Pocket Guide

TeamSTEPPS® **2.0**

**Team Strategies & Tools
to Enhance Performance
and Patient Safety**

TeamSTEPPS 2.0 ESSENTIALS COURSE

📄 SUBSECTIONS

- TeamSTEPPS Framework and Key Principles
- Team Structure
- Communication
- Leading Teams
- Situation Monitoring
- Mutual Support
- Team Performance Observation Tool
- Summary

TIME: 2 hours

INSTRUCTOR OUTLINE: ESSENTIALS COURSE

👁 **Instructor Note:** This course is designed to teach TeamSTEPPS Fundamentals to staff who do not engage in the direct delivery of care, but rather contribute essential information to the ongoing delivery of safe care. As such, participants in this course are not intended to further train others.

It is important to note that the TeamSTEPPS Essentials Course is not interchangeable with the Fundamentals Course, nor is the Essentials Course a substitute for the basic education and skill practice offered through the Fundamentals Course.

The outline below provides instructors with information in planning the instruction of the Essentials Course.

🕐 **MODULE TIME:**

2 hours

✏ **MATERIALS:**

• SBAR Video (Nursing to Physician; SBAR_INPTMED_2.mpg)

• Brief Video 2 (Brief_LandD_2.mpg)

• Video Vignette (INPTSURG_Success_Complete_Vignette.mpg)

• Flipchart or Whiteboard (Optional)

• Markers (Optional)

Content	Page #	Approx. Time
1. Learning Objectives	5	2 mins
2. TeamSTEPPS Framework and Key Principles	6 - 7	5 mins
3. Team Structure	8 - 9	5 mins
4. Communication: SBAR, Call-Out, Check-Back, Handoff, and I PASS the BATON	10 - 14	20 mins
5. Leading Teams: Effective Leaders, Team Events, Briefs, and Debriefs	15 - 19	15 mins
6. Situation Monitoring: STEP, Cross-Monitoring, and I'M SAFE	20 – 24	20 mins
7. Mutual Support: Task Assistance, Feedback, Advocacy and Assertion, Conflict Resolution	25 – 30	15 mins
8. Team Performance Observation Tool	31 - 32	5 mins
9. Tools and Strategies Summary and Exercise	33 - 35	20 mins

INSTRUCTOR OUTLINE: ESSENTIALS COURSE (Continued)

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

- *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 some of the TeamSTEPPS tools and strategies in the long-term care setting.

  - http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/

- *TeamSTEPPS Primary Care Version:* Includes videos specific to the use of some of the TeamSTEPPS 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 some of the TeamSTEPPS tools and strategies by Rapid Response Teams.

  - http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/rrs/

- *DoD Patient Safety Program Toolkits:* Provides information about specific TeamSTEPPS tools and strategies, such as SBAR, briefs, huddles, and debriefs.

  - http://www.health.mil/dodpatientsafety/ProductsandServices/Toolkits

- *Comprehensive Unit-Based Safety Program (CUSP) "Implement Teamwork and Communication" Module:* Includes information and videos on some of the tools and strategies taught in TeamSTEPPS.

  - http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/implement/index.html

OBJECTIVES

SAY:

Following this course, you will be able to:

- Discuss the TeamSTEPPS framework and key principles;

- Describe the components of a multi-team system (MTS);

- Describe four communication tools and strategies;

- Describe effective team leader skills and three tools for leading teams;

- Define situation monitoring;

- Describe techniques for facilitating situation monitoring;

- Describe five tools and strategies for facilitating mutual support;

- Identify tools for use in conflict resolution;

- Describe observable behaviors associated with effective team performance;

- Summarize barriers to teamwork; tools and strategies to overcome teamwork barriers; and potential outcomes; and

- Apply TeamSTEPPS tools and strategies to a clinical scenario.

Pocket Guide

TeamSTEPPS 2.0

**Team Strategies & Tools
to Enhance Performance
and Patient Safety**

TeamSTEPPS FRAMEWORK
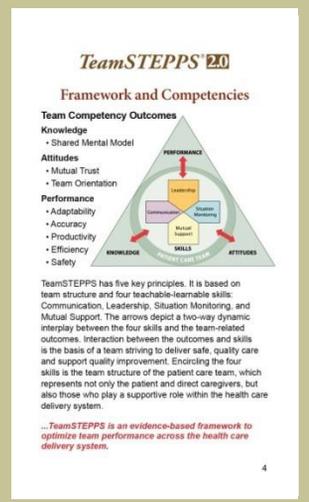
SAY:

TeamSTEPPS stands for: *Team Strategies and Tools to Enhance Performance and Patient Safety.*

TeamSTEPPS focuses on specific skills supporting team performance principles, including training requirements, behavioral methods, human factors, and cultural change designed to improve quality and patient safety.

