Video Discussion

- How are residents harmed as a result of medical errors?
- How can we prevent medical errors?
- What are the solutions?

...Improved teamwork and communications...
Ultimately, a culture of safety

Objectives

- Describe the TeamSTEPPS training initiative
- Explain resident safety in your nursing home
- Describe the impact of errors and why they occur
- Describe the TeamSTEPPS framework
- State the outcomes of the TeamSTEPPS framework

Teamwork Is All Around Us
Evolution of TeamSTEPPS

Curriculum Contributors

- Department of Defense
- Agency for Healthcare Research and Quality
- Research Organizations
- Universities
- Medical and Business Schools
- Quality Improvement Organizations
- Nursing Homes
- Hospitals—Military and Civilian, Teaching and Community-Based
- Healthcare Foundations
- Private Companies
- Subject Matter Experts in Teamwork, Human Factors, and Crew Resource Management (CRM)

"Initiative based on evidence derived from team performance... leveraging more than 25 years of research in military, aviation, nuclear power, business and industry... to acquire team competencies"
The Components of Resident Safety

Course Agenda

- Module 1—Introduction
- Module 2—Team Structure
- Module 3—Leadership
- Module 4—Situation Monitoring
- Module 5—Mutual Support
- Module 6—Communication
- Module 7—Summary—Pulling It All Together

Introductions and Exercise: Magic Wand

If I had a “Magic Wand” and could make changes within my unit or facility in the areas of resident quality and safety...
Why Do Errors Occur—Some Obstacles

- Workload fluctuations
- Interruptions
- Fatigue
- Multitasking
- Failure to follow up
- Poor handoffs
- Ineffective communication
- Not following protocol
- Excessive professional courtesy
- Halo effect
- Passenger syndrome
- Hidden agenda
- Complacency
- High-risk phase
- Strength of an idea
- Task (target) fixation

Institute of Medicine Report

Impact of Error:

- 44,000–98,000 annual deaths occur as a result of errors
- Medical errors are the leading cause, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS, or car accidents
- 7% of hospital patients experience a serious medication error

Federal Action:

By 5 years:
- ↓ medical errors by 50%
- ↓ nosocomial by 90%; and
- eliminate “never-events” (such as wrong-site surgery)

Cost associated with medical errors is $8–29 billion annually.

Medical Errors Still Claiming Many Lives

By Elizabeth Weise, USA TODAY

As many as 98,000 Americans die each year because of medical errors despite an unprecedented focus on patient safety over the last five years, according to a study released today. Significant improvements have been made in some hospitals since the Institute of Medicine released a landmark report in 2000 that revealed many thousands of Americans die each year because of medical mistakes.

But nationwide, the pace of change is painstakingly slow, and the death rate has not changed much, according to the study in *The Journal of the American Medical Association*.

The researchers blame the complexity of health care systems, a lack of leadership, the reluctance of doctors to admit errors and an insurance reimbursement system that rewards errors—hospitals can bill for additional services needed when patients are injured by mistakes—but often will not pay for practices that reduce those errors.

"The medical community now knows what it needs to do to deal with the problem. It just has to overcome the barriers to doing it," says study co-author Lucian Leape of Harvard’s School of Public Health.

The institute, a public policy organization, pushed key health care organizations to focus on patient safety, the new report says. As a result, reductions as much as 93% have been made in certain kinds of error-related illnesses and deaths.

Computerized prescriptions, adding a pharmacist to medical teams and team training in the delivery of babies are among the improvements medical centers are making, the study finds.

Hospitals that eliminate infections should receive bonuses, Leape says. "If insurance companies paid 20% more for patients in (intensive care units) where there were no infections, they’d cut costs substantially.

"We really need to rethink how we pay for health care. What we do now is pay for services, but what we should do is pay for health and outcomes."
What Comprises Team Performance?

- Knowledge
  - Cognitions “Think”
- Attitudes
  - Affect “Feel”
- Skills
  - Behaviors “Do”

...team performance is a science...consequences of errors are great...

Outcomes of Team Competencies

- Knowledge
  - Shared Mental Model
- Attitudes
  - Mutual Trust
  - Team Orientation
- Performance
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety

Sentinel event information provided by Joint Commission
Teamwork Actions

- Recognize opportunities to improve resident safety
- Assess your current organizational culture and supporting components of resident safety
- Identify a teamwork improvement action plan by analyzing data and survey results
- Design and implement an initiative to improve team-related competencies among your staff
- Integrate TeamSTEPPS into daily practice

“High-performance teams create a safety net for your healthcare organization as you promote a culture of safety.”

Supplemental Instructor Slides

Train-the-Trainer/Coach Session Agenda

- Module 1—Introduction
- Module 2—Team Structure
- Module 3—Leadership
- Module 4—Situation Monitoring
- Module 5—Mutual Support
- Module 6—Communication
- Module 7—Summary—Putting It All Together

- Change Management: How to Achieve a Culture of Safety
- Coaching Workshop
- Implementation
- Course Management
- Developing a Teamwork Improvement Action Plan
- Practice Teaching Session
Teamwork Encompasses CRM

DoD has led the way in team research and innovations

- Non-Health Care
  - Combat Information Centers
  - Joint Forces Operations
  - Emergency Management Communities
  - Army Special Forces
  - Tank, Submarine, and Air Crews

- Health Care
  - ED, OR, L&D, ICU, Dental, Nursing Home
  - Whole Hospital
  - Combat Casualty Care

...striving to be a high-reliability health care system...

Background: U.S. Army Aviation

- Army aviation crew coordination failures in mid-80s contributed to 147 aviation fatalities and cost more than $290 million
- The vast majority involved highly experienced aviators
- Failures were attributed largely to crew communication, workload management, and task prioritization

U.S. Navy Breakthroughs: Tactical Decisionmaking Under Stress (TADMUS)

- Cross-Training
- Stress Exposure Training
- Team Coordination Training (CRM)
- Scenario-Based Training and Simulation
- Team Leader Training
- Team Dimensional Training
- Team Assessment
**U.S. Air Force CRM History**

- Mid to late 80s, AF bombers and heavy aircraft started CRM training
- In 1992, Air Combat Command developed Aircrew Attention Management (CRM) Training
- By 1998, CRM deployed uniformly across the AF
- Steady decline in human factors based mishaps since CRM training deployed
- AF Medical Service adopted training, rolled out in 2000

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**Eight Steps of Change**

- Catalytic event drives need for change
- Build team, strategy, buy-in, establish goals
- Implement Action Plan, Train, Empower Others
- Test Intervention (Outcomes)
- Monitor, Integrate, Continuous Process Improvement

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**Roadmap to a Culture of Safety**

- Prepare the Climate
  - Build, sustain, strategy, align, establish goals
- Test Intervention (Outcomes)
- Implement Action Plan, Train, Empower Others
- Celebrate wins!
- Staying the course

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