 2014

Faculty/Students: Medicine, Nursing, Pharmacy, PT, OT, Radiologic sciences

Scenarios involving individuals suffering an Asthma, Diabetic, and Orthopedic medical incident during a natural disaster in a local Shopping Mall



Welcome
to
HAMILTON MALL'S
Health Screening Day
APRIL 21, 2014

Student Team Peer Evaluation



Team STEPPs Skill Domains	1	2	3	4	5
Team Structure					
<ul style="list-style-type: none"> Identifies goals, assigns roles and responsibilities, holds members accountable 	0%	11%	26%	47%	11%
Leadership					
<ul style="list-style-type: none"> Utilizes resources, delegates tasks and balance workload, conduct briefs, huddles, and debriefs, empowers members to speak freely 	0%	5%	21%	58%	16%
Situation Monitoring					
<ul style="list-style-type: none"> Includes patient/family in communication, cross monitors members and applies the STEP process, foster communication 	0%	16%	37%	37%	11%
Mutual Support					
<ul style="list-style-type: none"> Advocates for the patient, resolves conflict using Two-Challenge rule, CUS, and DESC Script, works collaboratively 	0%	5%	11%	68%	16%
Communication					
<ul style="list-style-type: none"> Provides brief, clear, specific and timely information, seeks and communicates information from all available sources uses SBAR, call-outs, check-backs and handoff techniques 	0%	42%	16%	32%	11%

(Students) Name one thing you learned that will help you communicate about your patients' safety

- Learn how to better communicate with teammates and other professionals
- Assign Roles
- Believe in myself and my knowledge
- The CUS method is very useful in voicing concerns
- To speak up when I think something is wrong
- Listen and provide feedback if things are being miscommunicated

TeamSTEPPS in the Hospital

- Implementing the **ABCDE Bundle**

ABCDE Bundle

(AB= Awakening and Breathing Trial Coordination, C= Choice of Sedation, D= Delirium Assessment and Management, E= Early Exercise and Progressive Mobility)

Interprofessional Staff from the various ICUs at Thomas Jefferson University Hospital, have been charged with implementing the ABCDE bundle attended a team building/communication workshop hosted by JCIPE

TeamSTEPPS & ABCDE Bundle

- **Brief Review of the ABCDE Bundle**
- **Overview of TeamSTEPPS emphasizing “SPEAK-UP”**
- **Brainstorming-Group: Issues & Solutions**
- **Simulation with debriefing**
- **Video example of good use of TeamSTEPPS**

DEMOGRAPHICS



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Profession							
Physician	Nurse	Respiratory Therapist	Pharmacist	Physician Assistant	Physical Therapist	Occupation Therapist	Other
6%	46%	15%	10%	0%	13%	6%	4%
Gender							
Male	Female						
21%	79%						
Race							
African American	Asian	Caucasian	Hispanic	Pacific Islander	Other	Not Answered	
10%	2%	73%	0%	0%	4%	10%	
Years of Practice							
0-2 years	3-5 years	6-10 years	11-15 years	16-20 years	21 + years	Not Answered	
10%	15%	31%	21%	2%	19%	2%	

Pre-Survey (post) ATTITUDES QUESTIONNAIRE

Question-	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1.) Teams that do not communicate effectively significantly increase their risk of committing errors.	0%	0%	2%	15%	81% / (96%)
2.) Poor communication is the most common cause of reported errors.	0%	2%	10%	52%	33% / (60%)
3.) Adverse events may be reduced by maintaining an information exchange with patients and their families .	0%	2%	0%	60%	35% / (69%)
4.) I prefer to work with team members who ask questions about the information I provide.	0%	0%	8%	58%	33% / (69%)
5.) It is important to have a standardized method for sharing information when handing off patients.	0%	0%	8%	44%	46% / (63%)
6. It is nearly impossible to train individuals how to be better communicators .	33% / 44%	52% / 50%	6% / 4%	6% / 0%	0% / (2%)

