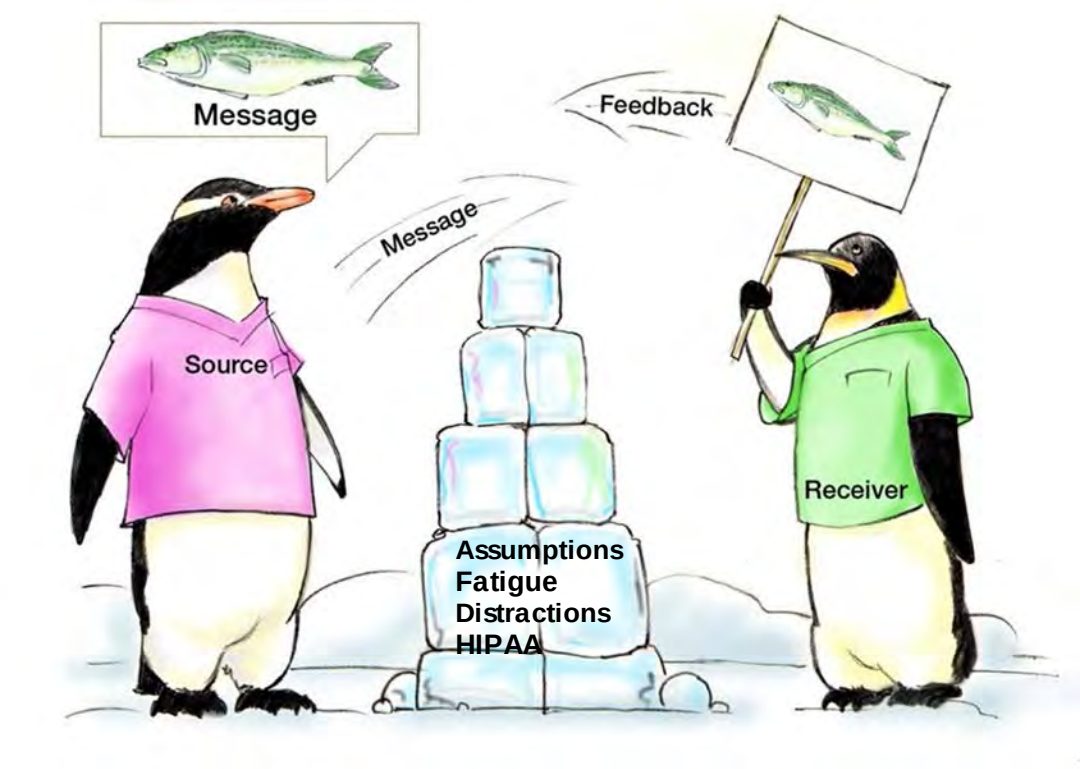


COMMUNICATION

SUBSECTIONS

- Importance of Communication
- Communication Definition, Standards, and Challenges
- Communication Challenges
- Information Exchange Strategies and Tools (e.g., SBAR, Check-Back, Call-Out, and Handoff)

TIME: 45 minutes

INSTRUCTOR OUTLINE: COMMUNICATION

Instructor Note: In this module, you will present information about communication. It is important to convey the importance of communication and how effective information exchange strategies can improve patient safety.

The Communication module includes the content provided in the outline below. More content is available than can be covered in the time provided; therefore, optional content and activities are noted. It is strongly recommended that instruction not focus solely on lecture, but also include exercises, videos, and other activities. As such, instructors should use the information below to plan how the module will be taught within the time available.

	Content	Page #	Approx. Time
1.	Introduction	5 - 6	3 mins
2.	Importance of Communication	7	2 mins
3.	Communication Failures	8 - 9	3 mins*
4.	Communication: Definition, Standards, Challenges	10 - 15	10 mins *(Challenges Examples*)*
5.	Information Exchange Strategies	16 - 28	30 mins
6.	Tools and Strategies Summary	29	2 mins
7.	Applying TeamSTEPPS Exercise	30	5 mins

*Although all instructional content and activities are recommended to ensure that participants achieve the learning objectives, these activities may be considered "optional" if time is constrained.

