The Effects of evidence - based TeamSTEPPS Interprofessional Communication and Teamwork Training on Patient and Provider Outcomes in Obstetrics and Gynecology division – Alwakra Hospital.

Authors: Dr. Almunzer Zakaria- Assisstant Excutive Director of Quality and Patient Safety- AWH

Co-Authors: Ms. Resmi Lekhadevi , Risk Management Reviewer- AWH.

Ms. Mr. Walid Desoky, Risk Management Reviewer- AWH.

Ms. Muna Atrash, Senior Quality Improvement Reviewer- AWH.

Dr. Mohamed Alloub, Manager Senior Consultant of Obstetrics and Gynecology- AWH.

Ms. Tamara Alshdafat, Director of Nursing Obstetrics and Gynecology- AWH

➢ Introduction

- TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based framework to optimize team performance across the healthcare delivery system. The core of the TeamSTEPPS framework is comprised of four skills: Leadership, Situation Monitoring, Mutual Support, and Communication.

➢ Background:

- Communication breakdown between healthcare providers, patient and healthcare providers themselves was one of the leading causes to most of the significant incidents in Obstetrics and gynecology division in Al Wakra Hospital. The number and severity of incident that was reported in 2018 through Electronic incident reporting system was high; upon intensive investigation of these incidents through Root cause analysis it was identified that there is a need for building an effective interprofessional communication process between healthcare providers and their patient which will have great impact on the shared decision making and patient's outcomes.
- Hence Al Wakra Hospital uses this tool for improving the interprofessional communication and teamwork among Obstetrics and gynecology division in Al Wakra Hospital.
- There are three phases to TeamSTEPPS implementation. For the intervention to be effective, a hospital or care system should complete key actions through the phases of 1) assessment; 2) planning, training and implementation; and 3) sustainment.

	Tool	Brief Description
Communication	SBAR	» A standardized technique for communicating critical information that requires immediate attention and action concerning a patient's condition. » SBAR stands for **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation/**R**equest.
	Call-out	» A tactic used to communicate important or critical information. It informs all team members simultaneously during emergent situations and helps team members anticipate next steps.
	Check-back	» A strategy for closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended.
	Handoff	» The transfer of information during transitions in care across the continuum. It provides an opportunity to ask questions, clarify and confirm. » A specific tool for this is "I PASS THE BATON" which is designed to enhance the information exchange.
Leadership	Brief	» A short session prior to the start of a procedure or event to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and likelycontingencies.
	Huddle	» Ad hoc meeting to re-establish situational awareness, reinforce plans already in place, and assess the need to adjust the plan.
	Debrief	» Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positivebehaviors.
Situation Monitoring	STEP	» A tool for monitoring situations in the delivery of health care and useful in situation monitoring of the patient. » STEP stands for **S**tatus of the patient, **T**eam members, **E**nvironment, **P**rogress toward goal.
	Cross-monitoring	A harm error reduction strategy that involves: » Monitoring the actions of other team members » Providing a safety net within the team » Ensuring that mistakes or oversights are caught quickly and easily » "Watching each other's back"
	I'M SAFE checklist	» A checklist used during situation monitoring by each team member to assess his or her own safety status. » I'M SAFE stands for **I**llness, **M**edication, **S**tress, **A**lcohol and Drugs, **F**atigue, **E**ating and Elimination.

➢ **Phase One**: Assessment

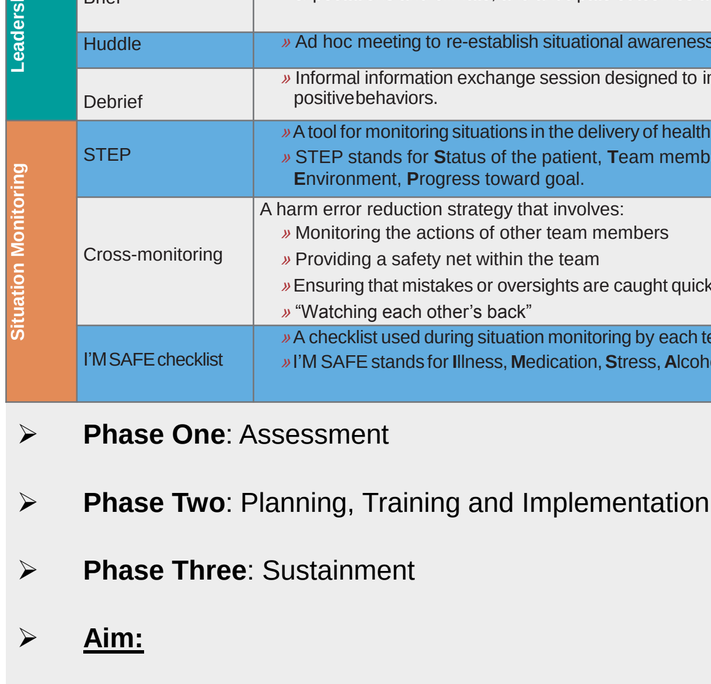
➢ **Phase Two**: Planning, Training and Implementation

➢ **Phase Three**: Sustainment

➢ Aim:

- Reduce the number of reported significant incidents from obstetrics and gynecology to less than 50% by June 2019 and to 25% by December 2019.

➢ Methodology:



➢ Measures:

- **Process Measures**

Total number of serious incidents reported → Through electronic incident reporting system → The number of cases → which underwent an adverse medical outcome committee investigation

- **Outcome Measures :**

Compliance rate of patient involvement → Debriefing during any high risk procedures → Number of staff who completed TeamSTEPPS training

➢ Changes:

- Training was provided to the team by quality and patient safety department to train the trainer.
- Both physicians and midwifes were engaged and champions were selected to be master trainer.
- Specific tools were introduced to the team to start with (Briefing, Huddles and debriefing).
- Monitoring the compliance of patient involvement in the briefing and debriefing session with the team.
- Good catch award was provided to those who worked as a patient safety advocate for their good practice.
- Introduce a new policy for involvement of patient spouse during the delivery procedure from start to the end.
- Introduce a new approach of unit based team to effectively manage their patients.

• Results:

- There was a decrease in the number of near misses and sentinel events following implementation of the Team STEPPS program. Unit based teams were effective in improving the frequency and quality of multidisciplinary communication, creating an improved climate for patient safety. Inclusion of patients and their families in team huddles and care planning has fostered greater patient engagement in the care process. Various interventions were effective in empowering front-line nursing staff to speak-up and improving patient outcomes

• Conclusion:

- Inclusion of patients and their families in team huddles and care planning has fostered greater patient engagement in the care process.
- Various interventions were effective in empowering front-line nursing staff to speak-up and improving patient outcomes.

• Sustainability Plan:

The implementation of TeamSTEPPS is still ongoing on 2019 to achieve the ultimate goal of reduction of significant incidents in obstetrics and genecology division and will be generalized to hospital wide to reduce the number of AMOC case investigations after serious or sentinel events.

• References:

➢ Health Research & Educational Trust. (2015, June). Improving Patient Safety Culture through Teamwork and Communication: TeamSTEPPS®. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org.

➢ Curtis, Ann, Improving Teamwork and Communication in the Operating Room Using Teamstepps® (October 19, 2015). Available at SSRN: https://ssrn.com/abstract=2959462 or http://dx.doi.org/10.2139/ssrn.2959462.

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