Post workshop Survey



**Name one thing that will help you
communicate about your patients'
safety:**

Speak -up

I am more confident now than I was in implementing the Bundle

46% Strongly Agree

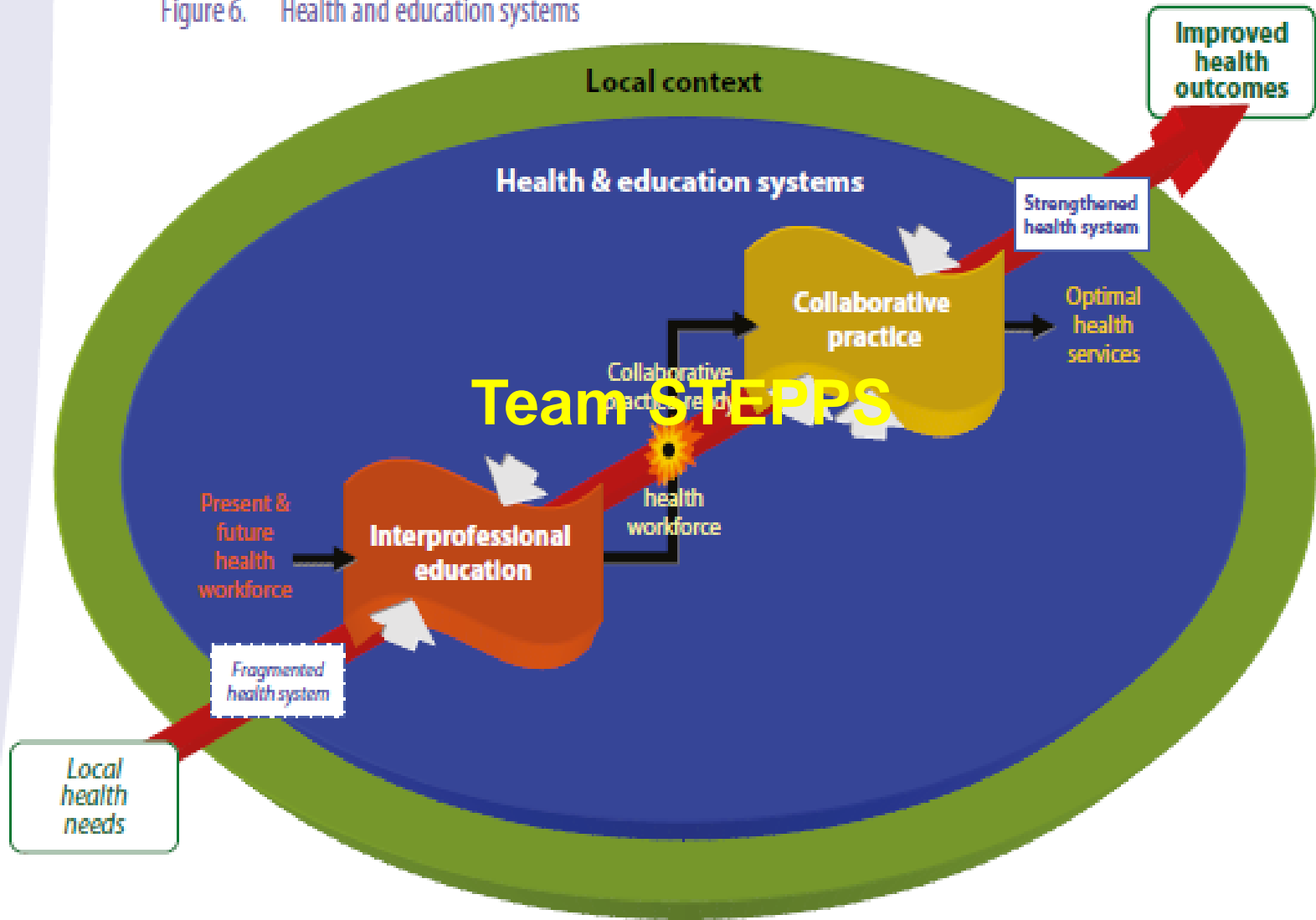
48% Agree

I am more confident now than I was before in communicating about my patients' safety.

40% Strongly Agree

50% Agree

Figure 6. Health and education systems



Landing on the Hudson



Jefferson Center for InterProfessional Education

http://www.jefferson.edu/university/interprofessional_education.html