MODULE TIME:

45 minutes

MATERIALS:

- Flipchart or Whiteboard (Optional)
- Markers (Optional)
- SBAR Video (Nurse to Physician; SBAR_INPTMED_2.mpg)
- Call-Out Video (Call-Out_LandD_2.mpg)
- Check-Back Video (Resident to Pharmacist; Check-Back_INPTSURG_4.mpg)
- Handoff Video (Nurse to Nurse; Handoff_INPTSURG_2.mpg)
- I PASS the BATON Video (I_PASS_the_BATON_ER.mpg)
- TeamSTEPPS Implementation Worksheet

Continued…

INSTRUCTOR OUTLINE: COMMUNICATION (Continued)

Additional Resources: Below are sources of additional information and videos you may want to use to customize this module to your participants.

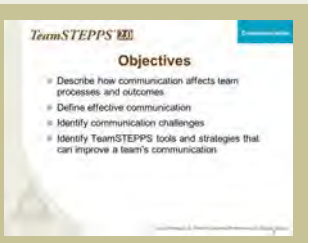
- ***TeamSTEPPS DVD:*** The TeamSTEPPS DVD includes Specialty Scenarios and additional videos that can be used to customize your instruction.
- ***TeamSTEPPS Long-Term Care Version:*** Includes videos specific to the use of the communication tools and strategies in long-term care.
  - http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/
- ***TeamSTEPPS Primary Care Version:*** Includes videos specific to the use of the communication tools and strategies in the primary care setting.
  - http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/
- ***TeamSTEPPS Rapid Response Systems Module (RRS):*** Includes videos specific to the use of the communication tools and strategies by Rapid Response Teams.
  - http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/rrs/
- ***DoD Patient Safety Program SBAR Toolkit:***
  - http://www.health.mil/dodpatientsafety/ProductsandServices/Toolkits/SBAR.aspx
- ***Comprehensive Unit-Based Safety Program (CUSP) "Implement Teamwork and Communication" Module:*** Includes information on some of the communication tools and strategies taught in TeamSTEPPS.
  - http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/implement/index.html

OBJECTIVES

SAY:

Following this module, you will be able to:

- Describe how communication affects team processes and outcomes;
- Define effective communication;
- Identify communication challenges; and
- Identify TeamSTEPPS tools and strategies that can improve a team's communication.



Slide

TEAMSTEPPS TEAMWORK SKILLS

Slide

SAY:

So far, we have covered the following in the TeamSTEPPS framework:

- **Team Structure**, which facilitates teamwork by identifying the individuals among which information must be communicated, a leader must be clearly designated, and mutual support must occur.

In this module, we will cover Communication. Communication is the lifeline of a well-functioning team and serves as a coordinating mechanism for teamwork. Effective communication skills are vital for patient safety and interplay directly with the other components of the TeamSTEPPS framework. Further, communication is the mode by which most of the TeamSTEPPS tools and strategies are executed. Therefore, this module serves as the basis for the leading teams, situation monitoring, and mutual support modules that will follow.

This module will discuss the standards of effective communication and will present information exchange strategies and specific tools to enhance communication among team members.

IMPORTANCE OF COMMUNICATION

Slide

SAY:

The continued importance of effective communication in care teams cannot be understated. According to sentinel event data compiled by the Joint Commission between 1995 and 2005, ineffective communication was identified as the root cause of 66 percent of reported errors. More recent Joint Commission data from 2010 to 2013 show that ineffective communication has remained among the top three root causes of sentinel events. As these data illustrate, failure to communicate effectively as a team significantly increases the risk of error.

Additional information about sentinel events and root causes can be found on the Joint Commission website:

Joint Commission

(OPTIONAL) COMMUNICATION FAILURES

Instructor Note: Create a slide showing your organizational data related to the top causal factors for inadequate information sharing using local, state, regional, or other benchmark data as appropriate. Discuss findings with the group regarding root cause analyses from events that occur in your organization or are noted on your slide.