Within this course, teamwork concepts are introduced, including specific tools and strategies for improving communication and teamwork, reducing chance of error, and providing safer patient care.

More than 30 years of research and evidence have been accumulated on teams and team performance in diverse areas, such as aviation, the military, nuclear power, health care, business, and industry. TeamSTEPPS has evolved from research in these high-risk fields to the health care environment, a high-risk, high-stakes environment in which poor performance may lead to serious consequences or death.

Based on research, we know what defines a team, what teamwork requires, how to train team members, and how to manage team performance. Researchers have linked team training programs to improved attitudes, increased knowledge, and improved behavioral skills. For example, a meta-analysis published in 2008 (Salas, et al., 2008) included a comprehensive search of team training literature from 1955 through 2007 and examined over 300 empirical articles. Although this meta-analysis was not specific to team training in health care, its results demonstrated evidence that team training had a moderate, positive effect on team outcomes.

TeamSTEPPS is built upon an evidence-based framework composed of four teachable, learnable skills: communication, leadership, situation monitoring, and mutual support—the core of the TeamSTEPPS model. The red arrows depict a two-way dynamic interplay between the four core skills and the team-related outcomes of enhanced knowledge, positive attitudes, and exceptional performance.

Encircling the four skills is the patient care team, which represents not only the patient and direct caregivers, but also those who play a supportive role within the health care delivery system.

KEY PRINCIPLES

👁 **Instructor Note:** The key principles presented on this slide align with the five core modules presented in the TeamSTEPPS Fundamentals Course.

SAY:

There are five key principles presented in this course. These principles correspond with the TeamSTEPPS Fundamentals course modules, which provide more indepth instruction to direct care staff. In this course, we will highlight key concepts from each module.

- **Team Structure** – Identifies the components of a multi-team system that must work together effectively to ensure patient safety.

- **Communication** – Process by which information is clearly and accurately exchanged among team members.

- **Leadership** – The ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and team members have the necessary resources.

- **Situation Monitoring** – Process of actively scanning and assessing situational elements to gain information understanding, or to maintain awareness to support functioning of the team.

- **Mutual Support** – The ability to anticipate and support other team members' needs through accurate knowledge about their responsibilities and workload.

TEAM STRUCTURE

Multi-Team System
For Patient Care

Safe and efficient care involves
the coordinated activities of a
multi-team system.

Team Structure

SAY:

Team structure refers to the composition of a team. In health care, multiple teams are involved in patient care. This model is known as a multi-team system or MTS.

Each team within an MTS is responsible for various parts of patient care, but all must act in concert to ensure quality patient care.

A key component of the MTS is the patient. Patients are part of the patient care team and should be embraced and valued as contributing partners to patient care.

In addition to the patient, the multi-team system is composed of several different teams.

- **Core Team**

  Core Teams consist of team leaders and team members who are involved in the direct care of the patient. Core Team members include direct care providers and continuity providers. Continuity providers are those who manage the patient from assessment to disposition, such as case managers. The Core Team is based where the patient receives care.

- **Coordinating Team**

  The Coordinating Team is the group responsible for:

  – Day-to-day operational management;

  – Coordination functions; and

  – Resource management for Core Teams.

- **Contingency Teams**

  Contingency Teams are:

  – Formed for emergent or specific events;

  – Time limited; for example, a Code Team, Disaster Response Team, or Rapid Response Team; and

  – Composed of team members drawn from a variety of Core Teams.
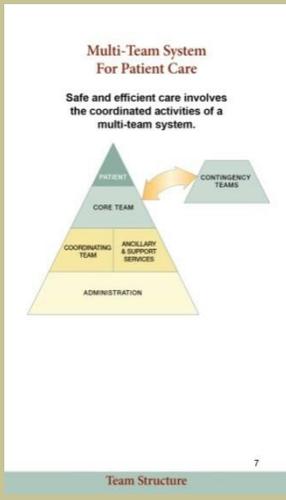
Continued…

TEAM STRUCTURE (Continued)

SAY:

Ancillary Services consist of individuals who:

- Provide direct, task-specific, time-limited care to patients;

- Support services that facilitate care of the patients; and

- Are often not located where the patients receive their routine care.

Ancillary Services are primarily a service delivery team whose mission is to support the Core Team. In general, an Ancillary Services team functions independently.

Support Services are primarily a service-focused team whose mission is to create efficient, safe, comfortable, and clean health care environments, which impact the patient care team, market perception, operational efficiency, and patient safety.

ASK:

- What are the Ancillary and Support Services in your facility?

SAY:

Administration includes the executive leadership of a unit or facility and has 24-hour accountability for the overall function and management of the organization. Administration shapes the climate and culture for a teamwork system to flourish by:

- Establishing and communicating vision;

- Developing and enforcing policies;

- Setting expectations for staff;

- Providing necessary resources for successful implementation;

- Holding teams accountable for team performance; and

- Defining the culture of the organization.

