POMONA VALLEY HOSPITAL

APPLYING THE TEAMSTEPPS APPROACH
WHO WE ARE

- 437 BED, Teaching Hospital
- NOT-FOR-PROFIT
- 10 FWY, Pomona
TEAM STEPPS

- Physician Champion
- “Buy-in” from above
- CEO, VP Nursing
- Medical Director
- QM
- Insurance Carrier
Drills: Turning a Team of Experts into an Expert Team

Practice Makes Perfect

ORGANIZATIONAL DRILLS

After the Institute of Medicine’s (IOM) report—To Err is Human: Building a Safer Health System—teamwork, coordination, and communication began to be recognized as key ingredients in the delivery of safe health care. Long recognized by aviation and other high-risk industries, drills and simulation are some of the most useful tools for evaluating and testing responses to low-volume, high-risk events. The basic elements of a health care facility’s drill program, including the frequency of drills, are largely governed by regulatory and accrediting agencies such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), Det Norske Veritas – Germanischer Lloyd (DNV-GL), and National Fire Protection Agency.

When establishing a schedule of drills and exercises to practice, consider including participation with community partners, such as the local Police and Fire Departments and the Emergency Medical System, especially during community or statewide disaster drills. Use these activities’ lessons learned to improve your elements of performance and response.

In the publication, ‘drill’ and ‘simulation training’ are used interchangeably.

What is a Drill?

- A practice or tool to model a real-life or hypothetical event in order to examine certain goals and objectives.
- An exercise training for health care professionals for high risk, low volume situations in a controlled setting which demonstrates understanding and is used as an opportunity to learn without any expense on patient mortality or morbidity.
- Repetitive practice.

Why Drill?

While training takes on many forms, drills are most efficacious for practicing events that are regarded as emergent or high acuity, preparing people for error-prone, high-risk or low-volume situations. These types of events are encountered infrequently and it is difficult to perform the appropriate interventions with a high degree of reliability without simulation training. (1) Obstetrical emergencies, such as shoulder dystocia and post partum hemorrhage (PPH), are classic examples of the types of events that benefit from simulation. Given an increased focus on patient safety, the need for standardized, on-demand educational opportunities to help ensure “readiness,” and the ability to practice and hone skills in a controlled environment, simulation has become an increasingly important tool for education and skill acquisition, turning the focus on learning and not on assessment alone.

The following post partum hemorrhage (PPH) case depicts how simulation might have been useful in avoiding or mitigating an adverse outcome:

Case example 1:

A 25-year-old gravida 2, para 1 presented to the hospital at 38 weeks gestation in active labor with contractions 2-3 minutes apart and some vaginal bleeding. An ultrasound was performed soon after admission revealing a partial placenta previa. Pitocin augmentation was started. Four hours after admission, the patient’s vital signs remained stable, occasional variable decelerations were noted and spontaneous rupture of membranes occurred. In response to increased vaginal bleeding, the patient consented to emergent Cesarean section. The infant was delivered with apgars of 0 and 9.
TEAM STEPPS

• Simulation Committee
• Submissions for simulation requests
• Application rejected if communication is not one of the main objectives
• MDs invited to observe
• Staff invited, QM, etc.
TEAM STEPPS

- Main Concepts introduced at House-wide Orientation
- SBAR
- Residency Program
- Rapid Response Team
Key Principles

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

**Communication**
Structured process by which information is clearly and accurately exchanged among team members.

**Leadership**
Ability to maximize the activities of team members by ensuring that 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 or understanding, or to maintain awareness to support team functioning.

**Mutual Support**
Ability to anticipate and support team members’ needs through accurate knowledge about their responsibilities and workload.
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.”
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?
## Vaginal Breech Scenario: Roles/Leadership

<table>
<thead>
<tr>
<th>Team Roles and Leadership</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td><strong>Roles</strong></td>
<td></td>
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<tr>
<td>Each team member had a clear role</td>
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<tr>
<td>There was a team leader</td>
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<tr>
<td><strong>Adaptability</strong></td>
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<tr>
<td>Team members responded well to different situations</td>
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<tr>
<td><strong>Responsibility</strong></td>
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<tr>
<td>Team members assumed responsibility for their role</td>
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<tr>
<td><strong>Advocate</strong></td>
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<tr>
<td>Tasks were delegated appropriately</td>
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<tr>
<td><strong>Feedback</strong></td>
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<td>There were regular updates on progress</td>
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<td>A running commentary was provided</td>
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<tr>
<td><strong>Support</strong></td>
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<tr>
<td>Team members did not argue about issues</td>
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<tr>
<td>None of the team members decided to &quot;go it alone&quot;</td>
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“Speak-up Team-up”

- C.U.S – Trauma Training
- Two Challenge Rule
- RRT Debriefing
- Article in Physician’s Newsletter
CHALLENGES

• Culture
• Stakeholder involvement
• Training Time/Resources
• Personal Awareness
• Interpersonal Relationships
• Competing Priorities
• Silos
LOOKING AHEAD...

- Expanding/Empowering
- Developing Clinical III Staff
- Formalizing
- Training Staff
- Academic Partnering
A Typical Lunch Break at Pomona Valley