TeamSTEPPS Learning Benchmarks

Instructions: These questions focus on medical teamwork and communication and their effect on quality and safety in patient care. For each of the following questions, please ***circle the letter next to the one best answer***.

1. A nurse is called to the phone to receive a telephone order from the doctor about a patient she is taking care of today. After clearly establishing the patient and physician identities, the **best** procedure for the nurse would be:

    a. Listening to the order, calling the pharmacist, writing the details on the order sheet, and bringing the drug to the bedside.
    b. Refusing to take this telephone order and indicating that she can't be sure of the physician's thought process.
    c. Listening to the order, repeating back what the doctor said, and then writing it down in the patient's medical record.
    d. Listening to the order, asking the charge nurse how to spell the drug's name, asking the family member if that was in the plan for today, and carrying out the order.
    e. Listening to the order, writing it on the order page, reading the order back to the physician, and seeking his verification of the order's accuracy.

2. A nurse is very concerned about a baby he is taking care of and feels it would be best to have the attending pediatrician come to the bedside immediately to evaluate. Checking around the unit, he locates the pediatrician, but she is busy dictating a consultation. The nurse's **best** action is to:

    a. Wait quietly, but tap his foot rhythmically to indicate urgency.
    b. Quickly explain the infant's worrisome appearance and state, "I need you right now!"
    c. Walk away, planning to check back in a few minutes.
    d. Interrupt, shake her shoulder, and pull her quickly toward the crib.
    e. Leave his pager number with the clerk with instructions to have her call.

3. A surgeon, anesthesiologist, nurse, and technologist are in the OR for a complicated case, which will start shortly. The surgeon, as team leader, should:

    a. Go scrub and tell the circulating nurse to “get the ball rolling.”
    b. Reassure the new team that she has plenty of experience with tough cases like this one and not to worry, and say, “I’ll tell you what you need to know.”
    c. Introduce herself, briefly describe the situation, plan, and potential pitfalls and ask for input from the team members.
    d. Explain the need for extra speed during this complicated case and set expectations for rapid turnover between cases.
    e. Pull out the x rays and textbook and explain the details of the surgery to the rest of the crew, emphasizing the strict need for following protocols.

Questions 4, 5, 6, and 7 are linked:

4. The team is making great progress with the procedure until the nurse recognizes that the doctor is clearly making a dangerous mistake in asking for a dose that is 10 times the usual dose. Very concerned, she asks the doctor if he’s sure that is what’s wanted. Giving her a nasty look, he growls, “Well, that’s what I asked for, isn’t it?.” Confident that the dose is way off base, her next action should be to:

    a. Walk away and indicate discouragement at being treated so rudely.
    b. Say loudly, “That’s a huge mistake, doctor; nobody uses a dose like that!”
    c. Not say anything for fear of making the doctor even more angry.
    d. Ask the secretary to put in a stat page to the nursing supervisor.
    e. Say, “I’m very concerned about the safety of that dose, Doctor; it’s much higher than I’ve ever seen given.”

5. For the real-life situation in question 4 above, a nurse in the same circumstances, but NOT confident and NOT positive that the dose is too high, but still **very concerned** about the patient’s safety, should take the following course of action:

    a. Walk away and indicate discouragement at being treated so rudely.
    b. Say loudly, “That’s a huge mistake, doctor; nobody uses a dose like that!”
    c. Not say anything for fear of making the doctor even more angry.
    d. Ask the secretary to put in a stat page to the nursing supervisor.
    e. Say, “I’m very concerned about the safety of that dose, Doctor; it’s much higher than I’ve ever seen given.”

6. The **doctor** on this procedure team (questions 4 and 5), upon being challenged by the nurse about the potentially dangerous medication dose, and realizing she is right, should respond by:

    a. Demanding that this nurse be replaced immediately.
    b. Saying," You're right. Thanks for watching my back; it's been a bad day."
    c. Saying, "I'm the doctor, do what I say."
    d. Calling his partner on his cell phone to discuss the case.
    e. Telling the worried patient, "Sometimes these dosages are confusing."