SBAR

SBAR

A technique for communicating critical information that requires immediate attention and action concerning a patient's condition

Situation – What is going on with the patient?

"I am calling about Mrs. Joseph in room 251. Chief complaint is shortness of breath of new onset."

Background – What is the clinical background or context?

"Patient is a 62-year-old female post-op day one from abdominal surgery. No prior history of cardiac or lung disease."

Assessment – What do I think the problem is?

"Breath sounds are decreased on the right side with acknowledgment of pain. Would like to rule out pneumothorax."

Recommendation and Request – What would I do to correct it?

"I feel strongly the patient should be assessed now. Can you come to room 251 now?"

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Communication

VIDEO TIME:

1:35 minutes

MATERIALS:

- SBAR Video (Nurse to Physician; SBAR_INPTMED_2.mpg)

SAY:

Within and across components of a multi-team system, communication is critical to the effectiveness of a team and to ensuring patient safety. TeamSTEPPS provides several communication strategies that can be used to ensure effective communication.

The first technique is SBAR. SBAR 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."

SBAR is an easy-to-remember tool that is useful for framing any conversation, often a critical one requiring a clinician's immediate attention and action. In phrasing a conversation with another member of the team, consider presenting the:

- 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?

Let's look at a short video clip in which the SBAR technique is used.

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 nurse initiated a recommendation for additional labs, and a plan was discussed for future care.

CALL-OUT

SAY:

Another communication tool is the call-out.

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.

Communication

Call-Out

Strategy used to communicate important or critical information

- Informs all team members simultaneously during emergent situations
- Helps team members anticipate next steps
- Important to direct responsibility to a specific individual responsible for carrying out the task

Example during an incoming trauma:

Leader: "Airway status?"

Resident: "Airway clear"

Leader: "Breath sounds?"

Resident: "Breath sounds decreased on right"

Leader: "Blood pressure?"

Nurse: "BP is 96/62"

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CHECK-BACK

Check-Back

Using closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended

The steps include the following:
1. Sender initiates the message
2. Receiver accepts the message and provides feedback
3. Sender double-checks to ensure that the message was received

Example:
Doctor: *"Give 25 mg Benadryl IV push"*
Nurse: *"25 mg Benadryl IV push"*
Doctor: *"That's correct"*

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Communication

SAY:

A check-back is a closed-loop communication strategy used to verify and validate information exchanged. The 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.

As shown in the example on the slide, the doctor communicates an instruction, the nurse repeats it back, and the doctor closes the loop by verifying that the nurse received the message accurately.

HANDOFF

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 importantly, it maintains continuity of care despite changing caregivers.

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.

Additionally, handoffs include the transfer of knowledge and information about:

- The degree of certainty and uncertainty regarding a patient; for example, 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.

I PASS THE BATON

Handoff

Strategy designed to enhance information exchange during transitions in care

"I PASS THE BATON"

I	Introduction	Introduce yourself and your role/job (include patient)
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Present chief complaint, vital signs, symptoms, and diagnoses
S	Situation	Current status/circumstances, including code status, level of (un)certainty, recent changes, and response to treatment
S	Safety Concerns	Critical lab values/reports, socioeconomic factors, allergies, and alerts (falls, isolation, etc.)
THE		
B	Background	Comorbidities, previous episodes, current medications, and family history
A	Actions	Explain what actions were taken or are required. Provide rationale.
T	Timing	Level of urgency and explicit timing and prioritization of actions
O	Ownership	Identify who is responsible (person/team), including patient/family members
N	Next	What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

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Communication

SAY:

Each facility should determine a standard protocol for delivering handoffs and make the protocol known to staff. "I Pass the Baton" provides one option for conducting structured handoffs.

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?

EFFECTIVE TEAM LEADERS

SAY:

Another critical aspect of teamwork is effective team leadership. Team leaders are well-informed team members who make decisions and take actions. Team leaders establish the goals of the team and help maintain its focus.

There are two types of leaders: designated and situational. For a team to function successfully, a leader must be **designated**. In most clinical situations, the physician in charge is the designated team leader. **Situational** leaders emerge at designated times, such as during anesthesia induction, and at spontaneous times, for instance, the first responder to a code.

When leading teams, both designated and situational team leaders must possess a set of effective skills regardless of the type of team they are leading or the situation in which they are leading it. At its core, leading teams involves the following activities:

• Identifying a goal and defining a plan to achieve the goal;

• Assigning tasks and responsibilities;

• Sharing the plan;

• Monitoring the plan and progress toward the goal;

• Modifying the plan and communicating changes to all team members; and

• Reviewing the team's performance.

