Teamwork Training May Improve Inpatient Safety

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Patient safety problems in hospitals often stem from a lack of teamwork and poor communication, James Battles, Ph.D., said at a conference sponsored by the National Patient Safety Foundation.

"In health care, if we don't have good teamwork, patients die," said Dr. Battles, the senior service fellow for patient safety at the Agency for Healthcare Research and Quality (AHRQ).

"Teamwork is not unique to health care, and what we know about teamwork research comes from a number of disciplines, namely the military," he said.

In the wake of "To Err Is Human," the 1999 Institute of Medicine report that raised awareness of medical errors and called for better teamwork among physicians, AHRQ partnered with the Department of Defense to develop a teamwork training program. The resulting Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program was designed to help doctors and hospitals integrate teamwork principles into their daily activities as a way to reduce clinical errors and to improve patient outcomes, patient satisfaction, and hospital staff satisfaction.

Poor communication and other teamwork issues usually are to blame when a serious medical error occurs in a hospital, case studies have shown.

"There is a growing scientific body of literature that indicates that medical teamwork can improve the quality of the clinical process," Dr. Battles said.

One key characteristic of successful teams is a shared mental model, which means that members of the team are "on the same page" and have a mutual sense of trust and a sense of being part of a team working toward a common goal. Each member of a successful team knows his or her role. And the most successful teams have supportive leadership.

Physicians can download materials from the AHRQ Web site and customize them to suit their practices. TeamSTEPPS became widely available in November 2006, and about 50 medical centers across the United States have used the program to improve teamwork and patient safety in their facilities, Dr. Battles said.

TeamSTEPPS offers ways to transform hospital culture by addressing the root causes of serious safety problems, particularly failures of communication.

"The program offers an excellent model and thorough instruction on how an institution can alter [its] culture and support enhanced teamwork," Dr. Mark V. Williams, professor of medicine at Emory University in Atlanta and director of the Emory Hospital Medicine Unit, said in an interview.

"It especially empowers nurses and other health care staff to speak up and alert their colleagues and physicians when patient safety is at risk," said Dr. Williams, who is evaluating the TeamSTEPPS program for possible use at Emory.

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Key team events that make up the TeamSTEPPS program include briefs, huddles, debriefs, and conflict resolution, Heidi King, director of DOD's Healthcare Team Coordination Program, said at the meeting.

A brief is a short gathering of caregivers to review what is scheduled for the day. Topics include assignments, a review of relevant patient data, plans for specific patients, staff availability and workload, and resources.

"The idea is that we are creating words that people can use, when we say 'get together for a brief or a huddle,' everyone knows what is meant," Ms. King said. "What we call the 'huddle' is for problem solving and to reestablish situation awareness. An example of a huddle: When a core care team, such as a surgical team or ob.gyn. team, meets for a quick review prior to a specific procedure."

The debriefing is the step in which quality improvement occurs. Team members meet after the procedure or the next day to review events, even if everything went well the previous day. "This is where patient safety needs to take place, on the front lines of patient care," Ms. King said.

A debriefing may include conflict resolution. The TeamSTEPPS material offers a constructive approach to resolving conflicts among team members in a four-step process called the DESC:

- Describe the specific situation or behavior that caused conflict.
- Express how the situation made you feel and what your concerns are.
- Suggest alternatives and seek agreement.
- Consequences should be stated in terms of the impact on team goals.

The outcomes of the training can be measured by improvements in four core skill areas: leadership, situation monitoring, mutual support, and communication.

Program participants develop a combination of knowledge (of the shared goals), attitudes (of mutual trust and support), and skills (related to accuracy, efficiency, and safety) that ultimately improve patient safety, Ms. King said.

"The big thing is sustaining the changes in attitude," Ms. King said. "Implement the training in one section of the hospital, start monitoring what is going on, and communicate about what is working and not working, and then expand the training to other areas of the hospital," she advised.

To change a hospital culture with teamwork training, create opportunities for team members to practice what they learned, and celebrate success as a way to promote progress, she added.

