TeamSTEPPS 2.0 | Introduction

TeamSTEPPS 2.0 Pocket Guide

- ✓ Search for "teamstepps 2.0" in the App Store
- ✓ Install the TeamSTEPPS Pocket Guide on your phone

Know the plan, share the plan, review the risks

TeamSTEPPS 2.0

Team Strategies and Tools to Enhance Performance and Patient Safety

AHRQ Agency for Healthcare Research and Quality

DHA

TeamSTEPPS 2.0 | Introduction

Acknowledgements

- This workshop is supported by the Nebraska Association for Healthcare Quality, Risk, and Safety
- All TeamSTEPPS materials are **freely available to the public** from https://www.ahrq.gov/teamstepps/instructor/index.html

TeamSTEPPS is NOT a product sold by a vendor; it is an evidence-based team training curriculum.

TeamSTEPPS 2.0 | Introduction

Announcements

Housekeeping

- Cell phones on vibrate
- Rest rooms
- Ask Questions!

Agenda

1:00 – 2:15	Active Learning about Leadership Skills
2:15 – 2:30	Communication
2:30 – 2:45	BREAK
2:45 – 3:45	Situation Monitoring and Mutual Support
3:45 – 4:00	Implementation and Wrap Up

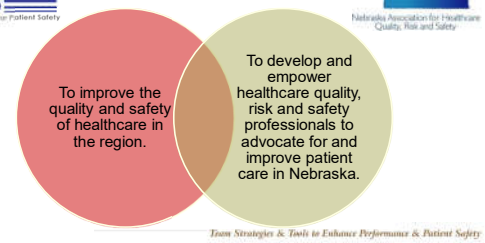
TeamSTEPPS 2.0 | Introduction

Introduction and Connection

"Hello! My name is Katherine Jones, I'm a physical therapist, health services researcher, and President of the Board of Directors of NCPS."

NCPS Nebraska Coalition for Patient Safety

NAHQRS Nebraska Association for Healthcare Quality, Risk and Safety



TeamSTEPPS 2.0 | Introduction

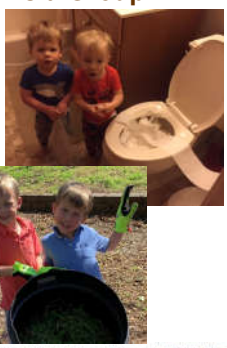
Expectations

1. Define a "team" and "team structure."
2. Explain the theory/rationale that supports the use of teamwork to manage complexity and improve staff resilience/team performance.
3. Practice using TeamSTEPPS® leadership strategies and tools to overcome barriers to team performance and improve staff resilience and patient safety.
4. Integrate TeamSTEPPS® strategies and tools for leadership, situation monitoring, mutual support and communication into a teamwork system that promotes psychological safety and organizational learning.

TeamSTEPPS 2.0 | Introduction

What Defines a Team vs a Group?

- Two or more people
- Interact dynamically, interdependently, and adaptively
- Toward a common and valued goal (14% of team function)
- Have complementary skills and specific roles or functions (12% of team function)



Salas et al. Does team training work? Principles for health care. Acad Emerg Med. 2008; 15:1-8.

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TeamSTEPPS 2.0 | Introduction

What is TeamSTEPPS™?

Team Strategies and Tools to Enhance Performance and Patient Safety

- An evidence-based **teamwork system** based on 40 years of research and implementation ("teamstepps AND evidence" in PubMed yields 59 publications)
- Principles, strategies, teachable tools designed to improve
  - ✓ Safety
  - ✓ Quality
  - ✓ Efficiency of health care

  Our Performance
- Practical and adaptable…a foundation for interprofessional education and practice

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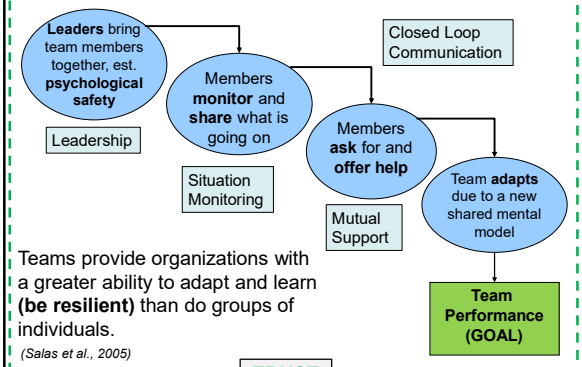
The Theory Behind the Training



Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

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TeamSTEPPS 2.0 | Leadership

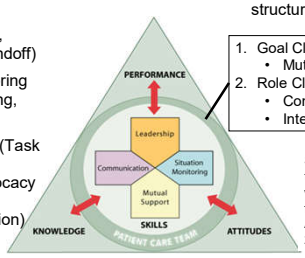
What will you learn?