It is critical that when leading teams, designated and situational leaders also:

• Establish "rules of engagement" under which team members will operate and perform their roles;

• Manage and allocate resources effectively to ensure team members have what they need to be successful;

• Provide feedback to team members regarding their assigned responsibilities and progress toward the team's goal;

• Facilitate information sharing among team members;

• Encourage team members to assist one another when needed;

• Facilitate conflict resolution; and

• Model effective teamwork.

TEAM EVENTS

SAY:

Leading teams involves team events that include the activities of planning, problem solving, and process improvement.

Three strategies that team leaders can use to facilitate these activities and promote teamwork are:

- Briefs;

- Huddles; and

- Debriefs.

As shown on the slide, briefs are conducted at the start of a shift or a case, for example, to share a plan with the team. We will review briefs in more detail shortly.

Huddles are ad hoc sessions to review and modify the established plans. These may involve reviewing the plans to ensure all team members continue to be on the same page or adjusting the plan based on known or anticipated changes.

Debriefs are conducted to review what has occurred, such as after a case. These sessions are intended to improve team performance by identifying and reinforcing what went well and what can be improved. We will review debriefs in more detail shortly.

BRIEF CHECKLIST

SAY:

Briefs are a strategy for sharing the plan when leading a team. During a brief, which is sometimes referred to as a team meeting, the following information should be discussed:

- Team membership and roles—who is on the team and who is the designated team leader;

- Clinical status of the team's patients—the current condition, diagnosis, and status of each patient assigned to the team;

- The plan of care for each of the team's patients—what is to be accomplished, what are the expected outcomes, and who is to do it; and

- Issues affecting team operations—resources normally available that may be restricted during the current shift.

Defining clear goals and a plan to achieve those goals is an important part of the brief as well as establishing clear roles and expectations for each team member. Successful teams measure their effectiveness in terms of how well they are performing against the established plan. The designated team leader usually conducts the brief, and team members actively participate.

Similar to a preflight checklist used in aviation, the team leader should cover the items on this (or a similar) checklist. Conducting a brief at the beginning of a shift or prior to a case provides an ideal forum for communicating with other team members about the goals for each patient and the plan of care to ensure patient safety.

ASK:

- Have you participated in a brief? Did the items on this checklist occur? If not, what was not done?

SAY:

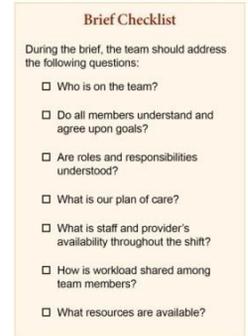Let's look at a short video clip that demonstrates a team conducting a brief.

DO:

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

DISCUSSION: Go to next page >

Continued…

VIDEO TIME:

36 seconds

MATERIALS:

- Brief Video 2 (Brief_LandD_2.mpg)

BRIEF CHECKLIST (Continued)

💬 **DISCUSSION:**

- Who is the designated team leader?

  - Dr. Upton. He set the tone by coordinating the brief and establishing a plan of care for Mrs. Keys.

- Did the team develop a comprehensive plan for Mrs. Keys?

  - Yes. Dr. Upton sought input from all team members before communicating the care plan. Team members were well aware of their roles and responsibilities and were eager to share information. Questions were encouraged.

- Did the team address contingencies and was the patient included in those discussions?

  - Yes. The team understood what specific factors could lead to C-section and Dr. Upton made plans to communicate that information to Mrs. Keys.

DEBRIEF CHECKLIST

SAY:

Research has shown that teams who effectively debrief their own performance can improve their teamwork in real time.

Debriefs include:

- Accurate recounting and documentation of key events;

- Analysis of why the event occurred, what worked, and what did not work;

- Discussion of lessons learned and how the team can alter the plan for the next time;

- Reinforcement of what went well and how the team can repeat the behavior or plan the next time; and

- Establishment of a method to formally change the existing plan to incorporate lessons learned.

Debriefs are most effective when conducted in an environment where honest mistakes are viewed as learning opportunities. Debriefs can be a brief (about 3 minutes or less) team event, typically initiated and facilitated by the team leader.

This checklist can be used by the team during a debriefing to ensure that all information is discussed.
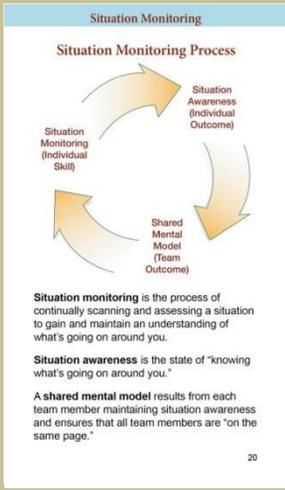
Here are two guidelines for conducting debriefs:

- Facilitate the discussion as a leader by asking questions related to team performance. For example, questions might include: What did we do well? What did not go well that we can improve?

