Culture Change with TeamSTEPPS®: Leading from the C-Suite



Ann Gaffey, RN, MSN, CPHRM, DFASHRM
SVP, Healthcare Risk Management
Sedgwick

Siri Nelson, MHA, FACHE
Chief Administrative Officer
Sutter Lakeside Hospital

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Changing Culture Takes a Village!

Culture exists in some organizations 98% by default and accident, rather than by design



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Drivers of Culture Change

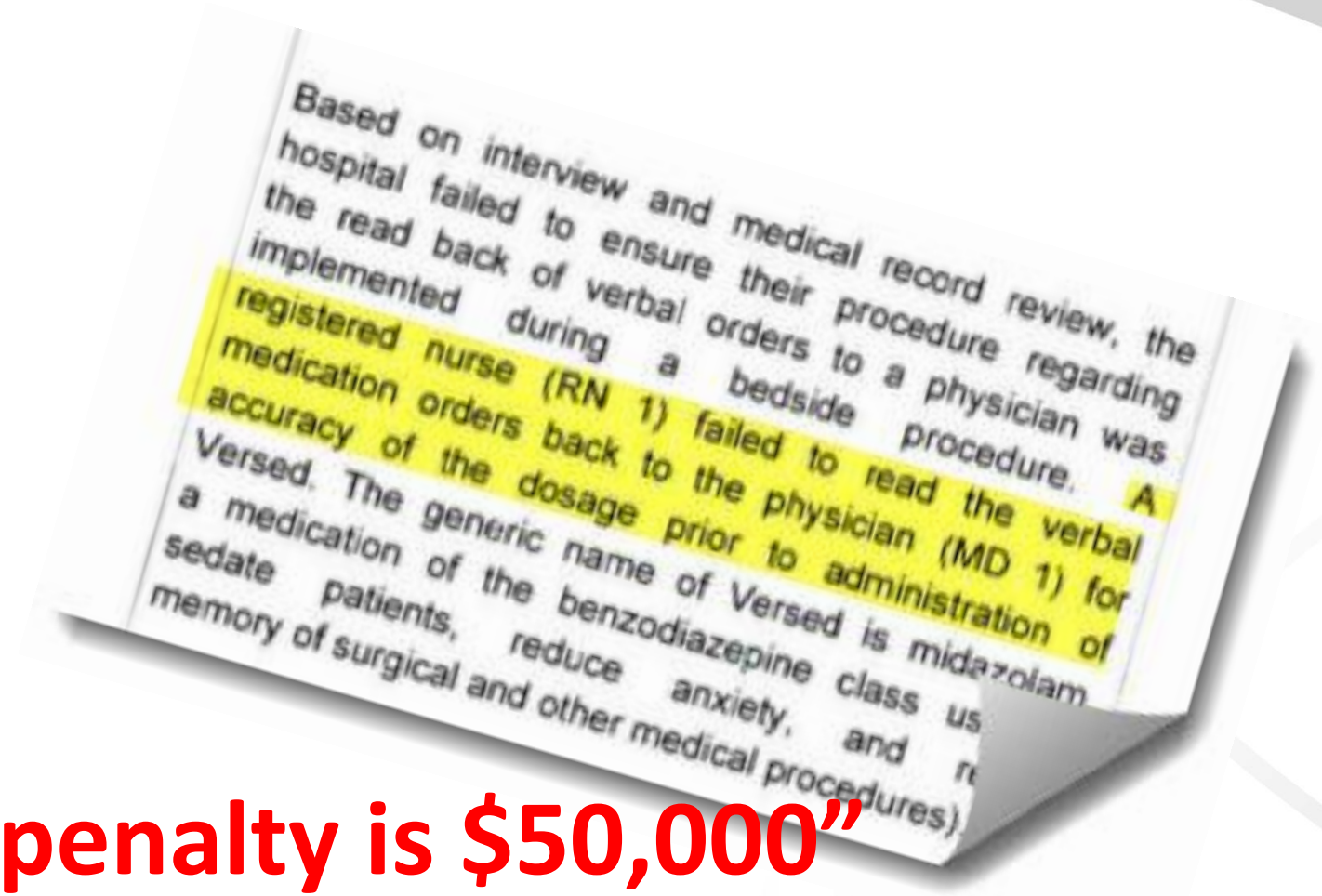
- Patient Satisfaction
- Staff Satisfaction
- Lawsuits
- Public opinion
- *Desire for a climate of trust and teamwork*

What the public sees:



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What the CFO sees:



