



TeamSTEPPS Introduction

Video Discussion

- How are patients 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*

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TeamSTEPPS Introduction

Objectives

- Describe the TeamSTEPPS training initiative
- Explain your organization's patient safety program
- Describe the impact of errors and why they occur
- Describe the TeamSTEPPS framework
- State the outcomes of the TeamSTEPPS framework

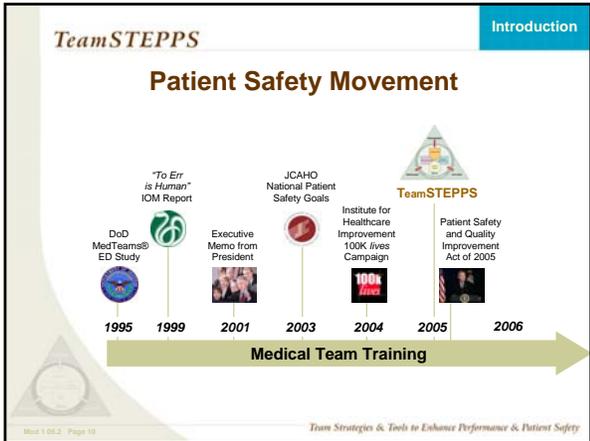
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TeamSTEPPS Introduction

Teamwork Is All Around Us



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- TeamSTEPPS** Introduction
- ### 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
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TeamSTEPPS Introduction

Introductions and Exercise: Magic Wand

If I had a "**Magic Wand**" and could make changes within my unit or facility **in the areas of patient quality and safety...**



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TeamSTEPPS Introduction

Why Do Errors Occur—Some Obstacles

- Workload fluctuations
- Interruptions
- Fatigue
- Multi-tasking
- 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

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TeamSTEPPS Introduction

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.

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TeamSTEPPS Introduction

Outcomes of Team Competencies

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

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TeamSTEPPS Introduction

Teamwork Actions

- Recognize opportunities to improve patient safety
- Assess your current organizational culture and existing Patient Safety Program components
- Identify teamwork improvement action plan by analyzing data and survey results
- Design and implement 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."

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TeamSTEPPS Introduction

Supplemental Instructor Slides

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TeamSTEPPS Introduction

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

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TeamSTEPPS Introduction

Teamwork Encompasses CRM

DoD has led the way in team research and innovations

- Non-Healthcare
 - Combat Information Centers
 - Joint Forces Operations
 - Emergency Management Communities
 - Army Special Forces
 - Tank, Submarine, and Air Crews
- Healthcare
 - ED, OR, L&D, ICU, Dental
 - Whole Hospital
 - Combat Casualty Care

Team Training
CRM
"Learning and Safety Culture"

...striving to be a high reliability healthcare system...

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TeamSTEPPS Introduction

Background: US 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

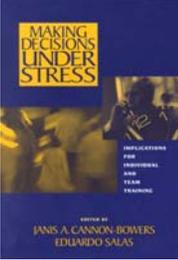



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TeamSTEPPS Introduction

US 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



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TeamSTEPPS Introduction

US Air Force CRM History

- Mid to Late 80s AF bombers and heavy aircraft started CRM training
- 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 adapted training, rolled out in 2000



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TeamSTEPPS Introduction

Eight Steps of Change



John Kotter

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