4 Categories of Strategies and Tools

1. Leadership (Briefs, Huddles, Debriefs)
2. Communication (SBAR, Call-out, Checkback, Handoff)
3. Situation Monitoring (Cross-Monitoring, STEP)
4. Mutual Support (Task Assistance, Feedback, Advocacy and Assertion, Conflict Resolution)

Team Structure

Teamwork requires a clearly defined team structure



1. Goal Clarity
   - Mutual Accountability
2. Role Clarity
   - Complementary Skills
   - Interdependent Tasks

Salas et al. Does team training work? Principles for health care. Acad Emerg Med. 2008; 15:1-8.

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TeamSTEPPS 2.0 | Introduction

Why Learn Teamwork?

- Team skills must be trained
- Teams that communicate effectively and back each other up reduce the frequency and risk of human error
- Teams are better able to use information, people, and resources than individuals
- Teams are the fundamental unit of learning in organizations
- Teams are a safety net for fallible human beings caring for complex patients in complex systems

Salas, Sims, Burke. Is there a "Big Five" in teamwork? Small Group Research. 2005; 36:555-599.
Edmondson AC. Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy. San Francisco: John Wiley & Sons; 2012.

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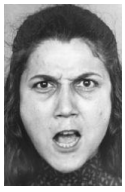
TeamSTEPPS 2.0 | Introduction

Why Learn Teamwork?

How humans think (cognitive bias) leads to human error

Individual humans have two ways of thinking and paying attention to stimuli in the world around them (we allocate our attention to two systems)

- System 1—Thinking fast…automatic, fast, no effort, no sense of voluntary control (low effort)
- System 2—Thinking slow…conscious decision to allocate attention to a specific mental activity (high effort) that can make us blind to other stimuli
- All decision-makers maker errors due to cognitive bias
- ¾ of diagnostic errors may be due to cognitive bias



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x 24

Kahneman D. Thinking Fast and Slow. New York: Farrar, Straus and Giroux, 2011.

O'Sullivan ED, Schofield SJ. Cognitive bias in clinical medicine. J R Coll Physicians Edinb. 2018; 48: 225–232.

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TeamSTEPPS 2.0 | Introduction

Example of Human Error (Task Fixation/Inattentional Blindness)

The Monkey Business Illusion - YouTu

Chabris C & Simons D. The Invisible Gorilla: How Our Intuitions Deceive Us. New York: Random House; 2010.

Kahneman D. Thinking Fast and Slow. New York: Farrar, Straus and Giroux, 2011.

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TeamSTEPPS 2.0 | Introduction

Humans in Organizations...

How we think...

- Fixate on a task
- Focus on one piece of information
- Focus on what was heard most recently
- Make decisions to avoid risk not to achieve a gain
- Make decisions based on context
- Prefer the simple answer

(Kahneman, 2011)

Faulty thinking in organizations leads to...

- Individuals working alone make errors when
  - executing known tasks
  - making judgments
- Individuals working in teams make errors when
  - coordinating and communicating with each other
  - designing their systems

TeamSTEPPS 2.0 | Introduction

Organizational Errors

	Individuals	Groups/Teams
High Certainty	**Task Execution**: Individuals perform well understood, routine tasks at risk of slips and lapses **Task Error Example:** Staff forget to conduct the 7 rights of medication administration	**Coordination:** Groups of people share well-understood information **Coordination Error Example:** Information about changes in the schedule not shared
Low Certainty	**Judgment**: Individuals perform unfamiliar processes that require decision-making; risk mistakes in applying rules and knowledge **Judgment Error Example:** Staff are unsure how to manage orthostatic hypotension, when to leave a patient alone in the bathroom	**System Interaction:** Multiple people involved in activity **System Error Example:** Lack of policy/procedures to conduct briefs, huddles, debriefs to establish plans, adjust plans, and learn from experience

(MacPhail & Edmondson, 2011)

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TeamSTEPPS 2.0 | Introduction

Summary: Barriers to Team Performance and Patient Safety (see Pocket Guide)

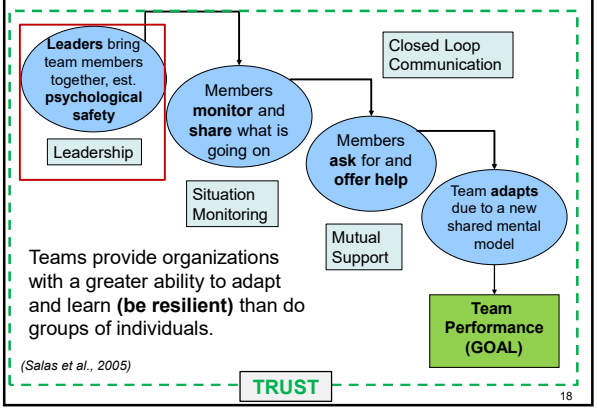
- Inconsistency in team membership
- Lack of time
- Lack of information sharing (feedback)
- Hierarchy (fear of speaking up)
- Defensiveness
- Conventional thinking
- Complacency
- Varying communication styles
- Conflict
- Lack of coordination and follow-up
- Distractions
- Fatigue
- Unmanaged workload
- Misinterpretation of cues
- Lack of goal and role clarity

