TeamSTEPPS
Strategies and Tools to Enhance Performance and Patient Safety
Ice Breaker
Do No Harm – Jess’ Story

Do no Harm Jess' Story
Medical Error

- Have you been affected by one?
- Has your family?
- Have you made one?

Accidental Deaths in the U.S.

- 120,000 deaths from medical error
- 43,649 motor vehicle deaths
- 14,986 deaths from falls
- 3,959 drowning deaths
- 329 commercial aviation deaths

An estimated one million people are injured by errors during hospital treatment each year and 120,000 people die as a result of those injuries, according to a study led by Lucian Leape of the Harvard School of Public Health. Here’s how that number compares with other causes of accidental death in the United States.*

Institute of Medicine Report

Impact of Error:

- 44,000–98,000 annual deaths occur as a result of errors
- Medical errors are the leading cause, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS, or car accidents
- 7% of hospital patients experience a serious medication error

Cost associated with medical errors is $8–29 billion annually.

Federal Action:

By 5 years;
- ↓ medical errors by 50%,
- ↓ nosocomial by 90%; and
- eliminate “never-events” (such as wrong-site surgery)
Patient Safety Movement

- DoD MedTeams® ED Study
- “To Err is Human” IOM Report
- Executive Memo from President
- JCAHO National Patient Safety Goals
- Institute for Healthcare Improvement 100K Lives Campaign
- Patient Safety and Quality Improvement Act of 2005

Medical Team Training
The Journey Towards Safety

- 2006: Institute of Medicine issues a 2nd report
  - At least 1.5 million Americans are sickened, injured or killed each year by errors in prescribing, dispensing and taking MEDICATIONS
  - DRUG ERRORS cause at least 400,000 preventable injuries and deaths in HOSPITALS each year, more than 800,000 in nursing homes and 530,000 among Medicare patients treated in outpatient clinics
We’re not there yet…
2010

Institute for Healthcare Improvement:

- Medical harm occurs 15 million times a year – that includes about 200,000 deaths caused by avoidable mistakes and hospital-acquired infections

Center for Disease Control:

- Approximately 1.7 million Hospital-acquired infections occur in U.S. hospitals each year, resulting in 99,000 deaths and an estimated $20 billion in healthcare costs
We’re not there yet…
2010

- TWO MAJOR FOLLOW-UP STUDIES PUBLISHED
  - Health and Human Services: Office of the Inspector General
  - New England Journal of Medicine
    - North Carolina hospitals from 2002-2007
We’re not there yet...

  - Medical mistakes contributed to the deaths of 15,000 patients in one month (October 2008)
  - Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable.
  - Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October 2008.
We’re not there yet...


- 18% of patients were harmed by medical care – some more than once! (2,341 patients studied)
- 63.1% of the injuries were judged to be preventable
- 42.7% required extra time in the hospital
- 2.9% suffered permanent injury
- 8% were life threatening
- 2.4% caused or contributed to a patient’s death
Why Do Errors Occur—Some Obstacles

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

Root Causes of Sentinel Events

(All categories; 1995-2005)

- Communication
- Orientation/training
- Patient assessment
- Staffing
- Availability of info
- Competency/credentialing
- Procedural compliance
- Environ. safety / security
- Leadership
- Continuum of care
- Care planning
- Organization culture

Percent of 3548 events

Targets for Teamwork
Dropping the Hammer…

- Medicare will reduce reimbursements to hospitals that fail to meet certain safety and quality standards.
- In 2015, hospitals with high rates of medical errors will lose 1% of their Medicare payments.
Dropping the Hammer…

- High rates of readmission and infection will also reduce payments
- Medicare will publish individual hospital infection and error rates.
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”
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
**Introduction**

- **Indemnity Experience**
  - Pre-Teamwork Training: 20
  - Post-Teamwork Training: 11
  - 50% Reduction

- **OR Teamwork Climate and Postoperative Sepsis Rates**
  - Group Mean
  - Low Teamwork Climate
  - Mid Teamwork Climate
  - High Teamwork Climate
  - AHRQ National Average

- **Length of ICU Stay After Team Training**
  - 50% Reduction

- **Adverse Outcomes**
  - 50% Reduction

- **OR Teamwork Climate Based on Safety Attitudes Questionnaire**
  - Low to High

- **(Mann, 2006)**
  - Beth Israel Deaconess Medical Center
  - Contemporary OB/GYN

- **(Sexton, 2006)**
  - Johns Hopkins
  - Johns Hopkins Journal of Critical Care Medicine
What Comprises Team Performance?

Knowledge
Cognitions
“Think”

Skills
Behaviors
“Do”

Attitudes
Affect
“Feel”

...team performance is a science...consequences of errors are great...
Outcomes of Team Competencies

- **Knowledge**
  - Shared Mental Model

- **Attitudes**
  - Mutual Trust
  - Team Orientation

- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety
Introductions and Exercise: Magic Wand

If I had a “Magic Wand” and could make changes within my unit or facility in the areas of patient quality and safety…