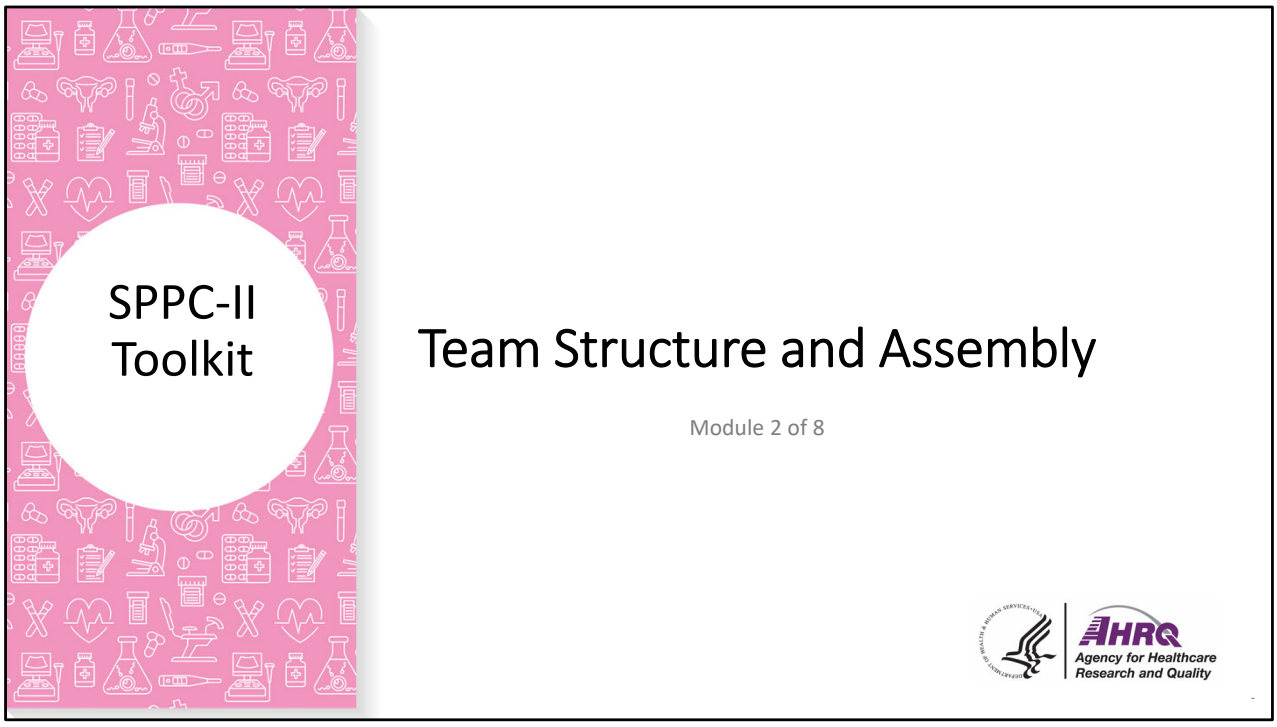
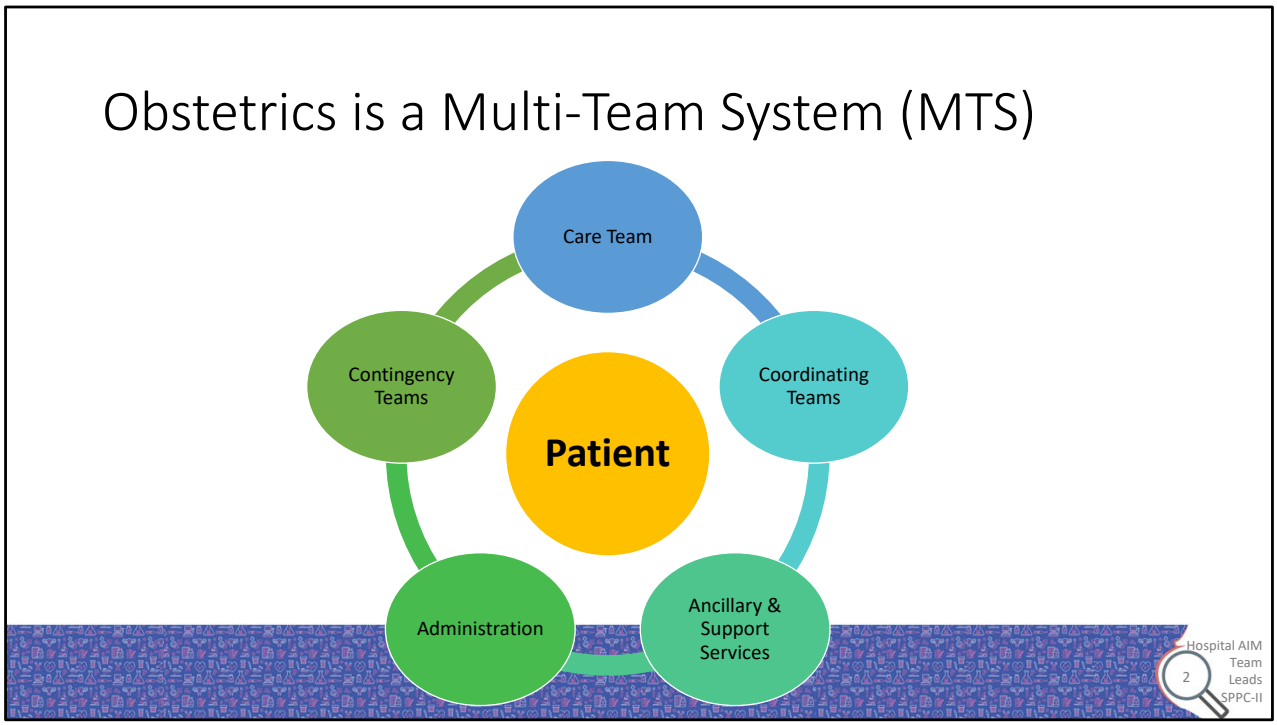


SCRIPT

Thank you for participating in the Safety Program for Perinatal Care II (also known as SPPC-II) Teamwork Toolkit presented by the Johns Hopkins University, Agency for Healthcare Research and Quality, and the Alliance for Innovation on Maternal Health.