- Recap the situation, background, and key events that occurred. Similar to the brief, the team leader should cover the items on this (or a similar) debrief checklist. This checklist can be used by the team during a debriefing to ensure that all information is discussed. The team leader should then summarize lessons learned and set goals for improvement.

These leadership techniques also help in maintaining an awareness of what is happening in your unit and with your team members. Situation monitoring is a continuous process that all team members should participate in.

Leadership

Debrief Checklist

The team should address the following questions during a debrief:

☐ Was communication clear?

☐ Were roles and responsibilities understood?

☐ Was situation awareness maintained?

☐ Was workload distribution equitable?

☐ Was task assistance requested or offered?

☐ Were errors made or avoided?

☐ Were resources available?

☐ What went well?

☐ What should improve?

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SITUATION MONITORING

Situation Monitoring

Situation Monitoring Process

Situation monitoring is the process of continually scanning and assessing a situation to gain and maintain an understanding of what's going on around you.

Situation awareness is the state of "knowing what's going on around you."

A shared mental model results from each team member maintaining situation awareness and ensures that all team members are "on the same page."

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SAY:

Situation monitoring is a continuous process because of the dynamic situations in which teams function. This process consists of three components:

- **Situation monitoring** (an individual skill) is the process of actively scanning and assessing elements of the situation to gain information or maintain an accurate understanding of the situation in which the team functions. Situation monitoring is a skill, which implies that it can be trained, developed, and improved. It enables team members to identify potential issues or minor deviations early enough so that they can correct and handle them before they become a problem or pose harm to the patient.

- **Situation awareness** (an individual outcome) is the state of knowing the conditions that affect one's work. It is a detailed picture of the situation. Note that situation awareness is not a static "thing" or concept. Because the situation and context in which the situation exists are dynamic and ever changing, team members must continually assess relevant components of the situation and update their individual situation awareness.

- **Shared mental models** (a team outcome) are the result of each team member maintaining his or her situation awareness and sharing relevant facts with the entire team. Doing so helps ensure that everyone on the team is "on the same page."

ASK:

- When have you used situation monitoring in your work?

- How did the information that you obtained from the environment affect how you approached or responded to the situation?

STEP

SAY:

How do you acquire a trained eye as you "monitor the situation" on your unit? What are relevant components of the situation that provide clues about impending complications or contingencies? The STEP process is a mnemonic tool that can help you monitor the situation and the overall environment.

The STEP process involves ongoing monitoring of the—

• **S**tatus of the patient

• **T**eam members

• **E**nvironment

• **P**rogress toward the goal

It is not only the responsibility of the direct care team to monitor these elements – anyone involved in the care of patients or the environment should be expected to monitor the situation.

Examples:

• The respiratory therapist notes that a ventilated patient is showing a marked increase in respiratory rate that might indicate an increased level of pain that cannot be communicated (**STATUS**).

• The patient's nurse is busy helping another patient (**TEAM MEMBERS**).

• It is a shift change, and everyone is busy, so you check the medication record and note that the patient is overdue for his morphine (**ENVIRONMENT**).

• You notify the oncoming nurse of your concern (**PROGRESS**).

STEP ASSESSMENT

SAY:

In a health care setting, the most obvious element of the situation requiring constant monitoring is your patient's status. Even minor changes in the patient's vital signs may require dramatic changes in the team's actions and the urgency of its response. When assessing patient status, consider:

- Patient history;
- Vital signs;
- Medications;
- Physical exam;
- Plan of care; and
- Psychosocial condition (e.g., patient's stress level).

You should also be aware of team members' status, including:

- Fatigue level;
- Workload;
- Task performance;
- Skill level; and
- Stress level.

You should be aware of the environment, including:

- Facility information;
- Administrative information;
- Human resources;
- Triage acuity; and
- Equipment.

And finally, you should assess your progress toward goals by asking key questions. These questions are:

- What is the status of the team's patients?
- Has the team established goals?
- Has the team accomplished their tasks or actions?
- Is the plan still appropriate?

CROSS-MONITORING

SAY:

Health care providers are just as prone to human error as the general population. Teams that recognize and maintain an awareness of their individual team members' functioning are more likely to provide constructive feedback, have a shared understanding of the situation, and lend support or assistance when needed.

Observing the actions of fellow team members – or cross-monitoring – is a safety mechanism that can be used to mitigate error before the patient is harmed. Commonly referred to as "watching each other's back," monitoring other team members by keeping track of their behavior and providing feedback ensures that procedures are being followed appropriately. It allows team members to self-correct their actions if necessary.

Staff members need to constantly be aware of the situation, anticipate next steps, "watch each other's back," and take appropriate corrective action to prevent errors from reaching the patient.