TeamSTEPPS 2.0 | Introduction

Think, Pair, Share…

- Think about your work as a team member in your facility...
  - ✓ What are the biggest **barriers to teamwork?**
  - ✓ Do errors occur because **individuals** make task and judgement errors?
  - ✓ Do errors occur because the **organization** hasn't identified when to use briefs to plan, huddles to adjust the plan, and debriefs to learn?
  - ✓ Discuss your thoughts with the person next to you?
- Share with the full group

Leaders Start the Teamwork



Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

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TeamSTEPPS 2.0 | Leadership

Leaders

- Continuously monitor the situation
- Initiate team meetings (briefs, huddles, debriefs)
  - ✓ Create an environment in which team members feel psychological safe to speak up about what is going on and to seek/offer task assistance
  - ✓ Ensure goals and roles are clear, tasks are delegated

- Manage resources
- Provide feedback for improvement

TeamSTEPPS 2.0 | Leadership

Two Types of Team Leaders

- **Designated** – The person assigned to lead and organize a team, establish clear goals, and facilitate open communication and teamwork among team members
- **Situational** – Any team member who has the skills to manage the situation at hand

Think back to the Tower Building Exercise...
- **There was no designated leader**
- **Did a situational leader emerge?**
- **How did absence of leadership affect performance?**

Effective Leaders

Leadership

- Conduct three types of team meetings
  1. Brief: short, planned meeting to share the plan and organize the team
     - ✓Clarify goals, roles, and responsibilities (delegate)
     - ✓Anticipate needs, establish contingencies, manage resources
     - ✓Know the plan, share the plan, review the risks
  2. Huddle: ad hoc meeting to monitor and adjust the plan
     - ✓Share information from individual situation monitoring
     - ✓Provide opportunities to seek and offer task assistance
  3. Debrief: planned or ad hoc meeting to review the plan and team performance after event
     - ✓Review what happened, why it happened (regarding task AND teamwork)
     - ✓Decide what will be done differently for a patient, what to apply to system
     - ✓Provide feedback and resolve conflict
- Create psychological safety and role model team behaviors and language

Be the change you want to see!

TeamSTEPPS 2.0 | Leadership

Brief to Share Plan

"Know the plan, share the plan, review the risks."

Brief Checklist

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

- ☐ Who is on the team?
- ☐ Do all members understand and agree upon goals?
- ☐ Are roles and responsibilities understood?
- ☐ What is our plan of care?
- ☐ What is staff and provider's availability throughout the shift?
- ☐ How is workload shared among team members?
- ☐ What resources are available?
- ☐ What are the risks?

TeamSTEPPS 2.0 | Leadership

Leading Teams…View a Brief

✓ Up next: Video from the long-term care setting.
Internet Citation: Agency for Healthcare Research and Quality. TeamSTEPPS Leadership Briefing (Long-Term Care). Content last reviewed April 29, 2015. Available at: https://www.youtube.com/watch?v=bRV-EEHZV10

✓ During the video think about how the designated leader
1. Starts the brief ("Today we are at full census....")
2. Clarifies roles and responsibilities
3. Delegates tasks ("Alicia, can you call the kitchen...?")
4. Creates awareness of a problem (Mrs. Smith was up for most of the night)
5. Creates psychological safety by using structure, thanking team members who respond, welcoming when a team member speaks up ("Yes, Mrs. Smith was found wandering last night....")

TeamSTEPPS 2.0 | Leadership

Leadership Reflection...Brief

What is the goal?	Tool Used?	What are the results?
To organize the team for the day	Brief	• All staff know they are at full census and not expecting admissions or discharges • All staff know Mr. Vega's family is taking him to the Dr. and Alicia is obtaining bagged lunch for him • All staff know Mrs. Smith's status has changed and she may have a UTI • Conducting the brief in an atmosphere of psychological safety created a shared mental model of the needs of the residents and contributed to team orientation and mutual trust

How can you use briefs in your setting to better organize your team?

TeamSTEPPS 2.0 | Leadership

Huddle to Monitor & Modify the Plan

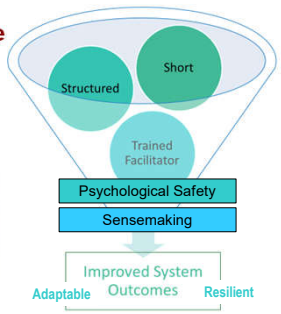
- An ad hoc, "touch base" meeting
- Called by anyone who recognizes the need to re-establish situation awareness (i.e. situational leader)
- Express concerns
- Discuss critical issues/emerging events
- Anticipate outcomes and contingencies
- Re-assign roles and tasks
- Assign resources

Leadership

Effective Debriefs

Debrief to Review Performance and Improve System Outcomes

"What went well? What didn't go well? What will we do differently next time?"