Examples of contributing factors can be found at:

http://Joint Commission

ASK:

- Can you describe an example in which a communication breakdown was the major contributing factor of an error in care?

Instructor Note: The following examples can be read aloud for discussion, using the questions listed below each example.

Example 1:

- A patient in the Emergency Department needs a chest X-ray to rule out a pneumothorax (collapsed lung). The physician requests that the nurse call for a chest X-ray and assumes she understands his intent of a portable stat. Instead, the patient is transported to X-ray for a standard AP and Lateral chest X-ray.

ASK:

- What might the physician have said to cause confusion?
- How could the physician more effectively communicate to the nurse what is needed?

Example 2:

- In obtaining consent for treatment, an explanation written in sufficient detail in lay terms and at the patient's level of understanding is necessary. One potential outcome of a precompressive lumbar laminectomy is loss of bowel and bladder control. A consent form that states the known risk as "loss of function of body organs" does not convey the full extent of risk associated with the procedure. A patient who fully understands the risks may choose to forgo the procedure.

ASK:

- How could the consent form be misleading to patients?
- What information should be included and communicated to the patient so they are fully informed of potential outcomes?

(OPTIONAL) COMMUNICATION FAILURES (Continued)

SAY:

Lack of communication among department staff can lead to failure to:

- Share information with the team;
- Request information from others;
- Direct information to specific team members; and

- Include patients and their families in communication involving their care.

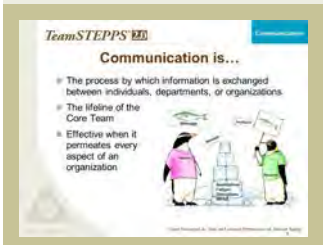
Examples of missed communication opportunities include:

- Unavailable or underutilized status board;
- Inconsistencies in the utilization of automated systems;
- Poor documentation—not timed, nonspecific, illegible, and incomplete; and

- Failure to seek input from the patient.

In this module, we will discuss approaches to promote effective communication.

COMMUNICATION IS…



Slide

SAY:

Communication is defined as the transfer or exchange of information from a sender to a receiver. More specifically, communication is a process whereby information is clearly and accurately conveyed to another person using a method that is known and recognized by all involved. It includes the ability to ask questions, seek clarification, and acknowledge the message was received and understood. One critical result of effective communication is a shared understanding, between the sender and receiver(s) of the information conveyed.

Two considerations in communication are whom you are communicating with and how you are communicating information.

- *Whom* you are communicating with, or the audience, will influence how information is conveyed. For example, an information exchange with a lab technician may differ from an exchange with a physician.
- In terms of *how* you communicate, there are two modes of communication: verbal and nonverbal.

We will cover standards of effective communication shortly. These relate primarily to verbal communication.

Nonverbal communication can take several forms. Written communication is common in health care. This form of nonverbal communication should adhere to many of the same standards we will discuss shortly. In addition, one should be mindful of standards associated with written communication, such as the Joint Commission's "Do Not Use" list of abbreviations.

More information about the "Do Not Use" List of Abbreviations can be found on the Joint Commission website:
http://www.jointcommission.org/facts_about_the_official/

Continued…

COMMUNICATION IS… (Continued)

SAY:

Another form of nonverbal communication is body language. The way you make eye contact and the way you hold your body during a conversation are signals that can be picked up by the person with whom you are communicating. Body language plays a significant role in communication. In a face-to-face communication, words account for 7 percent of the meaning, tone of voice accounts for 38 percent of the meaning, and body language accounts for the remaining 55 percent. Although powerful, this mode of communication does not provide an acceptable mode to verify or validate (acknowledge) information.

A third form of nonverbal communication is visual cues. For example, the use of color coding for assignments, charts, scrubs, orders, and so on can help team members identify the information they need quickly.

To avoid making assumptions that can lead to error, you should verify in writing or orally any nonverbal communication, such as body language or visual cues, to ensure patient safety. The simple rule is, "When in doubt, check it out, offer information, or ask a question."