7. If the doctor, in fact, is **correct** in his dosage (question 4) and the nurse was incorrect in her memory of the proper medication dosage, when this is suspected, the doctor's **best** action would be to:

    a. Call the pharmacist and ask her to send a package insert to review.
    b. Let the nurse know, in no uncertain terms, how it is inappropriate to challenge a senior physician.
    c. Request that the nurse be sent for retraining and put a notation in her file.
    d. Stop action, verify the correct dose, and thank the nurse for her concern regarding patient safety.
    e. Call the team together afterwards and have the nurse explain her mistake.

8. A night nurse is concerned about the changing circumstances for an inpatient and knows it will be necessary to call and awaken the covering physician. Getting his thoughts and information together, he plans to structure the phone call using a proven structured communication technique, SBAR. He plans to introduce himself, identify the patient, and describe:

    a. Situation, Background, Assessment, Recommendations.
    b. Sleep, Bathroom Activities, Results.
    c. Systems, Background, Alimentary, Respiratory.
    d. His pleasant memories of summer vacation at the S-BAR Ranch.
    e. Social Background, Assurance, Reassurance.

9. In the ambulatory clinic, the primary care team is evaluating a patient who likely will need an urgent referral to a specialist. Continuity of care and patient safety are usually enhanced by all of the following **except**:

    a. Considering the specialist to be part of the treatment team and sharing information.
    b. Withholding the reason for referral from the patient to decrease fear.
    c. Using a structured and detailed handoff document.
    d. Creating a reminder for seeking the lab and consultation results.
    e. Instructing the patient to call if he hasn't yet been seen in a certain timeframe.

10. After an unsuccessful effort by the code team, the most helpful pathway toward team performance improvement involves:

    a. The leader telling everyone what they did wrong.
    b. Meeting as a team to debrief the events.
    c. Explaining the protocol deviations.
    d. Blaming the people who made mistakes.
    e. Attending the autopsy.

11. During closure of a complex surgical case, the sponge count comes up one short after two careful counts. The surgeon ignores the request by the circulating nurse to help find a solution and continues the closure. The **best** action for the concerned circulating nurse would be to:

    a. Explain the current hospital policy and required actions.
    b. Page the medical director.
    c. Call the operating room supervisor.
    d. Scream at the doctor to stop the closure.
    e. Convince the anesthesiologist to make the surgeon respond.

12. The new resident working in the clinic is having real difficulties interacting with the nurse (who has been working there for a decade). The nurse continually is telling her what to do, but in front of the patients. The **best** course of action for the resident is to:

    a. Tell the nurse to stop undercutting her.
    b. Ask the nurse for a quick meeting to discuss criticisms in front of patients.
    c. Tell the clinic manager to have a talk with the nurse.
    d. Complain to the attending that the nurse is hypercritical and ineffective.
    e. Just let the patients know that the nurse is having a bad day.

13. The technologist is setting up for a procedure and notices that the doctor seems to be on the wrong side of the patient and may be making a mistake. The doctor has often been short tempered around the nurses and techs and doesn't take suggestions very well. The **best** action for the technologist is to:

    a. Call for a supervisor to come into the room.
    b. Quietly observe and hope that the doctor notices.
    c. Let the patient and doctor figure it out.
    d. Ask the doctor if he knows what he is doing.
    e. Call for a "time-out" to verify the procedure.

14. A nurse working in the Emergency Department overhears the doctor on the team make a misstatement about a sick patient, a comment that could result in a medical error and poor outcome. The nurse's correction of the misstatement is **best** interpreted as:

    a. A breach of etiquette in the Emergency Department.
    b. An interference in the doctor's business.
    c. An action of cross-monitoring that makes teamwork safer.
    d. An action the doctor will likely get defensive about.
    e. A wrong-headed approach to teamwork.

15. In the interest of patient care quality and safety, it is expected and mandatory that:

    a. Conflict is avoided at all cost.
    b. People always do the right thing.
    c. Members speak up if they are concerned.
    d. Leaders not make mistakes.
    e. Everyone agrees with the plan.

Instructions: For each of this series of questions, based on your knowledge of medical communication, teamwork, and patient care quality and safety, **select the one *best* answer**.

B-1. The attribute ***least* likely** to be found in a medical team that is functioning in a **highly effective** manner is:

    a. Adaptability.
    b. Complacency.
    c. Trust.
    d. Respect.
    e. Information sharing.

B-2. Recent research about the **causes of errors** in healthcare delivery frequently focuses on:

    a. Outdated equipment.
    b. Incompetent providers.
    c. System problems.
    d. Lack of caring.
    e. Stupidity.