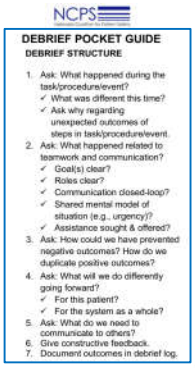


(Allen et al., 2018; Edmondson, 2012; Smith-Jentsch et al., 1998; Smith-Jentsch et al., 2008; Tannenbaum & Cerasoli, 2013)

Leadership

Pocket Guide to Structure Debriefs

Available at: https://www.nepatientsafety.org/resources-tools/

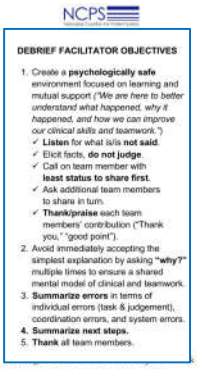


NCPS

DEBRIEF POCKET GUIDE

DEBRIEF STRUCTURE

1. Ask: What happened during the task/procedure/event?
   - ✓ What was different this time?
   - ✓ Ask why regarding unexpected outcomes of steps in task/procedure/event.
2. Ask: What happened related to teamwork and communication?
   - ✓ Goal(s) clear?
   - ✓ Roles clear?
   - ✓ Communication closed-loop?
   - ✓ Shared mental model of situation (e.g., urgency)?
   - ✓ Assistance sought & offered?
3. Ask: How could we have prevented negative outcomes? How do we duplicate positive outcomes?
4. Ask: What will we do differently going forward?
   - ✓ For this patient?
   - ✓ For the system as a whole?
5. Ask: What do we need to communicate to others?
6. Give constructive feedback.
7. Document outcomes in debrief log.



NCPS

DEBRIEF FACILITATOR OBJECTIVES

1. Create a **psychologically safe** environment focused on learning and mutual support (*"We are here to better understand what happened, why it happened, and how we can improve our clinical skills and teamwork."*)
   - ✓ **Listen** for what is/is **not said**.
   - ✓ Elicit facts, **do not judge**.
   - ✓ Call on team member with **least status to share first.**
   - ✓ Ask additional team members to share in turn.
   - ✓ **Thank/praise** each team members' contribution ("Thank you," "good point").
2. Avoid immediately accepting the simplest explanation by asking **"why?"** multiple times to ensure a shared mental model of clinical and teamwork.
3. **Summarize errors** in terms of individual errors (task & judgement), coordination errors, and system errors.
4. **Summarize next steps.**
5. **Thank** all team members.

TeamSTEPPS 2.0 | Leadership

Leading Teams…View a Huddle and Debrief

✓ Up next: Video from the primary care setting.
Internet Citation: Leadership. Content last reviewed February 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/teamstepps/officebasedcare/2_leadership_good/index.html
Available at: https://www.youtube.com/watch?v=kefIIW7_DVo

✓ During the video think about:

1. How the leaders created psychological safety
2. The problem or breakdown that occurs
3. How a huddle was used to manage the problem
4. How a debrief was used to review team performance
5. The results of using the tools (resilience?)

TeamSTEPPS 2.0 | Leadership

Outpatient Leadership Reflection

What is the problem?	Tool Used?	What are the results?
Triage nurse calls in sick	Huddle Debrief	• Situational leader began the adaptation process • Designated leader set expectations, thanked, asked if everyone was attending debrief, asked open-ended questions, provided affirming feedback ("point taken") • The huddle allowed all team members to understand the plan to manage the workload so that patients were seen in a timely manner. • The debrief created a contingency plan for future times when a person calls in sick. • Conducting the huddle and debrief improved trust and adaptability/resiliency among the team and may have prevented patients from seeking emergency care.

How can you use huddles and debriefs in your setting to better manage changing workloads and learn from experience?

TeamSTEPPS 2.0 | Leadership

Debriefs Improve Team Performance

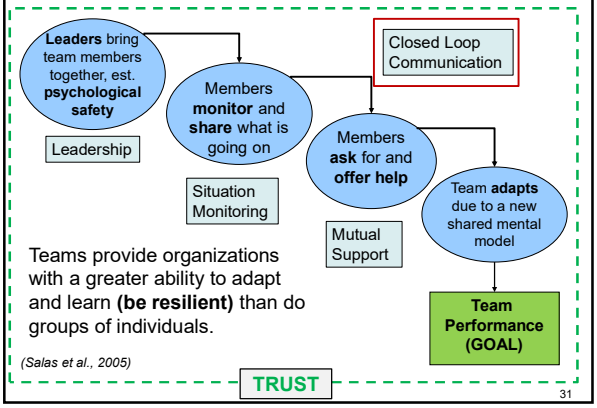
Review of 46 studies found:

- ✓ Conducting debriefs improved a team's performance by 25%
- ✓ Debriefs conducted by a trained facilitator were three times more effective than debriefs not conducted by a trained facilitator
- ✓ Highly structured debriefs were more effective than less structured debriefs...use the pocket guide to create psychological safety

Conclusion: Organizations can improve team performance by implementing structured debriefs conducted by trained facilitators who establish psychological safety.