This module will introduce concepts of team structure and assembly.

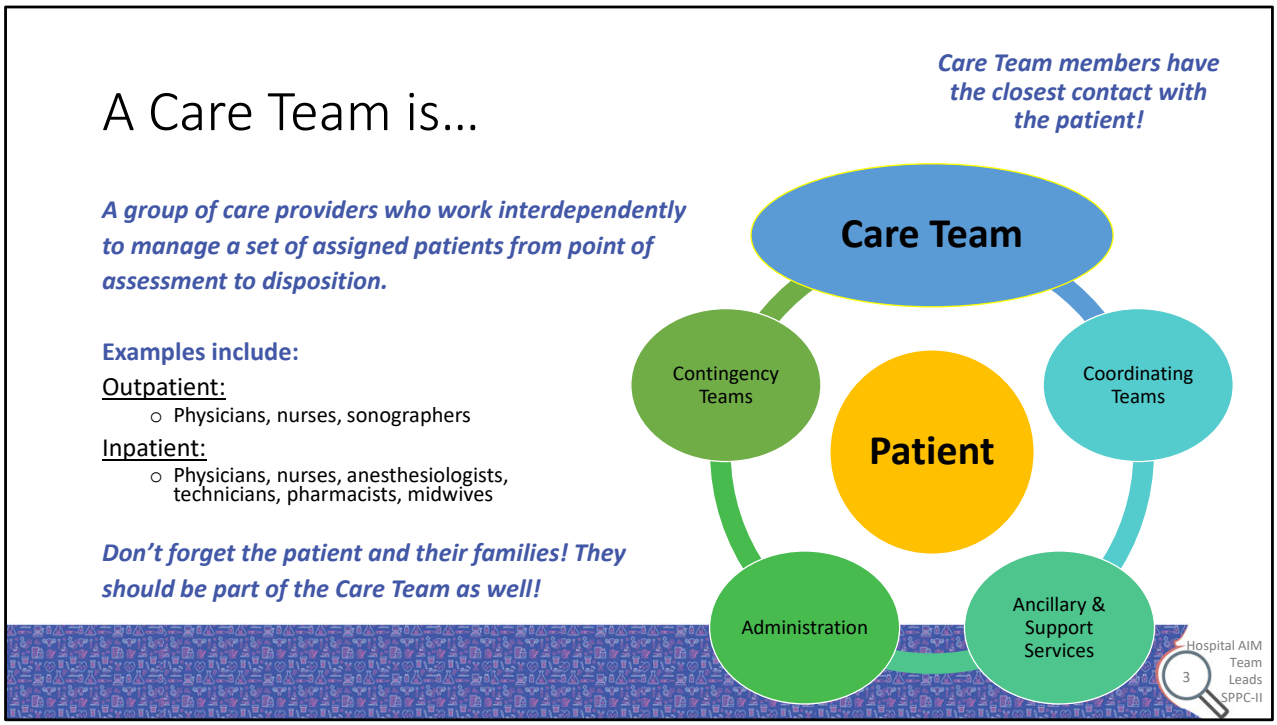


SCRIPT

We have discussed what defines a team, but in healthcare, multiple teams are involved in patient care. This slide shows the model of a multi-team system (MTS). Each team within a multi-team system is responsible for various parts of patient care, but all must act in concert to ensure quality care.

An MTS is composed of several different teams. In healthcare, the various types of teams that make up a MTS might include Care Teams, Contingency Teams, Coordinating Teams, Ancillary and Support Services, and/or Administrative teams. Each of these team types may have larger or smaller roles in serving the patient at different points throughout the care continuum. They may also be more or less peripheral to the patient, who is at the heart of the multi-team system.

As we define these team types, think about whether representatives from these groups should be involved in the implementation of the SPPC-II Teamwork Toolkit at your facility.



SCRIPT

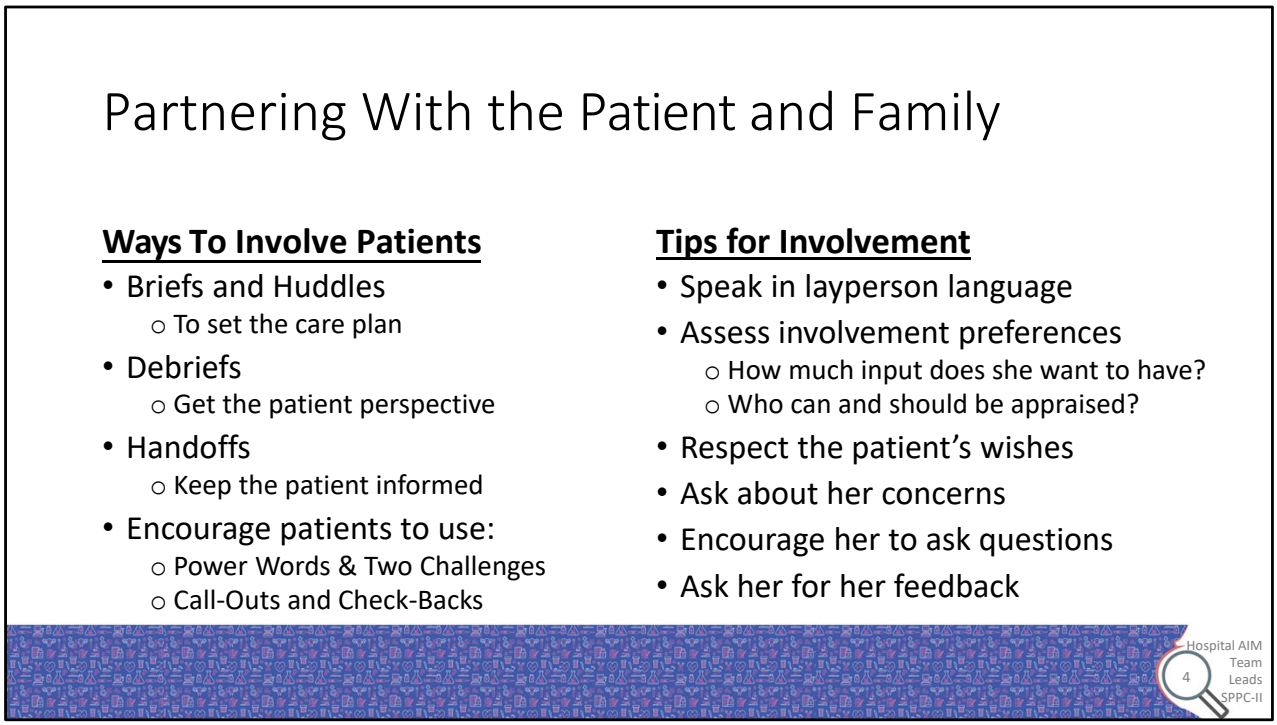
Care Teams consist of team leaders and team members who are involved in the direct care of the patient. Care Team members include direct care providers and continuity providers. Continuity providers manage the patient from assessment to disposition, such as case managers. The Care Team is based where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

