Creating a Culture of Patient Safety: Session 4

Carla Snyder, MHA, MT(ASCP)SBB, CPHQ
Emily Barr, OTD, MBA, OTR/L, BCG

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Objectives

- Identify the foundational tenets of the TeamSTEPPS curriculum targeted towards patient safety
- Explain how TeamSTEPPS can enhance communication and teamwork among healthcare professionals
- Describe AHRQ's Surveys on Patient Safety Culture® (SOPS) and how they are used within organizations
- Evaluate a case study on a SOPS survey to determine areas of improvement related to quality, safety, effectiveness, and efficiency

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About TeamSTEPPS

- **Team S**trategies & **T**ools to **E**nhance **P**erformance and **P**atient **S**afety
- TeamSTEPPS is an evidence-based framework to optimize team performance across the health care delivery system
- Provides higher quality and safer patient care
- Follows a three-phased process for creating and sustaining a culture of safety
  - Pre-training assessment for site readiness
  - Training for onsite trainers and health care staff
  - Implementation and sustainment
- Specific curriculum with easy-to-use tools

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Framework and Competencies

Team Competency Outcomes

Knowledge
- Shared Mental Model

Attitudes
- Mutual Trust
- Team Orientation

Performance
- Adaptability
- Accuracy
- Productivity
- Efficiency
- Safety

Pocket Guide: TeamSTEPPS. Content last reviewed January 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

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Key Principles

- Team Structure
  - *Identification of the components of a multi-team system that must work together effectively to ensure patient safety*
- Communication
  - *Structured process by which information is clearly and accurately exchanged among team members*
- Leadership
  - *Ability to maximize the activities of team members by ensuring that team actions are understood, changes in information are shared, & team members have the necessary resources.*
- Situation Monitoring
  - *Process of actively scanning and assessing situational elements to gain information or understanding, or to maintain awareness to support team functioning*
- Mutual Support
  - *Ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload*

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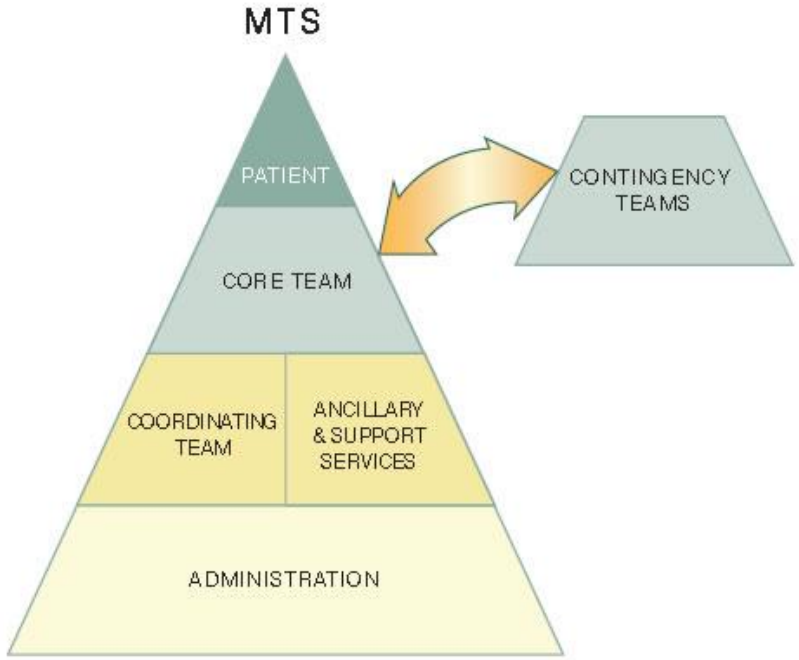
Team Structure



Multi-Team System for Patient Care

Safe and efficient care involves the coordinated activities of a multi-team system

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Communication

- SBAR
  - *A technique for communicating critical information that requires immediate attention and action concerning a patient's condition*
- Call-Out
  - *Strategy used to communicate important or critical information*
- Check-Back
  - *Using closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended*
- Handoff
  - *The transfer of information (along with authority and responsibility) during transitions in care across the continuum. It includes an opportunity to ask questions, clarify, and confirm*