(Tannenbaum & Cerasoli, 2013)

Closed Loop Communication Holds it all Together



Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

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TeamSTEPPS 2.0 | Communication

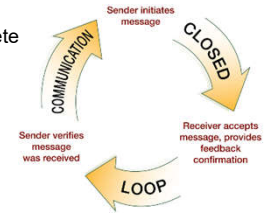
Communication is Verbal and Non-Verbal Information Exchange

SBAR
Call-out
Check-back
Handoff

Standards for effective communication...

- ✓ Structured
- ✓ Brief, clear, timely, complete
- ✓ Closed loop

- Improves and coordinates the teams performance
- Vital for patient safety and preventing conflict



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TeamSTEPPS 2.0 | Communication

Non-Verbal Communication from Body Language

"I'm not open to discussion" ... crossed arms, slouching, frowning, leaning too far forward, avoiding eye contact, overly intense

"I'm open to discussion" ... open arms and hands, respecting personal space, making eye contact, smiling

http://learnthat.com/6-worst-body-language-mistakes-you-can-make-in-an-interview/

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TeamSTEPPS 2.0 | Communication

SBAR: A technique for communicating information that requires immediate attention and action

Situation—What is going on?

Kerrie (PT): "Hi, John (RN). The situation is that I checked Mrs. Jones's orthostatic BP and her systolic pressure dropped by 25 mm Hg after 1 minute in standing."

Background—What is the background?

"I didn't see any changes in her medications. Is there anything else going on that would cause her BP drop so much when she stands?"

Assessment—Why is this important?

"Orthostatic hypotension is often missed as a fall risk factor. I don't want her to fall just before she is supposed to be discharged home."

Request—What needs to be done?

"Should we discuss this change with her doctor?"

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TeamSTEPPS 2.0 | Communication

Structured Communication…SBAR

✓ Up next: Video from the inpatient setting.
Internet Citation: TheTorontoRehab. SBAR: Effective Communication. Content last reviewed Sept. 17, 2010. Available at:
https://www.youtube.com/watch?v=fsazEArBy2g

✓ During the video think about:

1. The pharmacist's goal for the communication.
2. How did SBAR increase the likelihood that the provider had the information needed to respond to the pharmacist's recommendation?
3. How SBAR facilitated communication that was complete, clear, and timely.

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TeamSTEPPS 2.0 | Communication

Communication Reflection...SBAR

What is the problem?	Tool Used?	What are the results?
Patient's pain is not controlled, she is sedated and falling during rehabilitation.	SBAR	• Clear communication between the pharmacist to the physician regarding the problem and the pharmacist's recommendation. • Pharmacist and physician develop a plan (shared mental model) that seeks to improve patient safety and accommodate the patient's preference to go to the reunion. • The clear communication facilitates trust and adaptability between the pharmacist and physician.

Would communication be more brief, clear, and timely if your team used SBAR to structure verbal and written communication?

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TeamSTEPPS 2.0 | Communication

Call-Out: A technique for communicating important/critical information to multiple team members at the same time so they can anticipate next steps. The call-out is directed to the person who is responsible for carrying out the task.

Example from the inpatient obstetric setting. Available at: Labor and Delivery: Call-Out | Agency for Healthcare Research and Quality (ahrq.gov)

During the video think about:

1. Why the nurse directed her comments to Dr. Dean
2. How the call-out alerted team members to likely next steps.
3. How the call-out ensured a shared mental model of the nurse's sense of urgency.

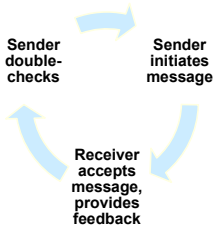
TeamSTEPPS 2.0 | Communication

Check-Back: Using closed-loop communication to ensure information conveyed by the sender is understood by the receiver as intended.

Kerrie (PT): "Hey, John (RN) I checked Mrs. Jones's orthostatic BP and her systolic pressure dropped by 25 mm Hg at 1 min after standing."

John: "I'll tell the rest of the team Mrs. Jones is having orthostatic hypotension when she stands."

Kerrie: "Yes, that's right. Be sure to provide hands on support with the gait belt. Should we talk to her doctor?"



TeamSTEPPS 2.0 | Communication

Handoff is…

The transfer of information, **responsibility, and accountability** during transitions in care across shifts and settings

- ✓ Includes an opportunity to ask questions, clarify, and confirm that the handoff is understood and accepted
- ✓ Best done face-face, verbally
- ✓ In contrast to SBAR, a hand-off addresses safety concerns and clarity about who owns or is accountable for what happens next

TeamSTEPPS 2.0 | Communication

Hand-off Tool: "I PASS THE BATON"