Care Teams should be small enough to ensure situation monitoring, development of situation awareness, and direct, unfiltered communication between members. To establish a shared mental model, Care Teams should be large enough to include skill overlap between members to allow for workload sharing and redistribution when necessary.

Care Team leadership is dynamic; Care Team leaders are required to take on different roles at various points in the plan of care. Often these may be non-leadership roles, such as supporting a nurse starting an IV.

Examples of Care Teams include:

- ***Outpatient (prenatal clinic)*:**
    - The Care Team may be composed of the obstetrician, clinic nurse, and administrative staff member responsible for treating a patient.
- ***Inpatient (labor and delivery floor/unit)*:**
    - The Care Team may be composed of the obstetrician and Labor & Delivery (L&D) nurse responsible for the delivery, and the anesthesia staff responsible for the epidural for the patient.
- ***Inpatient (operating room)*:**
    - The Care Team may be composed of the surgeon, the anesthesiologist, the circulating nurse, and the scrub technician.



SCRIPT

It is critical to acknowledge that a patient care team is not complete without the patient. Patients and their families should be embraced and valued as contributing partners to patient care.

Throughout this course, you will learn several teamwork skills, tools, and strategies that can be adapted for use by patients and their families. Thinking about how to include patients is an important part of your implementation planning that you might find challenging.

Examples of effective strategies for involving patients in their care include:

- Including the patient in bedside rounds.
- Conducting handoffs at the patient's bedside.
- Providing patients with tools for communicating with their care team.
- Involving patients in key committees.
- Actively enlisting the patient's participation.

A number of organizations provide information, materials, and suggested strategies

related to patient engagement, including AHRQ, the DoD Patient Safety Program, the Joint Commission, the National Patient Safety Foundation (NPSF), the U.S. Department of Health and Human Services (DHHS), the Institute for Healthcare Improvement (IHI), and Consumers Advancing Patient Safety (CAPS).

Note: The tools on this slide will be defined and explored in detail in later modules of the toolkit.

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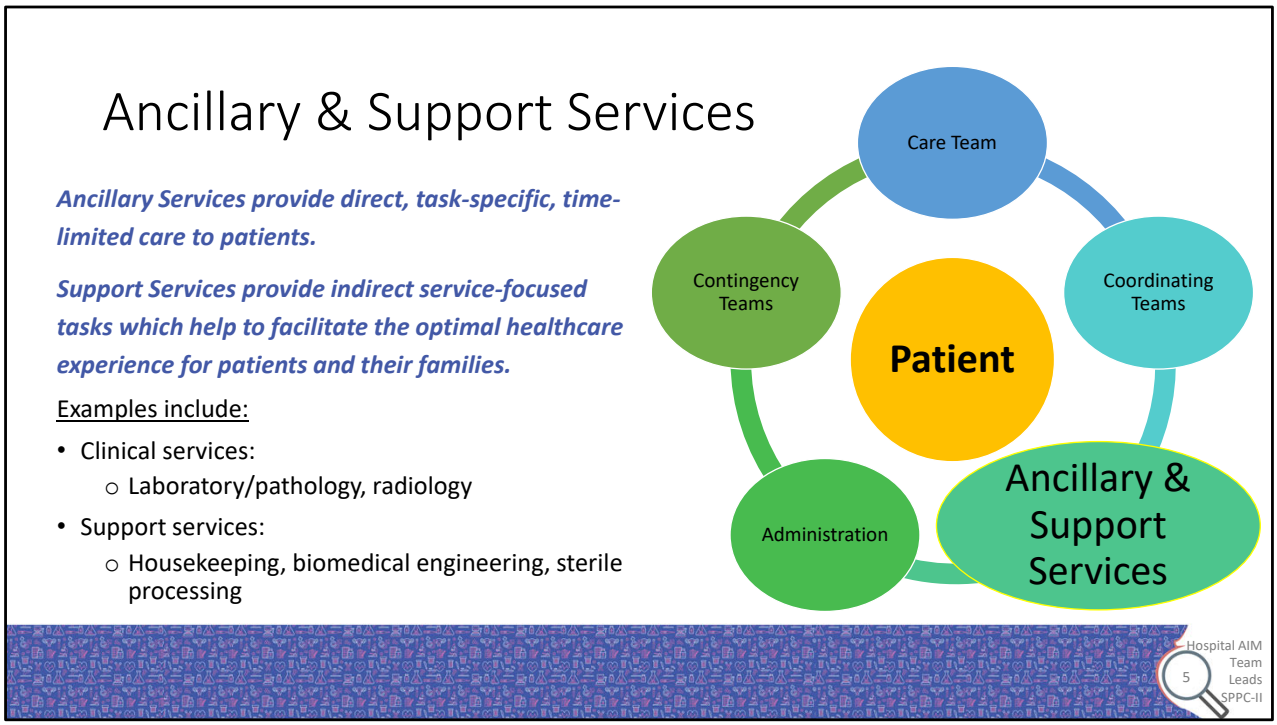
Example resources:
The AHRQ-funded Guide to Patient and Family Engagement in Hospital Quality and Safety
The U.S. Department of Defense (DoD) Patient Safety Program Team Up
DoD Patient Activation Reference Guide
The Joint Commission's Speak Up
Institute for Healthcare Improvement's (IHI) Ask Me 3: Good Questions for Your Good Health
U.S. Department of Health and Human Services' Partnering to Heal
IHI's Person- and Family-Centered Care Information
Information from Consumers Advancing Patient Safety



SCRIPT

Ancillary Services consist of individuals who:

- Provide direct, task-specific, time-limited care to patients.
- Support services that facilitate care of the patients.
- 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 Care 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 healthcare environments, which affect the patient Care Team, market perception, operational efficiency, and patient safety.