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Leadership

- Effective leaders
- Team Events
  - Sharing the Plan
    - Brief: *short session prior to start to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, anticipate outcomes and likely contingencies*
  - Monitoring and Modifying the Plan
    - *Huddle: Ad hoc meeting to re-establish situational awareness, reinforce plans already in place, and assess the need to adjust the plan*
  - Reviewing the Team's Performance
    - *Debrief: Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors*

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Leadership

Debrief Checklist

___ *Was communication clear?*
___ *Were roles and responsibilities understood?*
___ *Was situation awareness maintained?*
___ *Was workload distribution equitable?*
___ *Was task assistance requested or offered?*
___ *Were errors made or avoided?*
___ *Were resources available?*
___ *What went well?*
___ *What should improve?*

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Situation Monitoring

Status of the Patient

Team Members

Environment

Progress Toward Goal

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Mutual Support

- Task Assistance
  - *Helping others with tasks builds a strong team*
- Feedback
  - *Information provided to team members for the purpose of improving team performance*
- Advocacy and Assertion
  - *Advocate for the patient and assert a corrective action in a firm and respectful manner*
- Two-Challenge Rule
  - *Empowers all team members to "stop the line" if they sense or discover an essential safety breach*
- CUS

  I am Concerned!

  I am Uncomfortable!

  This is a Safety Issue!

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TeamSTEPPS Teamwork Perceptions Questionnaire

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/reference/teampercept.pdf

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Surveys on Patient Safety Culture®

- Purpose is to advance our scientific understanding of patient safety culture in healthcare
- Available settings

Topics Covered by the SOPS Hospital Survey 2.0

Composite Measures: A composite measure is a grouping of two or more survey items that assess the same area of culture. The 10 composite measures and 32 survey items assessed in the SOPS Hospital Survey 2.0 are:

- Teamwork (3 items)
- Staffing and Work Pace (4 items)
- Organizational Learning – Continuous Improvement (3 items)
- Response to Error (4 items)
- Supervisor, Manager, or Clinical Leader Support for Patient Safety (3 items)
- Communication About Error (3 items)
- Communication Openness (4 items)
- Reporting Patient Safety Events (2 items)
- Hospital Management Support for Patient Safety (3 items)
- Handoffs and Information Exchange (3 items)

Additional Measures: In addition to the composite measures, single item measures included assess:

- Number of events reported (1 item)
- Patient safety rating (1 item)
- Background questions (4 items)

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Surveys on Patient Safety Culture®

- Using the AHRQ Surveys on Patient Safety Culture
- Relating SOPS Patient Safety Culture Survey Data to Outcomes
  - “Hospital units with more positive SOPS scores had: 1) fewer hospital-acquired pressure ulcers and falls, 2) lower surgical site infection rates”.
  - “Hospitals with more positive SOPS scores had: 1) lower rates of in-hospital complications or adverse events as measured by AHRQ’s patient safety indicators, 2) Patients who reported more positive experiences with care”.

What Is Patient Safety Culture?. Content last reviewed March 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/sops/about/patient-safety-culture.html

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Surveys on Patient Safety Culture® Case Study

AHRQ Tools Improve Care, Safety for St. Luke's University Health Network Obstetric Patients

November 2019

"St. Luke's University Health Network—a non-profit, integrated network providing services at nine hospitals and more than 300 sites in Pennsylvania and New Jersey—is improving the culture of safety in its obstetrics (OB) units by using a combination of AHRQ's Surveys on Patient Safety Culture™ Hospital Survey (HSOPS) and TeamSTEPPS®. The network also used elements of AHRQ's Comprehensive Unit-based Safety Program (CUSP) and Toolkit for Reducing Central Line-Associated Blood Stream Infections (CLABSI) in developing a CLABSI checklist to improve care in the neonatal intensive care unit (NICU).

Initially, the OB unit—a high-risk area—was the focus for improvement efforts. Using the AHRQ hospital culture survey beginning in 2008 with OB staff allowed St. Luke's to discover opportunities to improve teamwork and communications. Because management found the survey produced valuable information, they expanded the survey to include all staff members in the network."

AHRQ Tools Improve Care, Safety for St. Luke's University Health Network Obstetric Patients. Content last reviewed November 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/news/newsroom/case-studies/201906.html

Surveys on Patient Safety Culture® Case Study

“Armed with survey data, the health system then launched TeamSTEPPS training for its employees. TeamSTEPPS, developed jointly by AHRQ and the Department of Defense, is an evidence-based set of teamwork tools aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare professionals.