Let's try an exercise to demonstrate cross-monitoring. Find a partner so you are each in a pair. With your partner, share an example of a situation in which cross-monitoring was successful and one in which cross-monitoring should have been used but was not.

DO:

Give the pairs a few minutes to share their examples with one another. Then, bring the participants back together.

ASK:

• What are some of the examples of successful cross-monitoring you shared?

• What are some of the examples of situations in which cross-monitoring should have been used but was not?
  SAY:

Another tool for monitoring fellow team members and your own effectiveness is the I'M SAFE tool.

I'M SAFE CHECKLIST

Situation Monitoring

Each team member is responsible for assessing his or her own safety status

I'M SAFE Checklist

☐ **I** = Illness
☐ **M** = Medication
☐ **S** = Stress
☐ **A** = Alcohol and Drugs
☐ **F** = Fatigue
☐ **E** = Eating and Elimination

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SAY:

Awareness of your own condition to ensure that you are fit and ready to fulfill your duties is essential to delivering safe, quality care. Team members should assess and report if there is a personal situation affecting their ability to perform.

"I'M SAFE" is a simple checklist that can be used to determine both your co-workers' and your own ability to perform safely. I'M SAFE stands for—

- **Illness**. Am I feeling so bad that I cannot perform my duties?

- **Medication.** Is the medication I am taking affecting my ability to maintain situation awareness and perform my duties?

- **Stress.** Is there something—such as a life event or situation at work—that is detracting from my ability to focus and perform my duties?

- **Alcohol/Drugs.** Is my use of alcohol or illicit drugs affecting me so that I cannot focus on the performance of my duties?

- **Fatigue.** The effects of fatigue should not be ignored. Team members should alert the team regarding their state of fatigue For example, saying "Watch me a little closer today; I only had three hours of sleep last night."

- **Eating and Elimination**. Has it been 6 hours since I have eaten or used the restroom? Many times we are so focused on ensuring our patient's basic needs that we forget to take care of our own. Not taking care of our elimination needs affects our ability to concentrate and stresses us physiologically.

Teams should be encouraged to set goals concerning the items on this checklist. For example, setting a goal that everyone will be given the opportunity to take a break and have lunch today.

ASK:

- In your current situation would you feel able to express that you're not safe?

- What are the factors that inhibit you from doing so and/or that contribute to your inability to do so?

- If you feel inhibited, what can you and your team do to change the culture?

SAY:

For this to be successful, there must be a culture in place in which staff feel safe to be honest without fear of reprisal, retribution, or disdain.

TASK ASSISTANCE

SAY:

Mutual support, which is commonly referred to as "backup behavior," is critical to team performance. Mutual support is derived from situation monitoring through the ability to anticipate patient needs, as well as other team members' needs, with accurate knowledge of their responsibilities.

One method of providing mutual support is through task assistance. This includes both asking for assistance when needed and offering assistance to team members when the opportunity arises. Task assistance may involve asking for assistance when overwhelmed or unsure, helping team members to perform their tasks, shifting workload by redistributing tasks to other team members, delaying or rerouting work so the overburdened member can recover, and/or filling in for overburdened team members when necessary.

Task assistance is guided by situation monitoring, because situation awareness allows team members to effectively identify when they, or other team members, need assistance.

To a certain degree, some of us have been conditioned to avoid asking for help because of the fear of suggesting lack of knowledge or confidence. Many people refuse to seek assistance when overwhelmed by tasks. In support of patient safety, however, task assistance is expected.

ASK:

- What can happen when we are overwhelmed and we do not seek task assistance?

SAY:

Error vulnerability is increased when people are under stress, are in high-task situations, or are fatigued. One of the most important concepts to remember with regard to task assistance is that assistance should be actively given and offered whenever there is a concern for patient safety.
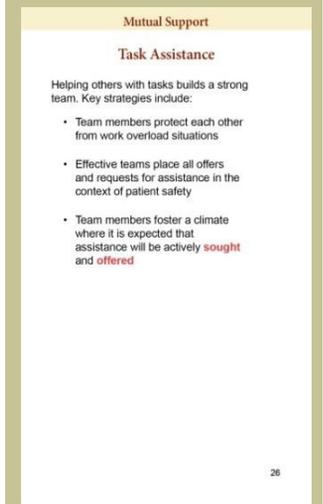
FEEDBACK

Feedback

Information provided to team members for the purpose of improving team performance

Feedback should be:

- Timely – given soon after the target behavior has occurred
- Respectful – focuses on behaviors, not personal attributes
- Specific – relates to a specific task or behavior that requires correction or improvement
- Directed toward improvement – provides directions for future improvement
- Considerate – considers a team member's feelings and delivers negative information with fairness and respect

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Mutual Support

SAY:

Another strategy to foster mutual support is feedback. Feedback is information provided for the purpose of improving team performance. The ability to communicate self-improvement information in a useful way is an important skill in the team improvement process. Feedback can be given by any team member at any time. It is not limited to leadership roles or formal evaluation mechanisms. Effective feedback benefits the team in several ways, including:

- Fostering improvement in work performance;

- Meeting the team's and individuals' need for growth;

- Promoting better working relationships; and

- Helping the team set goals for ongoing improvement.