ASK:

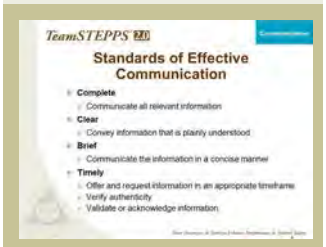
- Can you provide examples from your work setting when nonverbal communication produced a breakdown in teamwork?
- Did you know the actual intent of the person?

Instructor Note: If responses to the questions above do not provide sufficient examples, the one below may be read aloud to participants.

Example:

- The nonverbal cues an ED doctor gives when looking at an ECG would quickly tell the nurse the severity of the situation and might lead to proactive action. Likewise, the nonverbal cues from the nurse's face might communicate the urgency of the situation and need for interruption to a doctor who is with a patient's family members.

STANDARDS OF EFFECTIVE COMMUNICATION



Slide

SAY:

When sharing information with the team, which can include other providers, patients, or family members, communication must meet four standards to be effective.

Effective communication is:

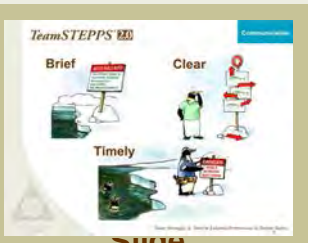
- **Complete**
  - Communicate all relevant information while avoiding unnecessary details that may lead to confusion
  - Leave enough time for questions, and answer questions completely
- **Clear**
  - Use information that is plainly understood (lay terminology with patients and their families)
  - Use common or standard terminology when communicating with members of the team
- **Brief**
  - Be concise
- **Timely**
  - Be dependable about offering and requesting information
  - Avoid delays in relaying information that could compromise a patient's situation
  - Note times of observations and interventions in the patient's record
  - Update patients and families frequently
  - Verify authenticity, which requires checking that the information received was the intended message of the sender
  - Validate or acknowledge information

Example:

A well-written discharge prescription is:

- Complete—It includes medication, dosage, and frequency
- Clear—It is clearly written and legible
- Brief—It contains only the necessary information
- Concise—It is written before discharge and filled when the patient is ready to leave the hospital

BRIEF, CLEAR, AND TIMELY



Slide

SAY:

Provide information that is brief, yet as complete as possible. Do not overexplain the situation; be concise.

Be clear—Plainly understood.

Timely—Looks like it may be a little too late for these penguins!

Instructor Note: (Time Permitting) Ask the question below before proceeding to the next slide, which will list communication challenges. You may wish to create a list of answers to the question on a flip-chart and then compare those to the challenges listed on the next slide.

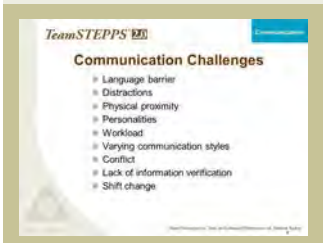
ASK:

- What could affect communication among team members?

MATERIALS:

- Flipchart or Whiteboard (Optional)
- Markers (Optional)

COMMUNICATION CHALLENGES



Slide

SAY:

Challenges may include:

- Language barriers—Non-English speaking patients/staff pose particular challenges*
- Distractions—Emergencies can take your attention away from the current task at hand
- Physical proximity
- Personalities—Sometimes it is difficult to communicate with particular individuals
- Workload—During heavy workload times, all of the necessary details may not be communicated, or they may be communicated but not verified
- Varying communication styles—Health care workers have historically been trained with different communication styles
- Conflict—Disagreements may disrupt the flow of information between communicating individuals
- Lack of verification of information—Verify and acknowledge information exchanged
- Shift change—Transitions in care are the most significant time when communication breakdowns occur

ASK:

- Have you experienced a situation in your unit involving a breakdown of communication?
- What are some examples?

**A TeamSTEPPS Limited English Proficiency Module is available on the AHRQ website:*
TeamSTEPPS Tools

(OPTIONAL) COMMUNICATION CHALLENGES EXAMPLES

Instructor Note: The following examples can be read aloud to the class and used to facilitate discussion about communication challenges.