Ask:

What are some examples of Ancillary and Support Services teams?

Possible answers:

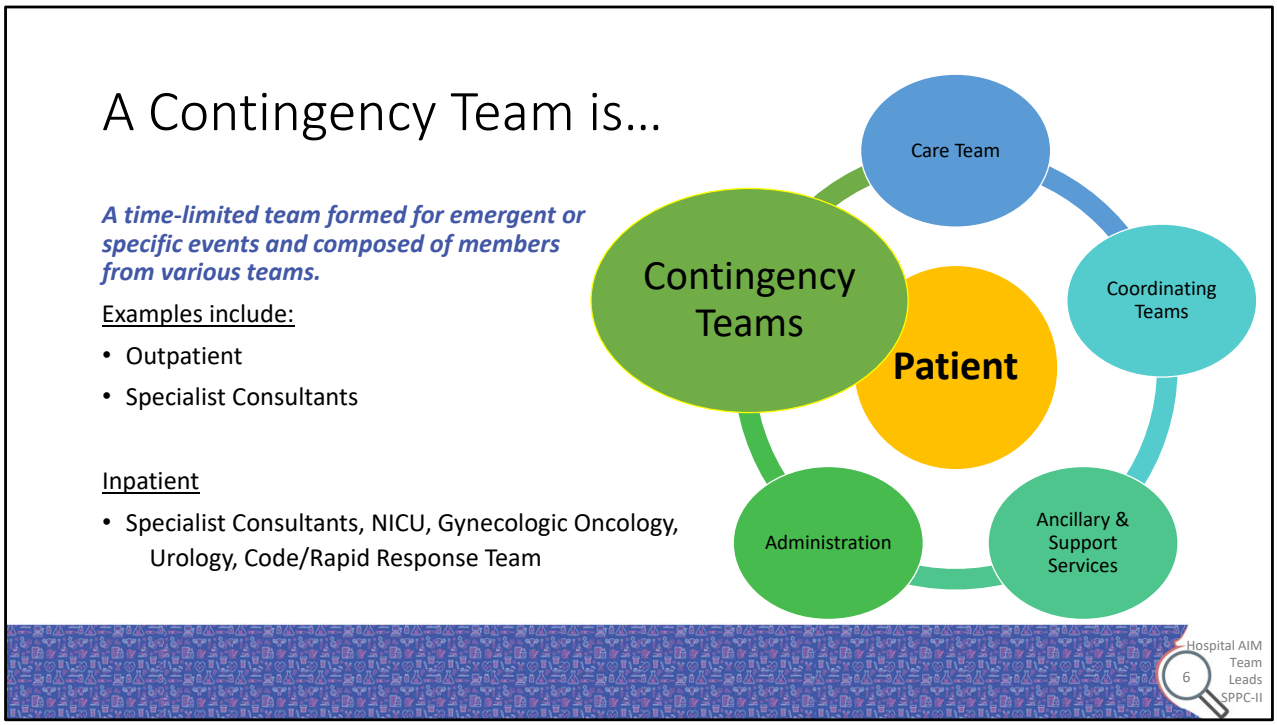
Clinical services:

Laboratory

- X-ray
- Pharmacy
- Radiology
- Pathology

Support Services:

- Housekeeping
- Sterile Processing
- Bioengineering
- Human Resource Management



SCRIPT

Contingency Teams are:

- Formed for emergent or specific events.
- Time limited (e.g., Code Team, Disaster Response Team, Rapid Response Team*).
- Composed of team members drawn from a variety of Care Teams.

Contingency Teams are responsible for immediate, direct patient care during emergency situations requiring more resources than are available to the Care Team. Their role may be very specific and limited to a certain situation, such as a Code Team, or they may be responsible for a broad category of situations, such as disaster response. They generally consist of preidentified members derived from varying units or Care Teams and have limited time to prepare for emergencies.

Because Contingency Team members are called together for emergent or specific events, they do not typically spend much time working together as a team. However, their individual roles are clearly defined, and leadership is designated based on patient needs and member expertise in dealing with the particular situation.

Examples of Contingency Teams include:

***Outpatient (prenatal clinic)*:**

The Contingency Team may be composed of a pharmacist who can be called on if a medication regimen is complicated and requires special expertise.