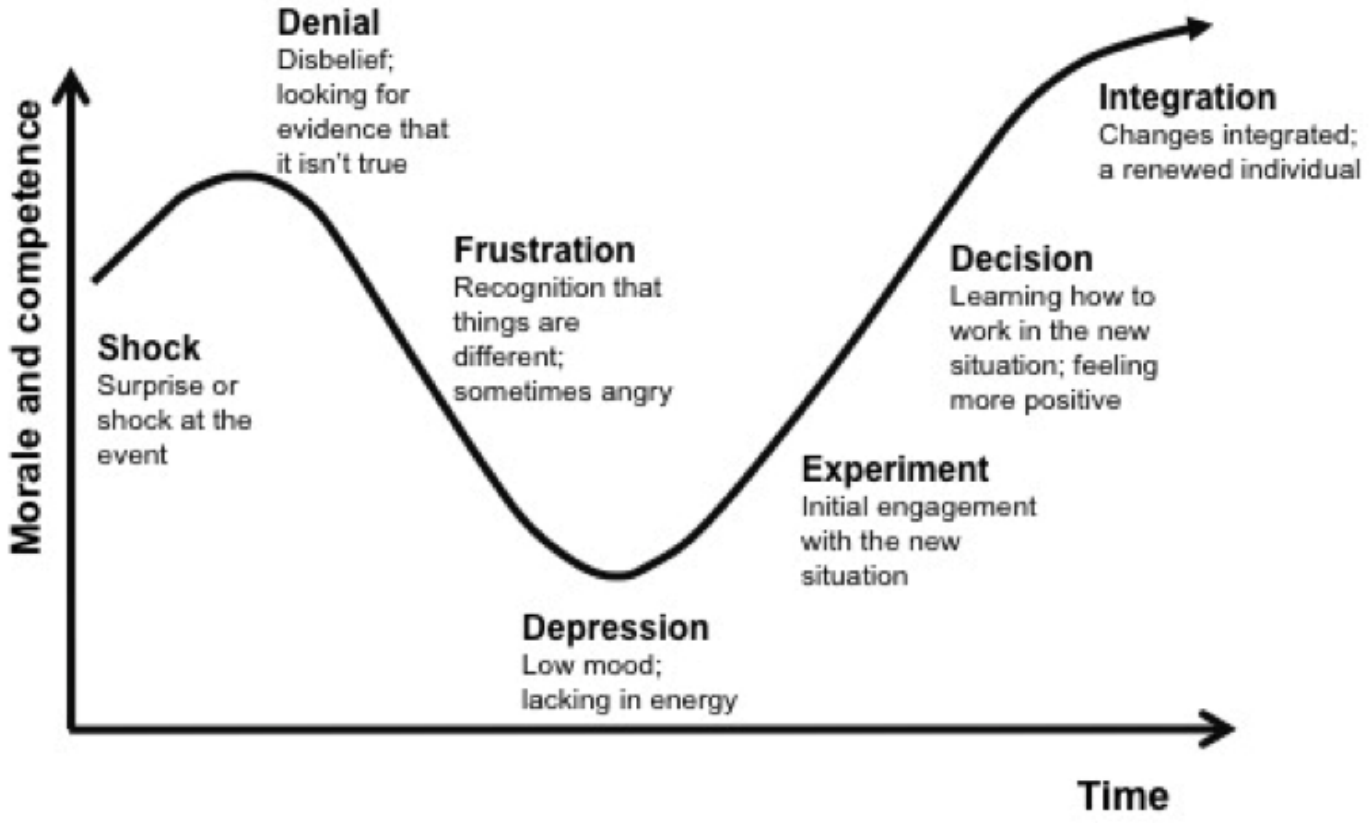
"The penalty is $50,000"

What staff live with:

E 347	Continued From page 1 procedure on counting sponges and miscellaneous items used for Patient 1 's surgical procedure which resulted in retention of a foreign object (lap sponge). On [redacted] 2011, Patient 1 underwent exploratory laparotomy (a laparotomy is a large incision made into the abdominal wall, and is used to visualize and examine the structures inside of the abdominal cavity). A lap sponge was left inside Patient 1 's abdomen just above the liver which required a second surgical procedure, on [redacted] 2011, under general anesthesia to remove a retained lap sponge. The facility's failure placed Patient 1 at risk for possible additional complications, including sepsis (invasion of the body by pathogenic microorganisms and their toxins), visceral perforation (damage or puncture wounds to organs), and the need for additional surgery/general anesthesia. Findings: On September 2, 2011, an unannounced visit was made to the facility to investigate an entity reported event regarding retention of a foreign object in Patient 1.		DEFICIENCY)
E 347	(Continued from page 1) dept safety talk opic: Safe and Quality Care: The importance of Communication and Culture. This OR safety talk continued until all staff involved received the talk FEMA – Surgicount Initiative 8/1/11 FEMA subgroup meets weekly to discuss the progress of implementation of the Surgicount Initiative. This group was primarily responsible for the policy standardization and revision across the health system. This group was responsible for ensuring that staff education was provided to all targeted areas throughout the Health System. Notification of Medical Staff Informational letter sent out to all Medical Staff from Surgicount representative staff. Email blast to all involved staff Email blast to all staff from the Director of Peri-operative services was sent. The email blast	8/14/2011 5/01/2012 8/8/2011 8/24/2011

