STEPPING into a Safer Environment

Wendy Bellows, BSN, RNC; Sally Bennett, PhD, MS, RN; Donna Marie Campbell, RN, C; Kimberly Paris, BSN, RN

Robert Packer Hospital, Sayre, PA 18840

Purpose

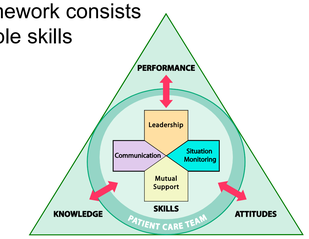
To ensure a culture of safety on an obstetrical unit, the TeamSTEPPS™ program, which focuses on promoting teamwork and communication to reduce errors and ensure patient safety, was implemented in June 2010.

Significance

Concentrating on the core concepts of the model, important changes resulted in positive outcomes related to both patient safety and Registered Nurse (RN) Satisfaction.

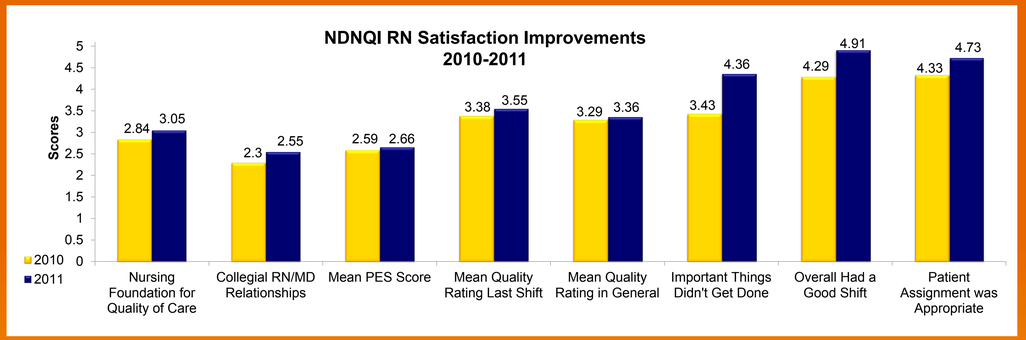
What is *TeamSTEPPS*™?

- **Team Strategies & Tools to Enhance Performance and Patient Safety**
- A powerful solution to improving patient safety based on 25 years of research from other high risk industries
- Increases TEAM awareness and clarifies the team roles and responsibilities
- Helps resolve conflict and improve information sharing, while eliminating barriers to quality and safety
- Highly effective medical teams using all available
  - Information
  - People
  - Resources
- The TeamSTEPPS™ framework consists of four teachable, learnable skills
  - Leadership
  - Mutual Support
  - Situation Monitoring
  - Communication



Disclosure

Poster Reference: TeamSTEPPS™ Instructor Guide



TeamSTEPPS™ Strategies

Barriers	Tools & Strategies	Outcomes
• Team member inconsistency	• Brief	• Shared Mental Model
• Lack of Time	• Huddle	• Adaptability
• Lack of Information Sharing	• Debrief	• Team Orientation
• Hierarchy	• STEP	• Mutual Trust
• Defensiveness	• Cross Monitoring	• Team Performance
• Conventional Thinking	• Feedback	• Patient Safety!!
• Complacency	• Advocacy and Assertion	
• Varying Communication Styles	• Two-Challenge Rule	
• Conflict	• CUS	
• Lack of Planning/Follow-Up	• DESC Script	
• Distractions	• Collaboration	
• Fatigue	• SBAR	
• Workload	• Call-Out	
• Misinterpretation of Cures	• Check-Back	
• Lack of Role Clarity	• Handoff	

Briefs

- Short session with all team members to assign roles, establish expectations and anticipate outcomes
- White Board Rounds
  - Interdisciplinary shift briefs
  - 8 a.m. and 8 p.m.

Debriefs

- Informal, recap of a situation, background and key events for all team members
- Held after an adverse/near miss event or positive occurrence

Huddles

- Quick, as needed, team gatherings to focus on a problem requiring immediate attention
- Re-establishes situation awareness
- Reinforces plans
- Can be organized by any team member

Implications for Practice

- Nursing Foundations for Quality of Care
  - A clear patient care philosophy pervades the unit for all disciplines
  - An active quality assurance program
- Collegial Nurse-Physician Relations
  - Physicians and nurses have good working relationships
  - Teamwork between nurses and physicians
  - Collaboration (joint practice) between nurses and physicians
- A Safer Practice Environment
- Unit Perceived Quality of Care
  - Nurses described an improved quality of care within the department
    - Last Shift
    - In General
- During their last shift, nurses more often
  - Felt important things were accomplished
  - Reported they had a “Good Shift”
  - Described their patient assignment as “Appropriate”

GUTHRIE