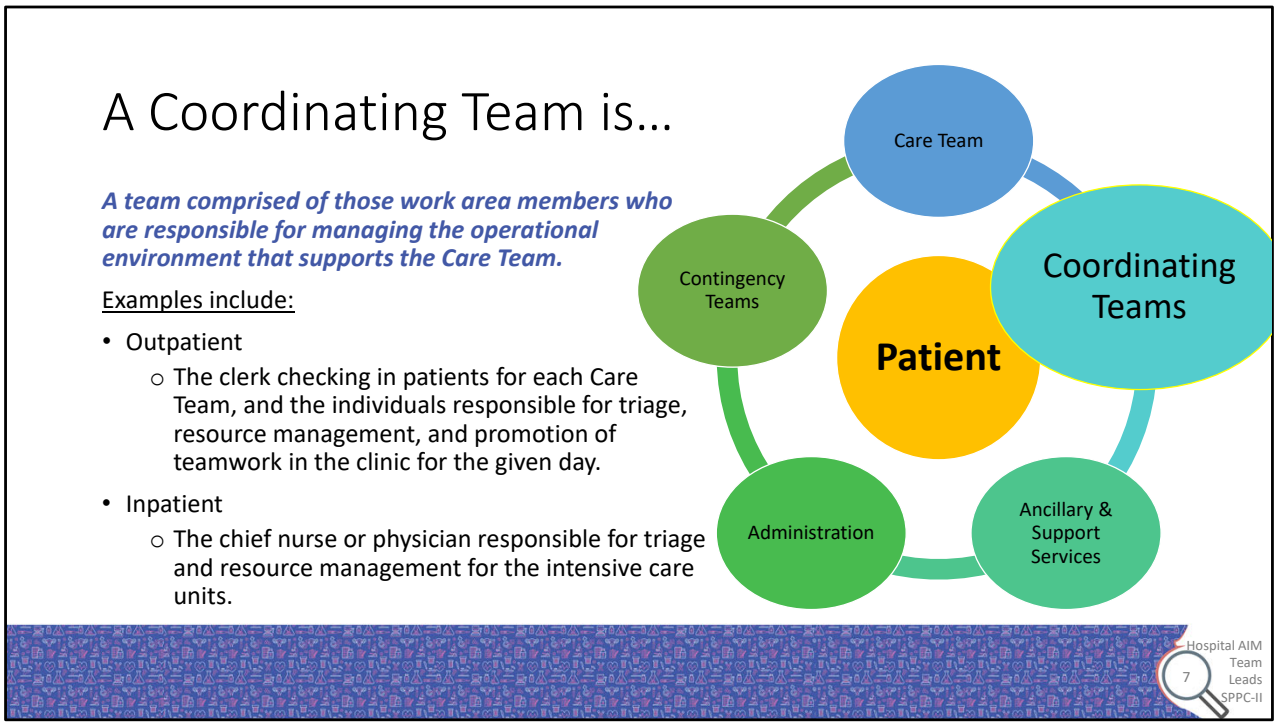
***Inpatient (labor & delivery floor/unit)*:**

The Contingency Team may be composed of the anesthesia team, and critical care/ ICU physician who can be called on if the patient has a complication or arrest.

***Inpatient (operating room)*:**

The Contingency Team may be composed of nursing and anesthesia staff from other operating rooms in the case of an emergency.

** A TeamSTEPPS Rapid Response Systems Guide is available from AHRQ. Select for more information.*



SCRIPT

The Coordinating Team is the group responsible for:

- Day-to-day operational management.
- Coordination functions, such as triaging emerging events and prioritizing decision making to ensure maximal support to the Care Team.
- Resource management for Care Teams, such as collaborating with the Administrative and Ancillary Teams to assign priorities and ensure throughput.
- Direct patient care may be a secondary function with the exception of small facilities.

Coordinating Teams frequently include experienced personnel with a strong clinical background. This combination enhances the ability of the Coordinating Team members to rapidly assess the overall picture, anticipate the needs or potential needs between and across teams, and make priority-based decisions.

Ask:

Who might be the members of the Coordinating Team for an outpatient clinic?

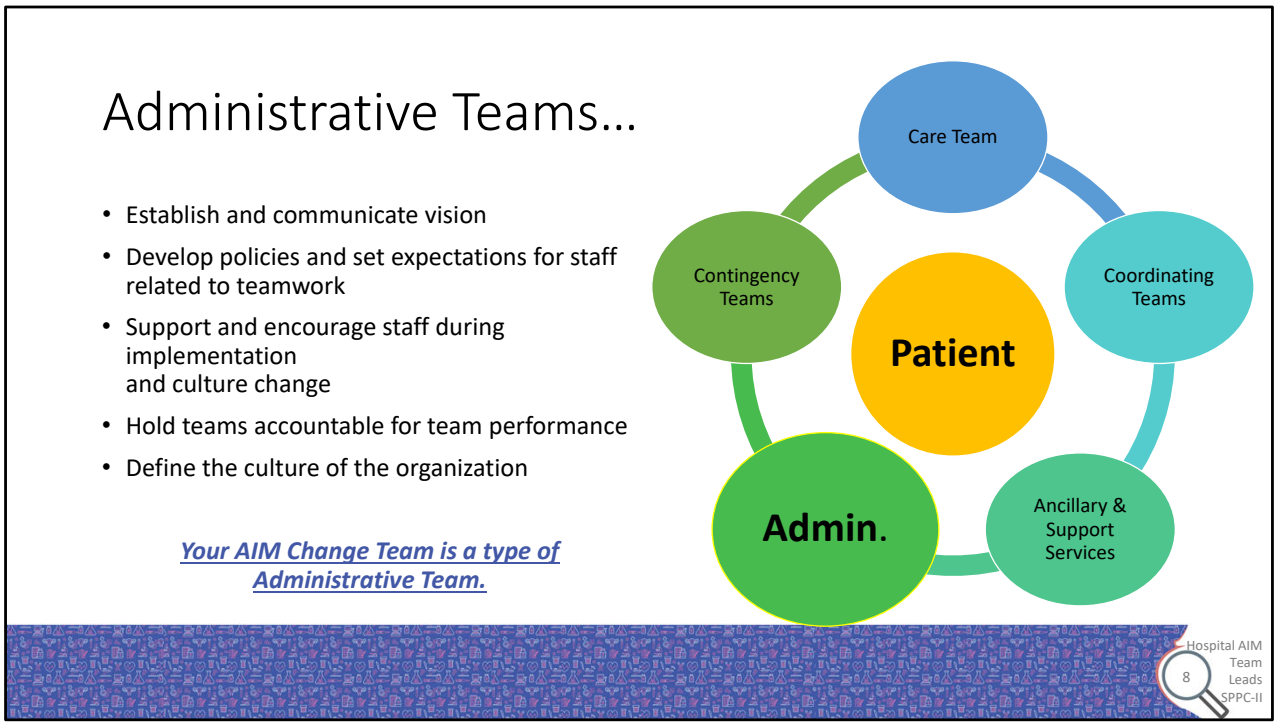
The clerk checking in patients for each Care Team, and the individuals responsible for triage, resource management, and promotion of teamwork in the clinic for the given day.

Who might be the members of the Coordinating Team in an inpatient setting?

The chief nurse or physician responsible for triage and resource management for the intensive care units.

Who might be the members of the Coordinating Team for an operating room?

The charge nurse, an anesthesiologist, and a unit clerk.



SCRIPT

Administration includes the executive leadership of a unit or facility and has 24-hour accountability for the overall function and management of the organization. The Administrative Team has no responsibility in the direct delivery of care but provides the framework and guidance that ensure that each team understands its role and responsibility and has access to the necessary resources to succeed.