Barriers to good teamwork include inconsistency in team activity, lack of information sharing, hierarchy, defensiveness, varying communication styles, overwork, misinterpretation of cues, and confusion about one's role. The TeamSTEPPS strategies of better communication through briefs and huddles, as well as through feedback, patient advocacy, and mutual support, can combat these problems, Ms. King said, and result in mutual trust, improved performance, and patient safety.

Developing a team mentality is easier said than done. "We all train separately, and we come together and are expected to work together," she acknowledged.

But physicians can learn the concept of better teamwork as a way to improve patient safety, said Dr. Alison Clay, who participates in TeamSTEPPS at Duke University in Durham, N.C.

TeamSTEPPS at Duke began in the pediatric ICU and it has spread to the operating room. "We are taking it to different parts of the hospital," said Dr. Clay, an internist with appointments to the departments of surgery, and of internal medicine and pulmonary critical care at Duke. The program is likely to move next to the hospital wards and hospitalists and attending physicians, and then to clinics, she said.

The program starts with lectures and conversation and then proceeds to use of simulations and a debriefing to assess how the participants worked as a team.

Dr. Clay has participated in the TeamSTEPPS curriculum, and she has trained to coach others in teamwork building in her role as the capstone course director for fourth-year medical students.

Dr. Clay has a unique perspective on patient safety: She was a victim of a medical error at Duke when she arrived at the emergency department as a patient and went into respiratory arrest after being given a medication meant for the patient across the hall.

"That's why communication is important," said Dr. Clay, who has shared her experience as a patient to emphasize the need for better patient safety measures.

"Concurrent with TeamSTEPPS, [there] are other efforts to teach safety involving all members of the team," Dr. Clay noted. "People have to … be open to the concept [of] using better teamwork to solve the problem." ■

For more information about TeamSTEPPS or to review and order materials, visit www.ahrq.gov/qual/teamstepps.

Hassles Continue in Second Year of Medicare Part D Program

BY MARY ELLEN SCHNEIDER
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SAN DIEGO — In the second year of Medicare Part D implementation, physicians continue to struggle with prior authorization requests and other hassles, Dr. Kay M. Mitchell said at the annual meeting of the American College of Physicians.

Although some of the paperwork burden remains, the prescription drug program is generally easier to manage now because patients and physicians are more familiar with the rules, said Dr. Mitchell, a geriatrician and a professor in the department of community internal medicine at the Mayo Clinic in Jacksonville, Fla.

"It's still going to cost us time and money," Dr. Mitchell said. "It doesn't matter how much we've worked at it."

For example, physicians continue to see requests for prior authorization and step therapy, said Neil M. Kirschner, Ph.D., ACP's senior associate of insurer and regulatory affairs. In addition, in 2007, several drugs were approved under both Medicare Part B and Part D, which could create denials, he said.

Officials at the Centers for Medicare and Medicaid Services are working on this issue and recommend that physicians write the diagnosis and "Part D" on the prescription, Dr. Kirschner said.

Physicians might experience some relief in terms of prior authorization and exceptions if their patients haven't changed drug plans, Dr. Mitchell said. CMS officials announced that prior authorizations and exceptions approved by a drug plan in 2006 are expected to continue this year if the beneficiary remains in the same plan and the expiration date hasn't occurred by Dec. 31, 2006. However, if the beneficiary changes plans, physicians might have to go through the same process again.

When you are faced with prior authorization, save time by having the patient collect the authorization forms and bring them into the office, Dr. Mitchell suggested. In her office, this saves office staff 20-35 minutes per prescription, she said.

Some physicians have decided to deal with the extra Part D paperwork by either hiring additional staff or designating staff to deal solely with Part D prior authorizations, denials, and appeals, Dr. Mitchell said. Some physicians use general office staff while others use nursing staff. Dr. Mitchell said she prefers to have one of her nurses work on Part D issues because she is already familiar with the patients and their medications.

Dr. Mitchell also recommended that staff members who are working on Part D issues attend continuing medical education meetings that focus on Part D.

During the course of Part D implementation, Dr. Mitchell also learned that insurers may ask for documentation justifying a switch in medications. To simplify that process, she recommends, keep a sheet in the front of the chart with information on medication changes and the reasons for the switch. ■