B-3. Who is ***the leader*** in medical teams?

    a. Doctor.
    b. Nurse.
    c. Supervisor.
    d. It depends on circumstances.
    e. Patient.

B-4. The best ***communication tool*** or method to get critical information to the whole team during an emergency or complex procedure is:

a. Call-out.
b. Check-back.
c. Write it on the white board.
d. Write it in the orders.
e. Time-out.

B-5. The main reason ***hierarchy*** can be a problem in a medical team setting is that:

a. The team leader may be obnoxious.
b. Members having important information may not speak up or be heard.
c. The nurse and doctor may disagree.
d. Patients may be upset at the team being bossed around.
e. It results in significant pay inequity.

B-6. A ***shared mental model*** is key for medical team members primarily because:

a. They need to have vision.
b. They all need to have the same understanding of the plan.
c. A mind is a terrible thing to waste.
d. Otherwise, leaders may go adrift.
e. Otherwise, patients will be confused.

B-7. The following are ***human factor problems*** that research has identified as contributing to medical error ***except:***

a. High workload.
b. Fatigue.
c. Distractions.
d. Friendship in the workplace.
e. Conflict and anger.

B-8. The BEST method of ***conflict resolution*** for medical teams in the workplace is:

a. Compromise.
b. Accommodation.
c. Avoidance.
d. Collaboration using the DESC script.
e. Dominance.

TeamSTEPPS Learning Benchmarks—Answer Key

This matrix presents the **best answer** and relates the question to specific TeamSTEPPS Curriculum, including tools and strategies.

Q	A	Tools, Strategies, or Concepts Covered
1	E	• Read-back • Communication accuracy • Correct sequence • Distinguish from check-back or say back
2	B	• Express version of SBAR • Explicit communication • Action oriented • Team priorities
3	C	• Team brief • Create a shared mental model • Respect for the input from all • Sharing the right information
4	E	• Two-Challenge rule • CUS (Concerned-Uncomfortable-Patient Safety) • Error reduction strategy • Maybe cross-monitoring
5	E	• Ditto above • Tries to emphasize that the nurse didn't have to know for sure that it was wrong…needs to speak up anyway if concerned • Team dynamics
6	B	• Response to two challenges by the nurse • Team dynamics • Acknowledgement • Respect for team input • Focus on the patient and safety
7	D	• Proper response to the question and concern for patient safety • Stop the line; resolve the confusion • Respect the input • Team dynamic • Focus on the safety, not the error • A debrief would be good, but not to have the nurse "explain her mistakes"
8	A	• SBAR
9	B	• Ambulatory setting • Primary-Specialist referral • Handoff • Considering strategies to avoid likely errors in primary care, such as followup • Patient as part of the team
10	B	• Debrief-the word more than the concept • Deals with issues of blame and error

Q	A	Tools, Strategies, or Concepts Covered
11	A	• Conflict • Unreasonable behavior • Solve it within the team if possible • Could DESC-IT, but probably not necessary • Referring to the policy and required actions should bring about the agreement to get an x ray (as is required)
12	B	• Conflict resolution • Solve it at the team level • Power differential • Knowledge differential • Criticism undermining patient relationship • Action: meet to discuss (in private)
13	E	• Team dynamics • Speaking up despite the hierarchy and difficult doctor • Use the “time-out” policy on behalf of patient safety • Anyone can call for clarification
14	C	• Cross-monitoring • Protecting the patient
15	C	• Speak up about any patient concerns (mandatory) • The other choices speak to reality issues for teams, differences from the ideal
B-1	B	• Complacency is not an attribute for highly effective teams; the others generally are seen in high-performing teams
B-2	C	• Communication accuracy
B-3	D	• It depends: the nurse may be the team leader in many venues: ED, L&D, med-surg units, etc. The physician/surgeon may be the team leader in the OR, Clinic, etc. The patient could be the team leader in the home or rehab setting
B-4	A	• Call-out
B-5	B	• Hierarchy • Speak up • Be heard • Leadership, decision making needs input from the whole team
B-6	B	• Need to have the same understanding of the plan and situation • Shared mental model
B-7	D	• Human factors • High workload • Distractions • Conflict • Anger
B-8	D	• Conflict resolution • DESC script • Collaboration