SAY:

Let's spend a few minutes reviewing an example or two of scenarios in which communication challenges are present.

Example 1:

A physical therapist sees a patient with carpal tunnel syndrome. The physical therapist discusses the case with the physician and recommends ice treatment to decrease inflammation. The physician agrees with the recommended treatment.

DISCUSSION:

- How would you communicate the treatment protocol to the patient?
- How would you ensure that the patient understands the treatment protocol?

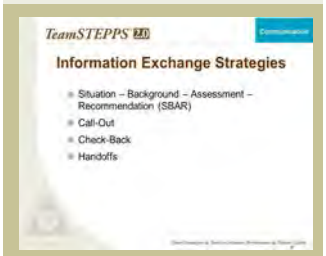
Example 2:

An 89-year-old female presents to the hospital and has a history of chest pain. Many tests are being run to determine the cause of the chest pain. The patient and her family decide they no longer want aggressive measures taken and request that the patient's code status be changed to DNR. The night shift documents in the progress note that the patient requested not to be resuscitated. The night shift does not flag the patient's chart, relay the information during shift change, or notify the attending physician. The morning shift does not read the night shift's notes because of several immediate emergencies.

DISCUSSION:

- Where might miscommunication occur in this situation?
- What are the possible outcomes?

INFORMATION EXCHANGE STRATEGIES



Slide

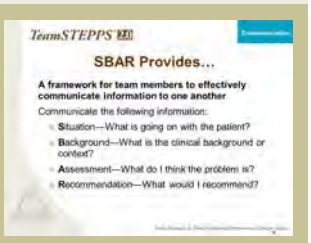
SAY:

A number of tools and strategies to potentially reduce errors associated with miscommunication or lack of information are listed. The following four strategies are simple to integrate into daily practice and have been shown to improve team performance:

- Situation−Background−Assessment–Recommendation (SBAR)
- Call-Outs
- Check-Backs
- Handoffs

Of these strategies, handoffs in particular can take many forms. In this course, we will describe the I PASS the BATON handoff tool in the most detail; however, it is only one tool among many that have been created to standardize the handoff process. Examples of additional handoff resources will also be presented.

SBAR PROVIDES…



Slide

SAY:

The SBAR technique provides a standardized framework for members of the health care team to communicate about a patient's condition. You may also refer to this as the ISBAR, where "I" stands for "Introductions."

In phrasing a conversation with another member of the team, consider the following:

- Situation—What is happening with the patient?
- Background—What is the clinical background?
- Assessment—What do I think the problem is?
- Recommendation—What would I recommend?

ASK:

- Have you used SBAR in your institution? If so, how was it used? What was the result of its use?
- What were the challenges to implement the use of SBAR and how were these challenges overcome?

SAY:

Although SBAR is typically used as a communication tool between clinical staff, it can also be modified for use by the patient to communicate with the care team. For example, your facility could provide patients with a version of SBAR to enable them to share information about their own situation, background, assessment, and recommendations, or to ask the care team about their care.

Additional information about partnering with patients and families can be found at the Department of Defense (DoD) website:

http://www.health.mil/dodpatientsafety/ProductsandServices/team up.aspx

SBAR VIDEO EXAMPLE

Slide

VIDEO TIME:

1:35 minutes

MATERIALS:

- SBAR Video (Nurse to Physician SBAR_INPTMED_2.mpg)

SAY:

Let's review how to properly use the SBAR technique. In this video, the patient's condition has worsened, resulting in a call to the physician on call. Watch the video to see the transfer of information using the SBAR technique.

DO:

Play the video by clicking the director icon on the slide.