Introduction:	Introduce yourself and your role/job (include patient)
Patient:	Identifiers, age, sex, location
Assessment:	Present chief complaint, vital signs, symptoms, and diagnosis
Situation:	Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment
Safety:	**Critical lab values/reports, socioeconomic factors, allergies, and alerts (falls, isolation, pressure ulcers, etc.)**
THE	
Background:	Comorbidities, previous episodes, current medications, and family history
Actions:	What actions were taken or are required? Provide brief rationale
Timing:	**Level of urgency and explicit timing and prioritization of actions**
Ownership:	**Who is responsible (nurse/doctor/team)? Include patient/family responsibilities**
Next:	**What will happen next? What is the plan? What might change? Is there a contingency plan?**

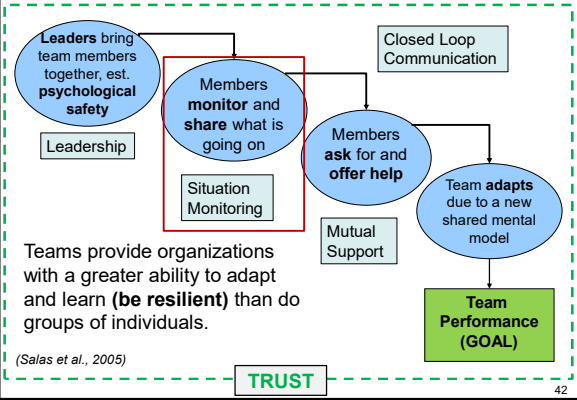
TeamSTEPPS 2.0 | Introduction

Think, Pair, Share…

- Think about a recent communication problem in your facility...
  - ✓ What were the **barriers to clear, brief, timely, closed-loop communication?**
  - ✓ Could use of SBAR, Call-Out Check-Back or I PASS the BATON have prevented the problem?
  - ✓ Discuss your thoughts with the person next to you?
- Share with the full group

Distractions
Personalities
Workload
Assumptions
History of conflict
Lack of verification

Situation Monitoring: What is Going On?



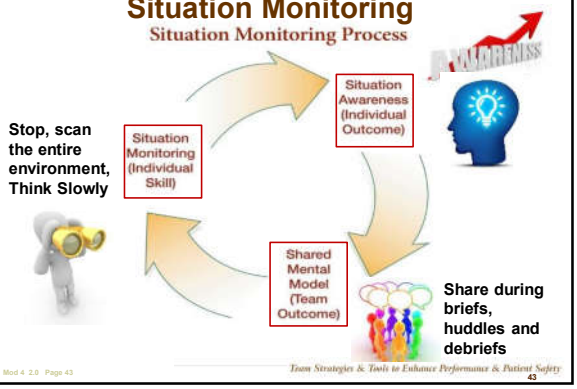
Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

TeamSTEPPS 2.0 | Situation Monitoring

Situation Monitoring

Situation Monitoring Process



TeamSTEPPS 2.0 | Situation Monitoring

Cross-Monitoring

- A process of ongoing monitoring in your environment to recognize risks and errors (individual and organizational)
- An opportunity to interrupt or correct an action, event, or the environment before there is harm to the patient or barriers to the team's goal
- "Watching each other's backs" as a safety net for human fallibility
- Providing feedback to ensure the procedures are being performed appropriately

"Mutual performance monitoring has been shown to be an important team competency."

McIntyre RM, Salas E. Measuring and managing for team performance: emerging principles from complex environments. In: Guzzo RA, Salas E, eds. Team effectiveness and decision making in organizations. San Francisco: Jossey-Bass; 1995. p. 9-45.

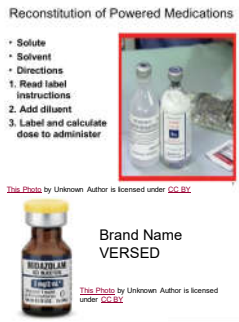
TeamSTEPPS 2.0 | Situation Monitoring

Why we need Cross-Monitoring

- Due to cognitive biases, different people often perceive the same situation differently
- Cross monitoring ensures
  - ✓ shared mental model of the environment
  - ✓ safety net for fallible team members

TeamSTEPPS 2.0 | Situation Monitoring

What Do You See?



Brand Name
VERSED

Laura (nurse mentee): RaDonda, I can see that you are reconstituting a medication.

RaDonda: "Yes, that's what the instructions say."

Laura: I thought the order was for Versed, which is midazolam. I don't think it is reconstituted. What drug do you have?

Recognize that cross monitoring is a safety net for human fallibility. Team members who cross monitor are supporting each other to improve their performance and patient safety.

TeamSTEPPS 2.0 | Situation Monitoring

Situation Monitoring

STEP

A tool for monitoring situations in the delivery of health care

Components of Situation Monitoring:

Status of the Patient or Project

Team Members

Environment

Progress Toward Goal

TeamSTEPPS 2.0 | Situation Monitoring

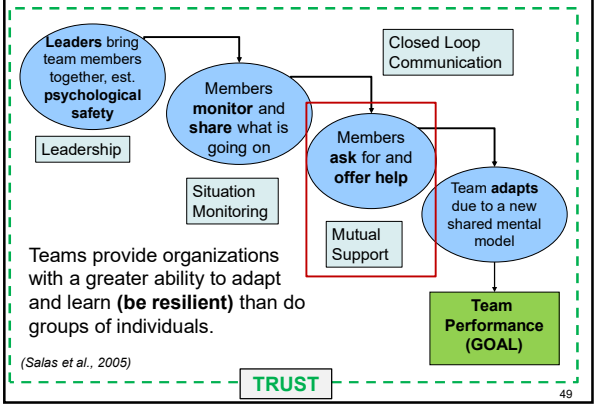
This Situation Wasn't Monitored

Setting: A busy Critical Access Hospital patient care unit.