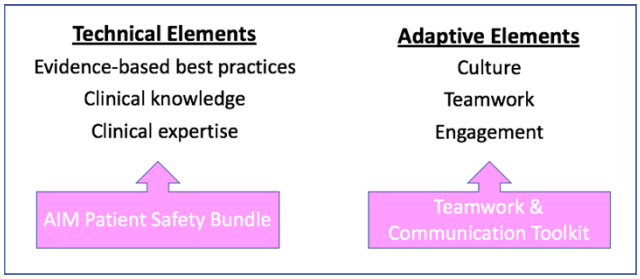
Administration creates the climate and culture for a teamwork system to flourish by:

- Establishing and communicating vision.
- Developing and enforcing policies and procedures that clearly articulate the roles and responsibilities of the other teams and team members.
- Setting expectations for staff.
- Providing necessary resources for successful implementation.
- Holding teams accountable for team performance.
- Defining the culture of the organization.

Administration should strive to create a learning culture where there is trust and transparency to create a safe environment to report, analyze, and share information openly. This philosophy serves to define a culture of safety; however, as examples in aviation and other high-risk industries have shown, the change will not happen overnight.

The Role of the Hospital AIM Team

- Administrative team working to spread and reinforce the AIM Patient Safety Bundle and Teamwork & Communication Tools to the rest of the unit.
- You are **champions** for this initiative!



SCRIPT

As AIM Team Leads in your home hospitals, you compose an administrative team whose objectives are to help your organization adopt the clinical and teamwork practices associated with the AIM Clinical Bundle your group is working on. Doing so will mean partnering with other teams in your unit, particularly the front-facing care team, to explain and reinforce both the technical elements described in the AIM patient safety clinical bundle and the teamwork and communication tools described in this workshop. Without champions, interventions often fail. So as members of the Hospital AIM team it is your responsibility to make sure this initiative does not get forgotten among the day-to-day challenges, tasks, and status quo.

Specific Situations

- Facility (and unit) size and type
  - Small vs large
  - Multispecialty vs exclusive obstetric facility
- Facility (and unit) location
  - Rural vs urban
- Team size
  - Few (e.g., 2 member) vs large
- Representative disciplines
  - Few vs multiple

SCRIPT

Before discussing the AIM Team structure, discuss how teams will vary based on various criteria such as size and location. Emphasize how adaptations of the team structure, function, and tool use are possible and strongly encouraged.

Hospital AIM Team Structure

- Your work is impossible without the assistance and collaboration of many others
- Your core team consists of anyone you work with interdependently and dynamically to provide high-quality, safe patient care

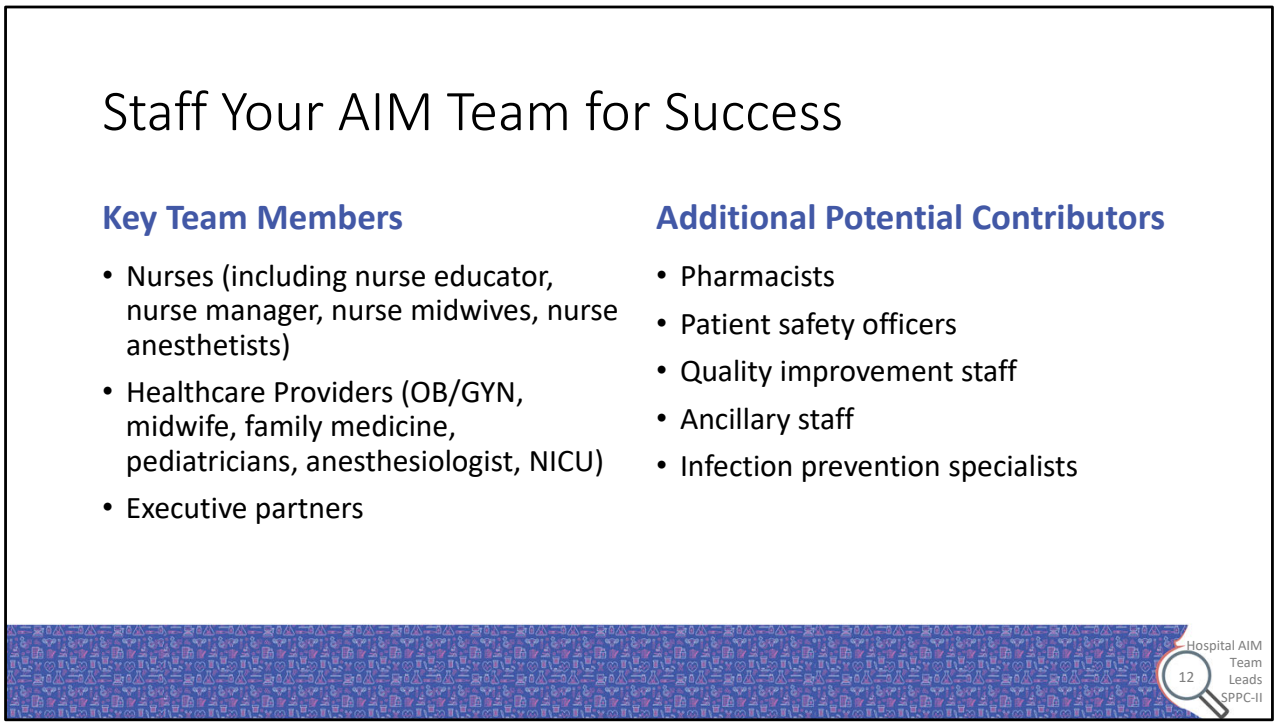
Stop for a moment and consider:

Who would you name as your teammates?

SCRIPT

Your work would likely be impossible without the assistance and collaboration of many others, each of whom serve a critical role. Good team structure promotes teamwork by including a clear leader, involving the patient and other stakeholders, and ensuring that all team members commit to their responsibilities. Your AIM team consists of anyone with whom you work interdependently and dynamically to implement the AIM objectives and the teamwork toolkit associated with your clinical bundle.