DISCUSSION:

- How did the SBAR technique improve communication between the nurse and physician?
  - The nurse identified herself and the reason she was calling
  - The physician was quickly made aware of Mrs. Everett's deteriorating situation
  - The nurse provided the background of the DVT diagnosis and all current labs
  - The recent assessment of the patient has led the nurse to call the physician with her concerns
  - The recommendation was initiated by the nurse for additional labs and a plan was discussed for future care
    - ❖ Some find recommendation difficult as they attempt not to diagnose but give broader indirect suggestions that may not provide clear or concise patient information

EXERCISE: SBAR

SAY:

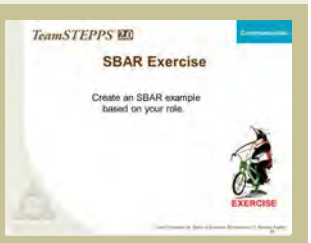
Take the next few minutes to create an SBAR example based on your specific role.

Instructor Note: You may want to write the following on a flipchart to remind participants of the SBAR acronym:

- Situation:
- Background:
- Assessment:
- Recommendation:

DO:

After a few minutes, ask for a few volunteers to share their examples. You may want to write out some of the examples shared by participants.



Slide

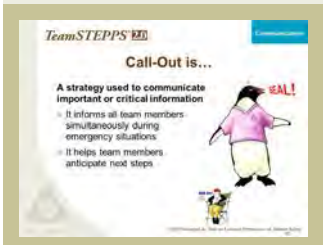
TIME:

10 Minutes

MATERIALS:

- Flipchart or Whiteboard (Optional)
- Markers (Optional)

CALL-OUT IS…



Slide

VIDEO TIME:
00:18 seconds

MATERIALS:

- Call-Out Video (Call-Out_LandD_2.mpg)

SAY:

A call-out is a tactic used to communicate critical information during an emergent event. Critical information called out in these situations helps the team anticipate and prepare for vital next steps in patient care. It also benefits a recorder when present during a code or emergent event. One important aspect of a call-out is directing the information to a specific individual.

ASK:

- In your unit, what information would you want called out?

DO:

Play the video by clicking the director icon on the slide.

DISCUSSION:

- How did the call-outs made by the nurse and intern aid the team during this emergent Labor and Delivery event?
  - Team members verbally confirmed critical information about the presence and duration of decelerations
  - The team was anticipating future actions, including a possible C-section and call to Attending
  - Information was directed by name to Dr. Dean for response and feedback

CHECK-BACK IS…

Slide

SAY:

A check-back is a closed-loop communication strategy used to verify and validate information exchanged. This strategy involves the sender initiating a message, the receiver accepting the message and confirming what was communicated, and the sender verifying that the message was received.

Here is an example of the use of a check-back:

- One member of the team calls out, "BP is falling, 80/48 down from 90/60." Another team member verifies and validates receipt of the information by saying, "Got it; BP is falling and at 80/48, down from 90/60." The original sender of the information completes the loop by saying, "Correct."

A check-back is an effective tool for all members of the team, including patients and their family members. For example, patients and families can use the check-back to verify the receipt of care instructions or confirm understanding of symptoms to monitor.

Now let's watch a short example.

DO:

Play the video by clicking the director icon on the slide.

DISCUSSION:

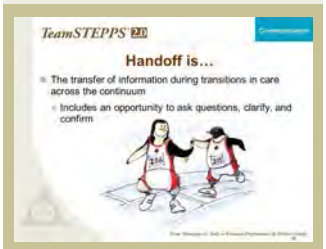
- Who was the sender? Who was the receiver?
  - Pharmacist was the sender
  - Resident was the receiver
- How did the sender and receiver "close the loop"?
  - The pharmacist says "Correct"
- What communication errors were avoided?
  - Pharmacist did not rely on memory to give correct dosing information
  - Resident wrote the exact dosing instructions to avoid depending on memory and could check back using notes since the dosing was more complicated by dilution
  - Errors caused by misunderstood dosage amounts or drugs with similar sounding names were avoided

VIDEO TIME:
00:15 seconds

MATERIALS:

- Check-Back Video (Resident to Pharmacist; Check-Back_INPTS URG_4.mpg)

HANDOFF IS…



Slide

SAY:

When a team member is temporarily or permanently relieved of duty, there is a risk that necessary information about the patient might not be communicated. The handoff strategy is designed to enhance information exchange at critical times such as transitions in care. More important, it maintains continuity of care despite changing caregivers.