ASK:

- Can you describe a situation in which you had to give feedback to another team member?

    - What was the situation?

    - What was the result?

ADVOCACY AND ASSERTION

SAY:

A third strategy used to facilitate mutual support is advocacy and assertion. Advocacy and assertion interventions are invoked when a team member's viewpoint does not coincide with that of a decisionmaker. In advocating for the patient and asserting a corrective action, the team member has an opportunity to correct errors or the loss of situation awareness. Failure to use advocacy and assertion has been frequently identified as a primary contributor to the clinical errors found in malpractice cases and sentinel events.

You should advocate for the patient even when your viewpoint is unpopular, is in opposition to another person's view, or questions authority. When advocating, assert your viewpoint in a firm and respectful manner. You should also be persistent and persuasive, providing evidence or data for your concerns.

Mutual Support

Advocacy and Assertion

Advocate for the patient
- Invoked when team members' viewpoints don't coincide with that of the decisionmaker

Assert a corrective action in a **firm** and **respectful** manner
- Make an opening
- State the concern
- State the problem (real or perceived)
- Offer a solution
- Reach agreement on next steps

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TWO-CHALLENGE RULE

SAY:

One strategy to facilitate team members' speaking up is the Two-Challenge Rule. It is important to voice your concern by advocating and asserting your statement at least twice if the initial assertion is ignored (thus the name, "Two-Challenge Rule"). These two attempts may come from the same person or two different team members.

• The first challenge should be in the form of a question.

• The second challenge should provide some support for your concern.

Remember this is about advocating for the patient. The Two-Challenge Rule ensures that an expressed concern has been heard, understood, and acknowledged.

There may be times when an initial assertion is ignored. If after two attempts the concern is still disregarded, but the member believes patient or staff safety is or may be severely compromised, the Two-Challenge Rule mandates taking a stronger course of action or using a supervisor or chain of command. This overcomes our natural tendency to believe the team leader must always know what he or she is doing, even when the actions taken depart from established guidelines. When invoking this rule and moving up the chain, it is essential to communicate to the entire medical team that additional input has been solicited.

If you personally are challenged by a team member, it is your responsibility to acknowledge the concerns instead of ignoring the person. Any team member should be empowered to "stop the line" if he or she senses or discovers an essential safety breach. This is an action that should never be taken lightly, but requires immediate cessation of the process to resolve the safety issue.

CUS

SAY:

Using the CUS technique provides another tool for conflict resolution, advocacy, and mutual support. Signal words, such as "danger," "warning," and "caution" are common in the medical arena. They catch the reader's attention. In verbal communication, "CUS" and other signal phrases have a similar effect . If all team members have a shared mental model and are on the same page, when these words are spoken all team members will clearly understand the issue and its magnitude.

To use CUS:

- First, state your <u>c</u>oncern.

- Then, state why you are <u>u</u>ncomfortable.

- If the conflict is not resolved, state that there is a <u>s</u>afety issue. Discuss in what way the concern is related to safety. If the safety issue is not acknowledged, a supervisor should be notified.

A few other phrases in use are:

- I would like some clarity about…

- Would you like some assistance?

CONFLICT RESOLUTION: DESC SCRIPT

DESC Script

A constructive approach for managing and resolving conflict

D = Describe the specific situation or behavior; provide concrete data

E = Express how the situation makes you feel/what your concerns are

S = Suggest other alternatives and seek agreement

C = Consequences should be stated in terms of impact on established team goals; strive for consensus

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Mutual Support

SAY:

Conflict can occur in teams and it is important to know how to handle such situations when they occur. The Two-Challenge Rule, which we have already discussed as a tool to advocate and assert for patient safety, can also be used as a conflict resolution strategy. When team members have different information, the Two-Challenge Rule can be used to bring up the different information so it can be addressed.

The DESC script can be used to communicate effectively during all types of conflict, and is most effective in resolving personal conflict. The DESC script is used in the more conflicting scenarios in which behaviors aren't practiced, hostile or harassing behaviors are ongoing, and safe patient care is suffering.

DESC is a mnemonic for:

> D = Describe the specific situation.

> E = Express your concerns about the action.

> S = Suggest other alternatives.

> C = Consequences should be stated.

Ultimately, consensus should be reached.

There are some crucial things to consider when using the DESC script:

- Time the discussion.