Stop for a moment and think about who you would name as your teammates. What are their names? Their job titles? Their responsibilities? Why is each one an essential team member?



SCRIPT

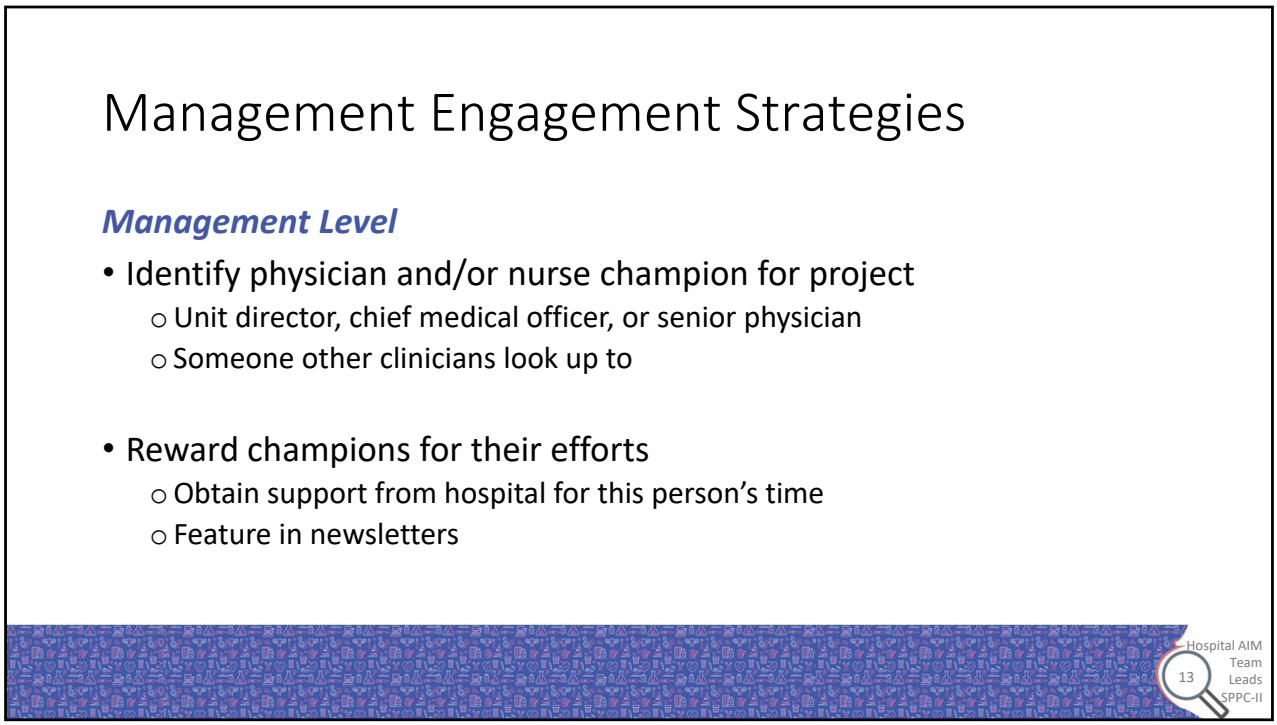
Key AIM Team members include—

- Nurses, including educators, managers, midwives, anesthetists, nurse practitioners, and L&D staff nurses;
- Physicians, including obstetricians, family medicine doctors, pediatricians, and anesthesiologists; and
- Senior executives.

Additional members who would be helpful to involve in the initiative are—

- Pharmacists,
- Patient safety officers,
- Chief quality officers,
- Ancillary or support staff, and
- Infectious disease specialists (if applicable).

The key team members—nurses, physicians, and senior executives—will help ensure the initiative is used effectively. However, input from other unit or hospital specialists is needed.



SCRIPT

As a Hospital AIM Team Leader, you are the first champion of the SPPC-II toolkit. However, you'd be well assisted if you could onboard physician or nurse champions who believe in the toolkit and are willing to help you gain buy-in from others.

These champions are ideally at the management level or higher and are people other clinicians respect and look up to. Senior management like unit directors or the chief medical officer will be of great value as they may be able to help you obtain resources that will facilitate the rollout and adoption of the teamwork tools and strategies. Of course, local leaders or even those who may not be in *formal* positions of power but who are seen as informal leaders within the OB department can also be valuable additions to your champion team.

If at all possible, reward champions for their efforts. Dedicated time support is always the ideal mechanism for showing appreciation and protecting the time champions have to contribute to the project, but other (free) ideas might include featuring them in newsletters or providing them with other valued opportunities to gain visibility and receive appreciation for their time and effort.

Staff Engagement Strategies

For Staff

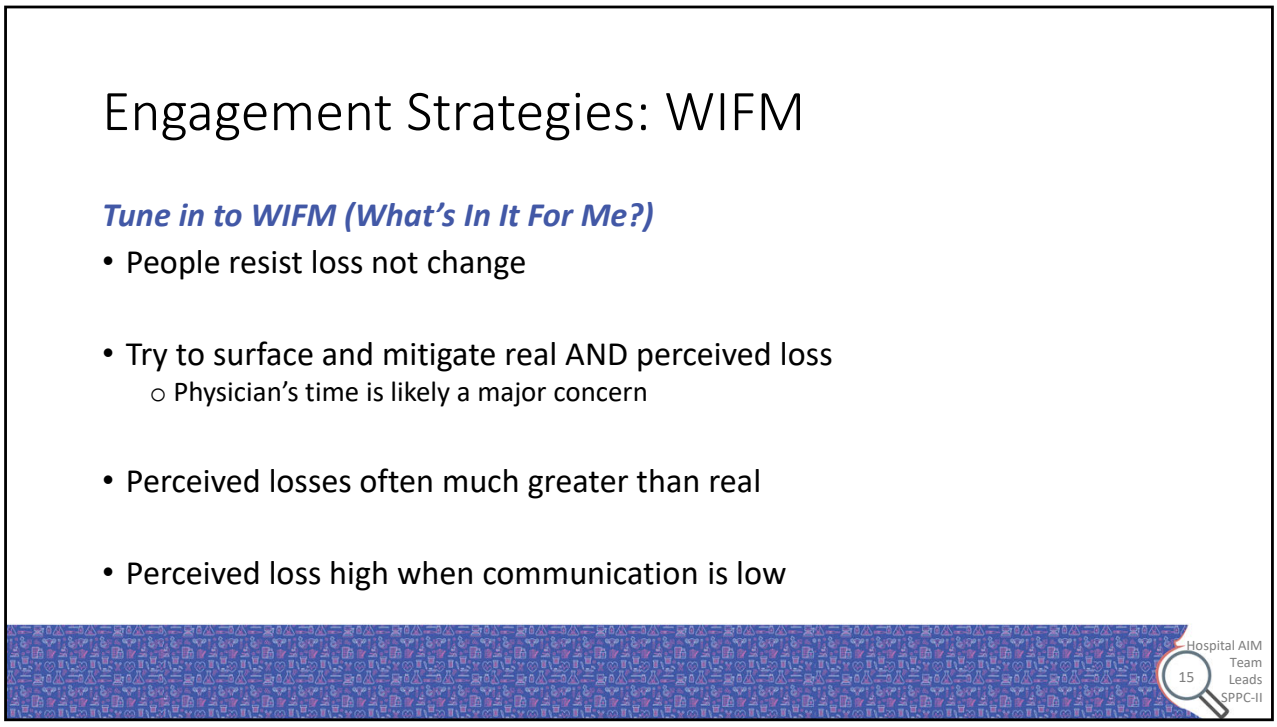
- Communicate prior to start of project
  - No surprises
  - Who, what, when, where, how
- Listen to those who resist/value the dissenter
- Create mechanisms to feed back results
- Provide opportunities to present to senior leaders