According to the Joint Commission: "The primary objective of a handoff is to provide accurate information about a patient's/client's/resident's care, treatment and services, current condition, and any recent or anticipated changes. The information communicated during a handoff must be accurate to meet patient safety goals."

The Joint Commission National Patient Safety Goals (NPSG 2E) mandate implementing the use of handoffs within each institution. In addition, a *standardized* approach to handoff communications, including an opportunity to ask and respond to questions, is required.

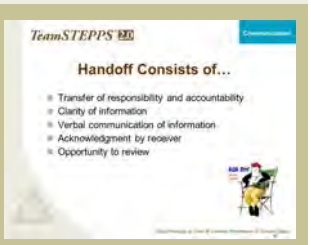
For more information about Joint Commission handoff solutions, visit their website:

Joint Commission

ASK:

- When do you typically use handoffs in your unit?
- What do you think makes an effective handoff?

HANDOFF CONSISTS OF…



Slide

SAY:

A proper handoff includes the following:

- **Transfer of responsibility and accountability**—When handing off, it is your responsibility to know that the person who must accept responsibility is aware of assuming responsibility. Similarly, you are accountable until both parties are aware of the transfer of responsibility.
- **Clarity of information**—When uncertainty exists, it is your responsibility to clear up all ambiguity of responsibility before the transfer is completed.
- **Verbal communication of information**—You cannot assume that the person obtaining responsibility will read or understand written or nonverbal communications.
- **Acknowledgment by receiver**—Until it is acknowledged that the handoff is understood and accepted, you cannot relinquish your responsibility.
- **Opportunity to review**—Handoffs are a good time to review and have a new pair of eyes evaluate the situation for both safety and quality.

In addition, handoffs include the transfer of knowledge and information about:

- The degree of certainty and uncertainty regarding a patient, such as whether a diagnosis has been confirmed;
- The patient's response to treatment;
- Recent changes in condition and circumstances; and
- The plan of care, including contingencies.

It is important to highlight that both authority and responsibility are transferred in a handoff. As identified in root cause analyses of sentinel events and poor outcomes, lack of clarity about who is responsible for care and decisionmaking has often been a major contributor to medical error.

Let's watch an example of a handoff.

DO:

Play the video by clicking the director icon on the slide.

DISCUSSION: Go to next page >

VIDEO TIME: 1:36 minutes

MATERIALS:

- Handoff Video (Nurse to Nurse; Handoff_INPT SURG_2.mpg)

Continued…

HANDOFF CONSISTS OF… (Continued)

DISCUSSION:

- What went well in the handoff in this video?
  - Continuity of care was maintained
  - Pain management was discussed
  - Medications were reviewed
  - Plan of care was discussed
  - High threats unique to Mrs. Peters were announced
  - Expectations and responsibilities for the handoff were completed
- Was there anything about the handoff that could have been improved?
  - Face-to-face or in-person handoffs allow you to see the nonverbal communication between you and the receiver for better confirmation that the message has been properly received

I PASS THE BATON

Slide

VIDEO TIME: 1:13 minutes

MATERIALS:

- I PASS the BATON Video (I_PASS_the_BATON_ER.mpg)

SAY:

Your facility should determine a standard protocol for delivering handoffs and make it known to everyone. "I PASS the BATON" is a TeamSTEPPS tool that provides one option for conducting a structured handoff.

I **Introduction**—Introduce yourself and your role/job (include patient)

P **Patient**—Name, identifiers, age, sex, location

A **Assessment**—Presenting chief complaint, vital signs, symptoms, and diagnosis

S **Situation**—Current status/circumstances, including code status, level of uncertainty, recent changes, response to treatment

S **Safety Concerns**—Critical lab values/reports, socio-economic factors, allergies, alerts (falls, isolation, etc.)