As a result of the TeamSTEPPS training and new procedures, the OB staff’s views of the hospital’s safety culture improved significantly. For example, the staff’s overall perception of safety jumped from 45 percent positive in 2008 to 81 percent positive in 2014 on HSOPS.”

AHRQ Tools Improve Care, Safety for St. Luke’s University Health Network Obstetric Patients. Content last reviewed November 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/news/newsroom/case-studies/201906.html

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Surveys on Patient Safety Culture® Case Study

“During the past decade, St. Luke’s has addressed a wide range of safety issues related to obstetric care. These efforts have succeeded in decreasing its early elective delivery rate from 17 percent in 2008 to zero in 2015. NICU admissions were also reduced, thus improving infants’ outcomes. As a result, the NICU realized approximately $79,000 in direct cost savings.

Leadership from two campuses, St. Luke’s Allentown and Bethlehem Hospitals, both of which have OB units, participated in bimonthly meetings early on to ensure a standardized approach to improvement, according to Kathy Nunemacher M.S.N., R.N., St. Luke Health Network’s director of data governance and reporting. At the time of the initiative, she served as the coordinator for clinical quality improvement in the women’s and children’s and oncology service lines.

‘We kept leaders and staff in the loop with a variety of communications methods: our OB performance improvement committee, grand rounds, unit meetings, and administrative and department meetings,’ she said.”

AHRQ Tools Improve Care, Safety for St. Luke’s University Health Network Obstetric Patients. Content last reviewed November 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/news/newsroom/case-studies/201906.html

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Surveys on Patient Safety Culture® Case Study

“Sharing hospital culture survey data from AHRQ’s HSOPS helped encourage OB teams to make positive changes, Nunemacher explained. Hospital leaders assembled monthly team meetings with PowerPoint presentations, held management meetings with updates, and reported standings on HSOPS results during TeamSTEPPS training to show before-and-after scores once TeamSTEPPS training was implemented.

Nunemacher said the St. Luke’s OB team customized and continues to use the following elements to maximize patient safety:

- Operational/management initiatives:
  - An algorithm to manage Category II fetal heart rate patterns.
  - OB hemorrhage task force.
  - Designation of OB clinical risk manager.
- Classes/training:
  - “My elearning” TeamSTEPPS classes.
  - Revised prenatal class curriculum.
  - Simulation training program for the entire care team.
- Checklists/guidelines:
  - Preeclampsia guidelines.
  - Nursing documentation checklists.”

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“Nunemacher noted that system leaders use HSOPS to give feedback to staff on their areas of strength and weakness. As a result of the positive experience in the OB units, St. Luke’s network has trained all inpatient and some outpatient staff members on TeamSTEPPS principles. This practice helps the entire staff remain focused on improving safety and sustaining improvement in the safety culture, she explained.

“TeamSTEPPS is now part of all of our new hire orientation,” Nunemacher said. “It has been particularly rewarding to see teams throughout the hospital customize the TeamSTEPPS curriculum to make it relevant to their respective clinical areas, such as new resident orientation.

“Our goal now is to roll out TeamSTEPPS refresher classes to all campuses, including our newly acquired campuses. A tenth hospital campus is planned to open in late 2019.”

AHRQ Tools Improve Care, Safety for St. Luke’s University Health Network Obstetric Patients. Content last reviewed November 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/news/newsroom/case-studies/201906.html

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Reflection, Discussion, Q&A

What is something new you learned today?

How are Just Culture, TeamSTEPPS, and the Surveys on Patient Safety Culture® intertwined?

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References

- AHRQ Tools Improve Care, Safety for St. Luke's University Health Network Obstetric Patients. Content last reviewed November 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/news/newsroom/case-studies/201906.html https://www.ahrq.gov/news/newsroom/case-studies/201906.html
- Pocket Guide: TeamSTEPPS. Content last reviewed January 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html
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Post Session Zoom Survey

Please respond to the following statements whose responses are formatted with the Likert scale of strongly disagree to strongly agree.

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Thank You

"Alone we can do so little; together we can do so much"- Helen Keller

"You need to be aware of what others are doing, applaud their efforts, acknowledge their successes, and encourage them in their pursuits. When we all help one another, everybody wins"- Jim Stovall

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