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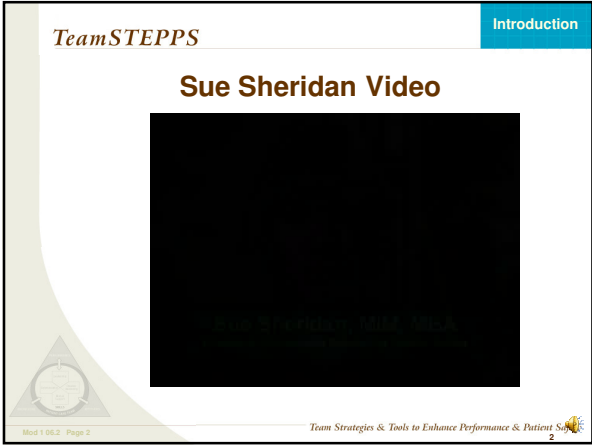
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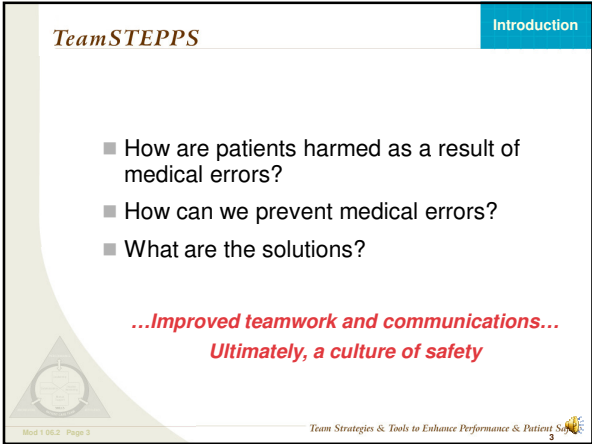
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**TeamSTEPPS** Introduction

### Objectives

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

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**TeamSTEPPS** Introduction

### Teamwork Is All Around Us

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**TeamSTEPPS** Introduction

**Length of ICU Stay After Team Training**  
(Pronovost, 2003) Johns Hopkins Journal of Critical Care Medicine  
Line graph showing a 30% reduction in ICU stay length after team training.

**OR Teamwork Climate and Postoperative Sepsis Rates**  
(Sexton, 2006) Johns Hopkins  
Bar chart comparing sepsis rates per 1000 discharges for different teamwork climates. High teamwork climate shows the lowest rate.

**Adverse Outcomes**  
(Mann, 2006) Beth Israel Deaconess Medical Center Contemporary OB/GYN  
Bar chart showing a 50% reduction in adverse outcomes after team training.

**Indemnity Experience**  
(Mann, 2006) Beth Israel Deaconess Medical Center Contemporary OB/GYN  
Bar chart showing a 50% reduction in indemnity experience (Malpractice Claims, Suits, and Observations) after team training.

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**TeamSTEPPS** Introduction

## Introduction

Evolution of TeamSTEPPS

**Curriculum Contributors**

- Department of Defense
- Agency for Healthcare Research and Quality
- Research Organizations
- Universities
- Medical and Business Schools
- Hospitals—Military and Civilian, Teaching and Community-Based
- Healthcare Foundations
- Private Companies
- Subject Matter Experts in Teamwork, Human Factors, and Crew Resource Management (CRM)

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**TeamSTEPPS** Introduction

## TeamSTEPPS

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

*“Initiative based on evidence derived from team performance...leveraging more than 25 years of research in military, aviation, nuclear power, business and industry...to acquire team competencies”*

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**TeamSTEPPS** Introduction

## Patient Safety Movement

The timeline shows key events in patient safety: 1995 (DoD MedTeams ED Study), 1999 ("To Err is Human" IOM Report), 2001 (Executive Memo from President), 2003 (JCAHO National Patient Safety Goals), 2004 (Institute for Healthcare Improvement 100k Lives Campaign), 2005 (TeamSTEPPS and Patient Safety and Quality Improvement Act of 2005), and 2006. A green arrow labeled "Medical Team Training" spans from 1999 to 2006.

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**TeamSTEPPS** Introduction

### The Components of a Patient Safety Program

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**TeamSTEPPS** Introduction

### Course Agenda

- Module 1—Introduction
- Module 2—Team Structure
- Module 3—Leadership
- Module 4—Situation Monitoring
- Module 5—Mutual Support
- Module 6—Communication
- Module 7—Summary—Pulling It All Together

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**TeamSTEPPS** Introduction

### Why Do Errors Occur—Some Obstacles

■ Workload fluctuations	■ Excessive professional courtesy
■ Interruptions	■ Halo effect
■ Fatigue	■ Passenger syndrome
■ Multi-tasking	■ Hidden agenda
■ Failure to follow up	■ Complacency
■ Poor handoffs	■ High-risk phase
■ Ineffective communication	■ Strength of an idea
■ Not following protocol	■ Task (target) fixation

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**TeamSTEPPS** Introduction

### What Comprises Team Performance?

*...team performance is a science...consequences of errors are great...*

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**TeamSTEPPS** Introduction

### Outcomes of Team Competencies

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

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**TeamSTEPPS** Introduction

### Teamwork Actions

- Recognize opportunities to improve patient safety
- Assess your current organizational culture and existing Patient Safety Program components
- Identify teamwork improvement action plan by analyzing data and survey results
- Design and implement initiative to improve team-related competencies among your staff
- Integrate TeamSTEPPS into daily practice.

*"High-performance teams create a safety net for your healthcare organization as you promote a culture of safety."*

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**TeamSTEPPS** Introduction

### Teamwork Encompasses CRM

DoD has led the way in team research and innovations

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



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

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**TeamSTEPPS** Introduction

### Background: US Army Aviation

- Army aviation crew coordination failures in mid-80s contributed to 147 aviation fatalities and cost more than \$290 million
- The vast majority involved highly experienced aviators
- Failures were attributed largely to crew communication, workload management, and task prioritization

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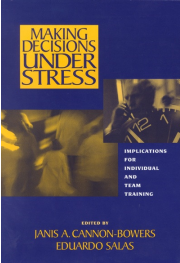
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**TeamSTEPPS** Introduction

### US Navy Breakthroughs: Tactical Decisionmaking Under Stress (TADMUS)

- Cross-Training
- Stress Exposure Training
- Team Coordination Training (CRM)
- Scenario-Based Training and Simulation
- Team Leader Training
- Team Dimensional Training
- Team Assessment



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**TeamSTEPPS** Introduction

## US Air Force CRM History

- Mid to Late 80s AF bombers and heavy aircraft started CRM training
- 1992 Air Combat Command developed Aircrew Attention Management /CRM Training
- By 1998, CRM deployed uniformly across the AF
- Steady decline in human factors based mishaps since CRM training deployed
- AF Medical Service adapted training, rolled out in 2000



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**TeamSTEPPS** Introduction

## Eight Steps of Change



John Kotter

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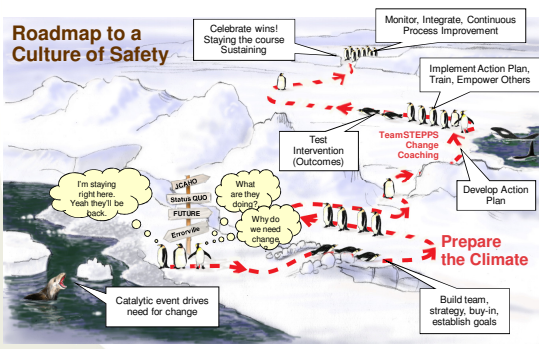
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**TeamSTEPPS** Introduction

## Roadmap to a Culture of Safety



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