SCRIPT

Getting staff on board and engaging them in the adoption of the tools is all about communication, which should be constant, clear, and timely. Staff should know exactly what is coming and what is expected, and there should not be any surprises about who, what, when, where, why, or how they are expected to participate.

You will likely hear grumblings and people who are really unhappy with having to do *more* work. There will be dissenters and resisters. As we'll talk about next, it's imperative you listen to these individuals and really sympathize with their concerns. Sometimes they have really valid points that you'd be smart to consider as you roll out the teamwork and communication toolkit.

Because communication is so key and feedback and voice of the staff are essential, you'll want to establish mechanisms for staff to be in touch with their ideas and concerns. You can do this however you like, either through face-to-face forums, email, or even anonymous feedback boxes.



SCRIPT

A huge part of gaining buy-in is convincing people what's in it for them. Adopting new practices is sometimes laborious, and in the case of the SPPC-II Teamwork Toolkit we are asking staff to commit a significant amount of time to completing the online modules and engaging in in-person facilitation sessions. They have to have a sense of why this will be helpful to them. As Hospital AIM Team Leads, it is part of your role to help them see the value in these tools. As you do so, it is helpful to remember a few pointers:

- **People resist loss, not change**. This axiom indicates that it's the fear of *losing* something, be it power, influence, time, or something else, that is more damaging to the uptake of new strategies than is the idea of doing something different. People get used to the status quo, and even if something new is better in the long term, people want to know what they are giving up versus gaining. In the current system they know what's broken, what's working, and what they can maneuver around. A new system presents an unknown opportunity that could be better or worse, and people are more fearful about the potential for worse than optimistic about the potential for better. The adoption of new teamwork tools presented in SPPC-II is expected to enable staff to do their job more efficiently, empower them to voice concerns, and/or provide better patient outcomes. However, these value adds need to be clearly explained within a framework that also acknowledges what they might have to give up.

- **The loss can be real or perceived**. Interestingly, people will often have incorrect perceptions of what they stand to lose, and even though these losses are not real, they are just as big a barrier to change as real loss. Therefore, as a Hospital AIM Team Lead you'll want to understand all perceived losses and make it clear when perceived losses are not real and empathize with staff when losses are real. **You may have a harder time convincing staff when perceived losses are not real**.
- **Communication is key**, especially when perceived loss is high. The only way to help staff feel more comfortable with change (and perceived loss) is to talk about it openly and transparently. You have to be sympathetic to their concerns and really understand their hangups if you are to gain their buy-in.

Successful AIM Teams

- Understand that patient safety culture is local
- Composed of engaged frontline providers who take ownership of patient safety
- Include staff members who have different levels of experience
- Tailored to include members based on clinical intervention
- Meet regularly (at least every other month)
- Have adequate resources

SCRIPT

To ensure a successful program, the team should be actively involved, willing to spread the interventions, and committed to sustaining the gains across the L&D unit. Remember that achieving the goals of the intervention rests with the team.

To encourage efficient implementation, all team members should understand and apply the following concepts:

- Culture is local,
- The team is composed of engaged frontline providers who take ownership of patient safety,
- The team includes members with different levels of experience,
- The team is tailored to include members based on the specific L&D intervention,
- The team meets regularly, and
- The team has access to resources necessary for the intervention.

Summary

- Patient care is better understood a multi-team system—or a "team of teams"
- Hospital AIM Teams are responsible for the rollout and adoption of the SPPC-II materials in their home organizations
- Staff your AIM Team with motivated champions from different roles and organizational levels
- Engage staff by communicating the WIFM

SCRIPT

In conclusion, patient care is better understood as multi-team system (MTS). Within this framework, Hospital AIM Teams are responsible for the rollout and adoption of SPPC-II materials in their home organizations. This means they will have to connect with different types of healthcare professionals within the MTS. Staffing the AIM Team with motivated champions from different roles and organizational levels will help create buy-in across all staff. One of the most important ways to create engagement is to communicate the WIFM—"what's in it for me"—so staff perceive a personal advantage to their involvement.

Additional Resources

- AHRQ's module for assembling a (CUSP) team for additional information about team member roles https://www.ahrq.gov/hai/cusp/modules/assemble/team-slides.html

SCRIPT

While it is beyond the scope of the SPPC-II Toolkit to fully describe the Comprehensive Unit-based Safety Program (CUSP), you may find that the information provided in AHRQ's CUSP module for assembling the team provides additional details about the various roles you might consider representing on your AIM team. The module is available at: https://www.ahrq.gov/hai/cusp/modules/assemble/team-slides.html.

Acknowledgments

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