THE

B **Background**—Comorbidities, previous episodes, current medications, family history

A **Actions**—What actions were taken or are required? Provide brief rationale

T **Timing**—Level of urgency and explicit timing and prioritization of actions

O **Ownership**—Who is responsible (nurse/doctor/team)? Include patient/family responsibilities

N **Next**—What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

DO:

Play the video by clicking the director icon on the slide.

DISCUSSION: Go to next page >

Continued…

I PASS THE BATON (Continued)

DISCUSSION:

- How was I PASS the BATON used in this physician-to-physician example?
  - Physician shift change (responsibility)
  - Evolving patient condition
  - Sharing of information for better decisionmaking between care leaders

ADDITIONAL HANDOFF TOOLS AND RESOURCES

Slide

SAY:

Numerous tools and resources are available to facilitate effective handoffs. Each facility should adopt the tool that best meets its needs. In addition to I PASS the BATON, other handoff tools and resources include:

- **ANTICipate:**
  - Stands for - **A**dministrative Data; **N**ew clinical information; **T**asks to be performed; **I**llness severity; and **C**ontingency plans for changes.
  - http://www.psnet.ahrq.gov/primer.aspx?primerID=9
- **I PASS:**
  - Stands for - **I**llness severity; **P**atient Summary; **A**ction list for the new team; **S**ituation awareness and contingency plans; and **S**ynthesis and "read back" of the information.
  - http://www.ipasshandoffstudy.com/
- **SHARQ:**
  - Stands for - **S**ituation; **H**istory; **A**ssessment; **R**ecommendations/Result; and **Q**uestions.
  - http://accc-cancer.org/oncology_issues/articles/MarApr2011/MA11- Sherer.pdf
- **HAND-IT:**
  - Stands for the **Hand**off **I**ntervention **T**ool.
  - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540511/
- **Patient Hand-Off Tool Kit:**
  - This resource includes 10 examples of handoff tools.
  - http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/
- **Safer Sign Out Form:**
  - This tool was developed to standardize the sign-out process.
  - http://safersignout.com/resources/

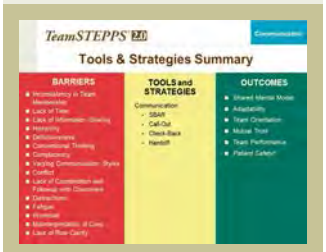
Continued...

ADDITIONAL HANDOFF TOOLS AND RESOURCES (Continued)

ASK:

- Can you describe an example of the handoff method used in your facility?
- Is the same handoff method used in every situation, or do they vary?

TOOLS AND STRATEGIES SUMMARY



Slide

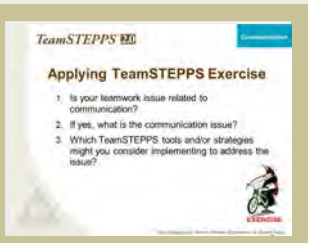
SAY:

Communication skills interact directly with leadership, situation monitoring, and mutual support:

- Team leaders require effective communication skills to convey clear information, provide awareness of roles and responsibilities, and provide feedback.
- Team members monitor situations by communicating any changes to keep the team informed and the patient protected.
- Communication facilitates a culture of mutual support when team members request or offer assistance and verbally advocate for the patient.

Communication tools that can enhance teamwork include the SBAR, call-out, check-back, and handoff. These tools facilitate effective and efficient communication within and across teams. Good communication facilitates the development of shared mental models, adaptability, mutual trust, and patient safety.

EXERCISE: APPLYING TEAMSTEPPS



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MATERIALS:

- TeamSTEPPS Implementation Worksheet

Instructor Note: This slide is intended for the Master Training course only. The previous slide should be the last one shown to staff participants at your organization.

SAY:

Now return to your TeamSTEPPS Implementation Worksheet. Think about the teamwork issue you previously identified. Then, review and answer the questions for Module 3.

Think about:

- Whether your teamwork issue relates to problems with communication; and
- Whether any of the tools and strategies covered in this module could be used to address your issue.

DO:

Ask a few individuals to report on their communication issue and which TeamSTEPPS tools or strategies they will consider implementing to address the issue.