- Work on win-win—Despite your interpersonal conflict with the other party, team unity and quality of care depend on coming to a solution that all parties can live with.

- Frame problems in terms of personal experience and lessons learned.

- Choose the location—A private location that is not in front of the patient or other team members will allow both parties to focus on resolving the conflict rather than on saving face.

- Use "I" statements rather than blaming statements.

- Critique is not criticism.

- Focus on what is right, not who is right.

TEAM PERFORMANCE OBSERVATION TOOL

SAY:

In review, several key concepts and tools or techniques can be used to work as an effective team and ensure patient safety. The Team Performance Observation Tool presents types of behaviors that you might observe in a team's performance.

- **Team Structure**

  – Assembles a team

  – Assigns or identifies team members' roles and responsibilities

  – Holds team members accountable

  – Includes patients and families as part of the team

- **Communication**

  – Provides brief, clear, specific, and timely information to team members

  – Seeks information from all available sources

  – Uses check-backs to verify information that is communicated

  – Uses SBAR, call-outs, and handoff techniques to communicate effectively with team members

- **Leadership**

  – Identifies team goals and vision

  – Uses resources efficiently to maximize team performance

  – Balances workload within the team

  – Delegates tasks or assignments, as appropriate

  – Conducts briefs, huddles, and debriefs

  – Role models teamwork behaviors

Continued…

TEAM PERFORMANCE OBSERVATION TOOL (Continued)

SAY:

- **Situation Monitoring**

  - Monitors the patient's status

  - Monitors fellow team members to ensure safety and prevent errors

  - Monitors the environment for safety and availability of resources (e.g., equipment)

  - Monitors progress toward the goal and identifies changes that could alter the care plan

  - Fosters communication to ensure team members have a shared mental model

- **Mutual Support**

  - Provides task-related support and assistance

  - Provides timely and constructive feedback to team members

  - Effectively advocates for patient safety using the Assertive Statement, Two-Challenge Rule, or CUS

  - Uses the Two-Challenge Rule, CUS, and DESC script to resolve conflict

The Team Performance Observation Tool is generic, meaning it is not designed to focus on any particular clinical unit. However, it can be customized as needed. Some ways the tool might be integrated into practices include:

- As a means for providing feedback and coaching to staff;

- As a checklist for reviewing some expected team behaviors in a staff or team meeting; and

- As a formal observation tool to evaluate the team's performance on the listed behaviors.

TOOLS AND STRATEGIES SUMMARY

SAY:

Throughout this course, you have received information about barriers to team effectiveness; tools and strategies to overcome such barriers; and the outcomes of effective teamwork.

You have learned communication tools, such as SBAR, handoffs, and call-outs. You have also learned about leadership strategies for managing resources, along with tools for facilitating team events, such as briefs, huddles, and debriefs. You have also learned the situation monitoring mnemonic STEP and mutual support tools, such as the Two-Challenge Rule, CUS, and DESC script.

Remember that enhanced patient safety is the ultimate outcome of consistently using the TeamSTEPPS tools and strategies to overcome barriers to team effectiveness.

EXERCISE: SUMMARY

SAY:

To review what we've learned across the modules, we will watch a video scenario of a team in action. As you watch the video, make note of the use of TeamSTEPPS tools and strategies that are used.

⊗ VIDEO TIME:

3:26 minutes

▭ MATERIALS:

- Video Vignette (INPTSURG_ Success_Com plete_Vignette .mpg)

- Flipchart or Whiteboard (Optional)

- Markers (Optional)

DO:

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

💬 DISCUSSION:

- Which TeamSTEPPS strategies and tools were used in this scenario?

  – Several TeamSTEPPS strategies and tools were used, including:

    – SBAR between the physician and the recovery room nurse

    – Structured handoff from recovery nurse to floor nurse

    – Brief at start of new nursing shift

    – Check-back by Mrs. Peters and her daughter of signs and symptoms to monitor

    – Check-back to confirm understanding of medication orders and dosing between the physician and pharmacist

- How did the use of these TeamSTEPPS tools and strategies affect the course and outcome of the scenario?

  – Information was continually shared with the care team, resulting in a shared mental model of Mrs. Peters' status and plan of care.

  – Team members appeared aware of their roles and responsibilities and ensured that the team leader (the physician) was informed of changes in Mrs. Peters' status, so that she could modify the plan of care.

  – Mrs. Peters was discharged because the team's performance ensured patient safety.

EXERCISE: SUMMARY (Continued)

SAY:

The most important thing to take away from this course is how you will apply the tools and strategies that you learned in your daily work.

💬 **DISCUSSION:**

- What are the top 3 to 5 actions you can commit to taking to improve teamwork and communication in your environment?

- How can you use the TeamSTEPPS Pocket Guide in the next week?