229 Beds
16 SNF
18 Acute
Psychiatric
Home Health
Hospice

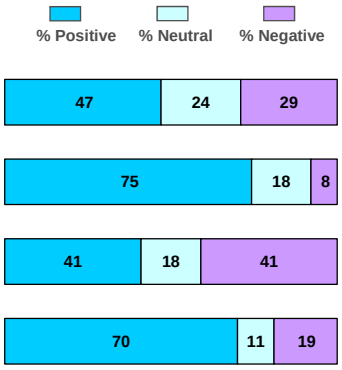
Redlands
Community Hospital,
Redlands, CA

1. Introduction & Overview
2. Maternal Child Services
3. Surgical Services
4. Cardiopulmonary Services

Importance of Communication

- Communication failure has been identified as the leading root cause of Sentinel Events over the past 10 years. The Joint Commission
- Communication failure is a primary contributing factor in almost 80% of more than 6000 root cause analyses of adverse events & close calls.
  VA Center for Patient Safety
- Communication failure is a contributing factor in 87% of the Sentinel/Never 27 events identified at RCH.

RCH Patient Safety Culture Survey:
Teamwork Across Hospital Units



Survey Items

1. There is good cooperation among hospital units that need to work together.
2. Hospital units work well together to provide the best care for patients.
3. Hospital units do not coordinate well with each other.
4. It is often unpleasant to work with staff from other hospital units.

RCH Patient Safety Culture Survey:
Hospital Handoffs & Transitions

Survey Items

1. Things “fall between the cracks” when transferring patients from one unit to another.
2. Important patient care information is often lost during shift changes.
3. Problems often occur in the exchange of information across hospital units.
4. Shift changes are problematic for patients in this hospital.

Executive Support

- Presentation to Administrative Council
  - Evaluated campus readiness and commitment
  - TeamSTEPPS tools to begin in **High Risk** areas
    - Perioperative Services
    - Maternal Child Services
    - **One** Ancillary Dept - Cardiopulmonary Services (Respiratory Therapy & Cardiology) since crosses all high risk areas
  - **SBAR** reintroduce in remaining departments

Medical Staff Support

- Presentation to Medical Executive Committee
- Identified Physicians suited to be Physician Champions
- Training of Physician Champions

TeamSTEPPS Rollout

Step 1- Identified core leadership group
Attended HASC presentation on TeamSTEPPS

Step 2 - Superuser Training: Directors, Managers, Educators and Supervisors

Step 3 – Developed “Introduction Video”

Step 4 – Presentation to Medical Executive Committee and key physicians

Step 5 – Staff Training (including video) and reinforcement

What is TeamSTEPPS™?

- Evidence-based Strategies & Tools to Enhance Performance & Pt Safety through a teamwork System proven to work in a hospital setting
- Designed to improve:
  - Quality – Safety - Efficiency of health care
- Practical and adaptable
- Provides ready-to-use materials for training and ongoing teamwork
- Promoted by the Institute for IHI as a vital step in increasing the safety of a healthcare organization

Tools/Techniques

- SBAR Communication Technique:
  - **Situation**
  - **Background**
  - **Assessment**
  - **Recommendations**

  Provides brief, clear, specific, and timely information

  Advantage: Receive information about patients in a standardized, complete, interactive manner… even in the middle of the night.

Why Use TeamSTEPPS?

- Goal: Produce highly effective medical teams that optimize the use of information, people and resources to achieve the best clinical outcomes
- Teams of individuals who communicate effectively and back each other up dramatically reduce the consequences of human error
- Team skills are not innate; they must be trained
- There are many products available that tell healthcare providers *What* to do. TeamSTEPPS not only describes ***what*** to do, but also guides us through the ***how*** and provides the needed resources.

Two Challenge rule

- CUS to convey urgency
  - **Concerned – I am concerned**
  - **Uncomfortable – I am uncomfortable**
  - **Safety – This is a safety issue**

"Cussing" empowers all team members to "stop the line" if they sense or discover an essential safety breach. The team member being challenged must acknowledge the concern.

Maternal Child Rollout

- Video shown at staff meetings
- SBAR/CUSS practice in staff meetings
- Peer Review Critique for all Maternal Child Services staff with SBAR/Cuss, Huddles, & Call Outs

Surgical Services TeamSTEPPS

- Introduction of TeamSTEPPS Program to staff
- 100% Commitment by Staff
- Physician Leadership Retreat with Team STEPPS Focus
- Identification of TeamSTEPPS Physician Champion

Anesthesia Involvement

- Dr. Linda Martin - TeamSTEPPS Physician Champion
- Collaborative Involvement to Create Scenarios
- Combined inservice with Anesthesia and Staff
- Commitment to improving Safe Patient Environment

Board Huddles / Reviews

- Daily Review of Surgical Room Events

Board Huddles / Reviews

- Discussion of Team STEPPS Application
- Individual Staff Account of Potential Improvement Opportunities
- Discussion of Main Team STEPPS acronym applied in Surgery (CUSS)
- Successes

Cardiopulmonary Services

- Cardiopulmonary Services chosen as a high risk ancillary service
- Staff training to perform SBAR rounds
- Use of TeamSTEPPS tools to create consistency of each practitioner's report

Improved Communication During ICU Rounds

- Pilot Team Members: ICU Intensivists, Charge Nurse ICU, PT Supervisor, Director Cardiopulmonary

Use of TeamSTEPPS tools to improve communication during ICU Rounds

- Plan: use SBAR during rounds
  - How to tailor it to effective ICU communication
  - Each team members role
  - Report Flow
  - “Rules of Engagement”

Ensuring Success

- Monthly SBAR observational performance audits on all shifts
- Physician interviews post SBAR communication and ongoing physician orientation
- Added to onboarding process for new staff and physicians
- Developing a program to implement the TeamSTEPPS tools campus-wide


Thank You!