Situation: Jane is new to the quality improvement position. She is working the floor, but is excited about a new project she has just started and wants to jot some ideas down for the QI team. She heads to the QI office, but doesn't tell the other 2 nurses (Doris and Mike) where she is going. She is only gone for 10 minutes. But, they needed help transferring a newly admitted patient from a gurney and couldn't find Jane. The other two nurses were angry with Jane for a week.

1. What was the status of the QI project? (urgent or not)?
2. Who was on the team at the time?
3. What was going on in the environment?
4. How could the team progress toward the goals of developing the QI project and managing the current workload?

Mutual Support: Essence of Teamwork



Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

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TeamSTEPPS 2.0 | Mutual Support

Mutual Support

Mutual support/back up behavior involves team members who:

1. Assist each other when work loads change...in support of patient safety, you are obligated to seek and offer task assistance. "I have 5 minutes, what can I do for you?"
2. Advocate for patients when patient safety is threatened (It's not who is right, but what is right for the patient). How can we feel safe speaking up?
3. Resolve conflict

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TeamSTEPPS 2.0 | Mutual Support

Mutual Support Tools

- Task Assistance—In support of patient safety, it is expected that assistance will be actively sought and offered.

  "I've got 5 minutes…what can I do for you?"
- Feedback for Improvement—should be timely, respectful, specific, and directed toward improvement.
- Advocacy and Assertion using the CUS Tool
- Resolve Conflict using DESC Script

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TeamSTEPPS 2.0 | Mutual Support

Feedback

- Was this feedback using SBAR
  - ✓ Timely and respectful?
  - ✓ Specific and directed toward improvement?
- ✓ What situations in your facility can most benefit from improved feedback?

Situation—*"Hi, Sally. I found Mrs. Jones trying to get up from the chair, so I grabbed the gait belt and walker and helped her. She said she asked you 20 minutes ago and you said you busy but would be back."*

Background—*"I know it's been a busy day. Remember in the team training, we talked about feedback and watching each others' backs?"*

Assessment—*"We all get overwhelmed at times, so don't be afraid to ask for help so we can keep our patients safe.*

Request—*"Let's ask the charge nurse about regularly calling huddles.*

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TeamSTEPPS 2.0 | Mutual Support

Advocacy and Assertion: CUS

Mod 4 2.0 Page 53 | Team Strategies & Tools to Enhance Performance & Patient Safety

TeamSTEPPS 2.0 | Mutual Support

Advocacy and Assertion: CUS

- Remember how John used a **Check-Back** to communicate that he would tell the rest of the team about Mrs. Jones's orthostatic BP? What if?

Kerrie (PT): "Hey, John, I checked Mrs. Jones's orthostatic BP. Her systolic pressure dropped by 25 mm Hg after 1 minute in standing."

John (RN): "I think she's just a little dehydrated."

Mary: "I'm concerned because 25 mm is a lot after 1 minute.

John: "She's getting ready to go home later today."

Mary: "I'm uncomfortable sending her home if we don't know what's causing her BP to drop when she stands. This is a safety issue."

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TeamSTEPPS 2.0 | Mutual Support

Conflict Resolution: DESC Script

A constructive approach for managing and resolving conflict:

D — **Describe** the specific situation **(When you…)**

E — **Express** your concerns about the action **(I feel…)**

S — **Suggest** other alternatives **(I suggest…)**

C — **Consequences** should be stated **(If not…)**

TeamSTEPPS 2.0 | Mutual Support

Conflict Resolution: DESC Script

Tips for Success

- Write out your DESC to remove emotion and address critical issues
- DESC should be timely and shared in a private setting
- Frame the conflict from your own experience by using "I" statements to minimize defensiveness
- Avoid blaming statements
- **Focus on what is right for the patient and not who is right**

TeamSTEPPS® | Mutual Support

DESC The Quality Project Conflict

Recall that the other nurses were frustrated that Jane left the floor without telling them so she could work on the QI project. How can Doris and Mike use the DESC Script to resolve this conflict with Jane?

Describe: Jane, you left a busy patient-care unit for non-urgent work.

Express: We needed your help for a transfer and didn't know where you were.

Suggest alternatives: In the future, monitor how busy we are and if you think you need to leave the floor, call a quick huddle so the team can discuss.

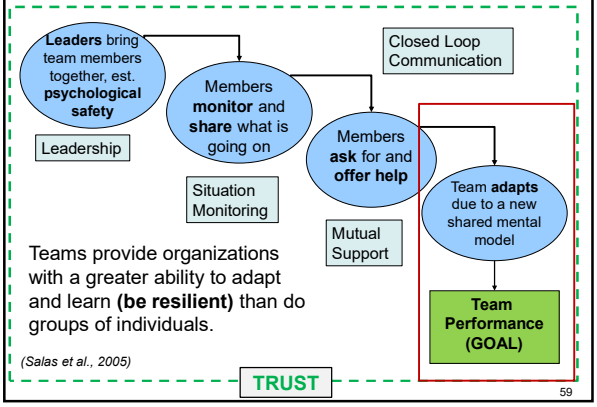
Consequences: If we don't monitor what is going on around us, we can't back each other up and prevent work overload and mistakes.

TeamSTEPPS® | Mutual Support

Tools & Strategies Summary

BARRIERS	TOOLS and STRATEGIES	OUTCOMES
■ Inconsistency in Team Membership ■ Lack of Time ■ Lack of Information Sharing ■ Hierarchy ■ Defensiveness ■ Conventional Thinking ■ Complacency ■ Varying Communication Styles ■ Conflict ■ Lack of Coordination and Followup With Coworkers ■ Distractions ■ Fatigue ■ Unmanaged Workload ■ Misinterpretation of Cues ■ Lack of Goal and Role Clarity	Leading Teams • Brief • Huddle • Debrief Communication • SBAR • Call-Out • Check-Back • Handoff Situation Monitoring • Cross Monitoring • STEP Mutual Support • Task Assistance • Feedback • CUS • DESC Script	■ Shared Mental Model ■ Adaptability ■ Team Orientation ■ Mutual Trust ■ Team Performance ■ *Patient Safety!!*

Conclusion



Teams provide organizations with a greater ability to adapt and learn **(be resilient)** than do groups of individuals.

(Salas et al., 2005)

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TeamSTEPPS 2.0 | Leadership

Team Meetings Improve Team Performance by Improving Resilience

- Resilience—ability to manage complexity, adapt to changing conditions
- Resilience requires ability to plan and anticipate (brief), monitor and respond (huddle), and learn from experience (debrief)
- Review of 36 studies found the following support resilience:
  - ✓ Frequently exchanging information between experts and novices
  - ✓ Combining perspectives of different team members
  - ✓ Using protocols and checklists
  - ✓ Creating a shared mental model of work as imagined (the policy/procedure) vs work as actually done

Conclusion: Implementing briefs, huddles, and debriefs are key strategies to improve organizational resilience in response to internal and external challenges. *(Iflaifel et al, 2020; Hollnagel et al., 2006)*

TeamSTEPPS 2.0

Leadership

Organizational Resilience Requires Psychological Safety

- Psychological safety: "A climate in which people feel free to express relevant thoughts and feelings."
- Biggest determinant of the success of team meetings is the extent to which team members feel free to speak up
- Team leaders create psychological safety
  - By using a structured format to conduct team meetings
  - By setting expectations... "We are here to...
  - Calling on team members to share ...
  - Being non-judgmental ... "What do we think?"
  - Praising participation, accepting/affirming feedback ("point taken", summarizing and thanking

Conclusion

Everything is awesome when you are part of a team!

- Teamwork is the best safety net we have for being a fallible human being
- Teamwork requires leaders to conduct effective team meetings (briefs, huddles, and debriefs) that establish psychological safety so team members speak up
- When team members speak up (situation monitoring), seek/offer support then the team is resilient (manages complexity, adapts, learns) and organizations learn

VE = Versed
VE = Vecuronium

Next Steps…Who, What, When

- Your facility must decide whether implementing effective team meetings is how you will begin to improve psychological safety and resilience
- Designated leaders (providers, managers) must decide whether they will learn to conduct effective team meetings (briefs, huddles, debriefs)
- If these decisions are made, then the organization must:
  - ✓ Restructure the organization to ensure staff learn the tools by providing additional training, reminders (e.g. pocket guides and forms), and feedback
  - ✓ Clarify roles and responsibilities...hold leaders accountable for conducting briefs, huddles, and debriefs
  - ✓ Routinize the use of the tools by changing policy/procedure, job descriptions, performance appraisals to include use of the tools

(Rogers, 2003)

TeamSTEPPS 2.0

Conclusion

Debrief

What went well during this training? Did we meet expectations? (Ask the person next to you)!

1. Define a "team" and "team structure."
2. Explain the theory/rationale that supports the use of teamwork to manage complexity and improve staff resilience/team performance.
3. Practice using TeamSTEPPS® leadership strategies and tools to overcome barriers to team performance and improve staff resilience and patient safety.
4. Integrate TeamSTEPPS® strategies and tools for leadership, situation monitoring, mutual support and communication into a teamwork system that promotes psychological safety and organizational learning.

What didn't go well?

What should I do differently next time?

Nebraska Coalition for Patient Safety

Thank you!

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