Uncertainty is inconvenient!

The Kübler-Ross change curve

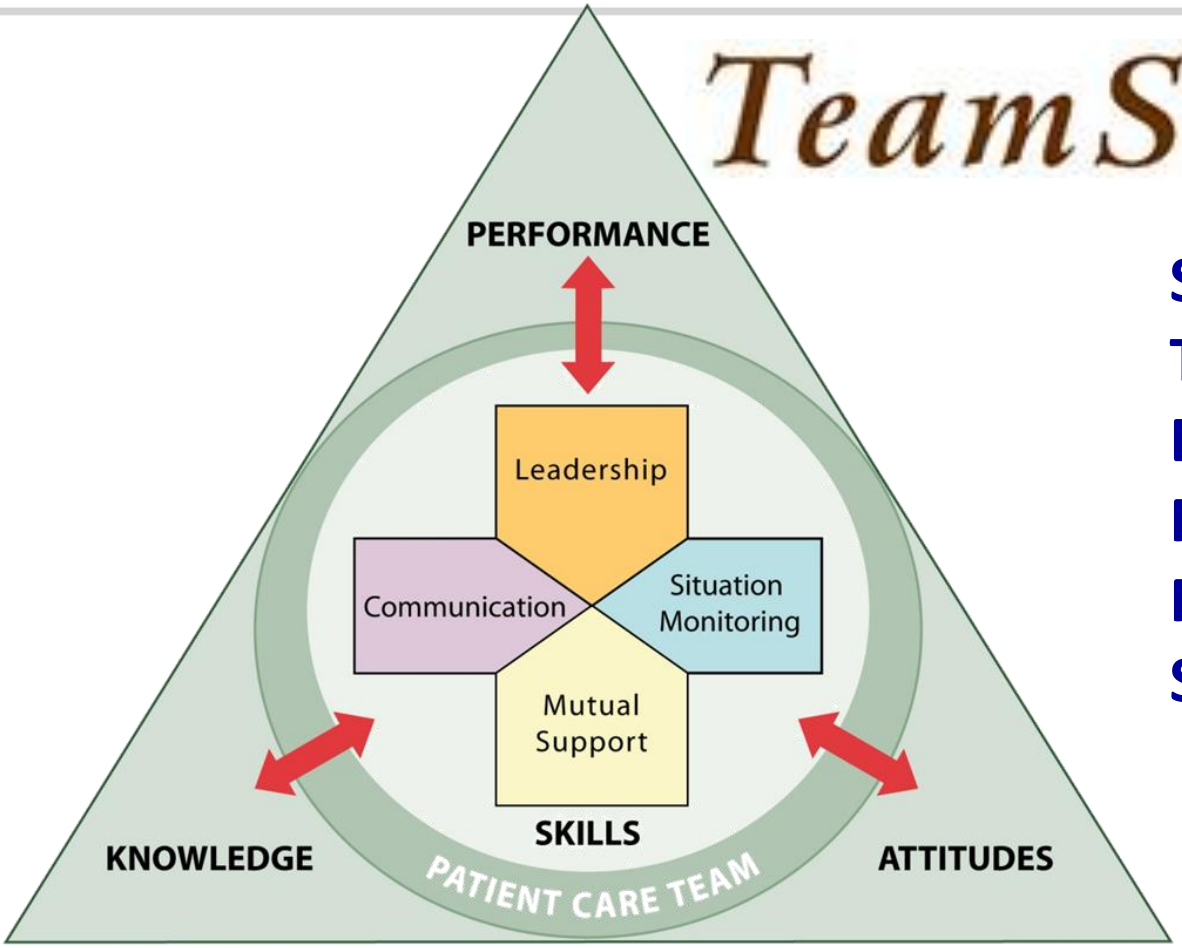


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S trategies and
T ools to
E nhance
P erformance and
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S afety

Perinatal Initiative

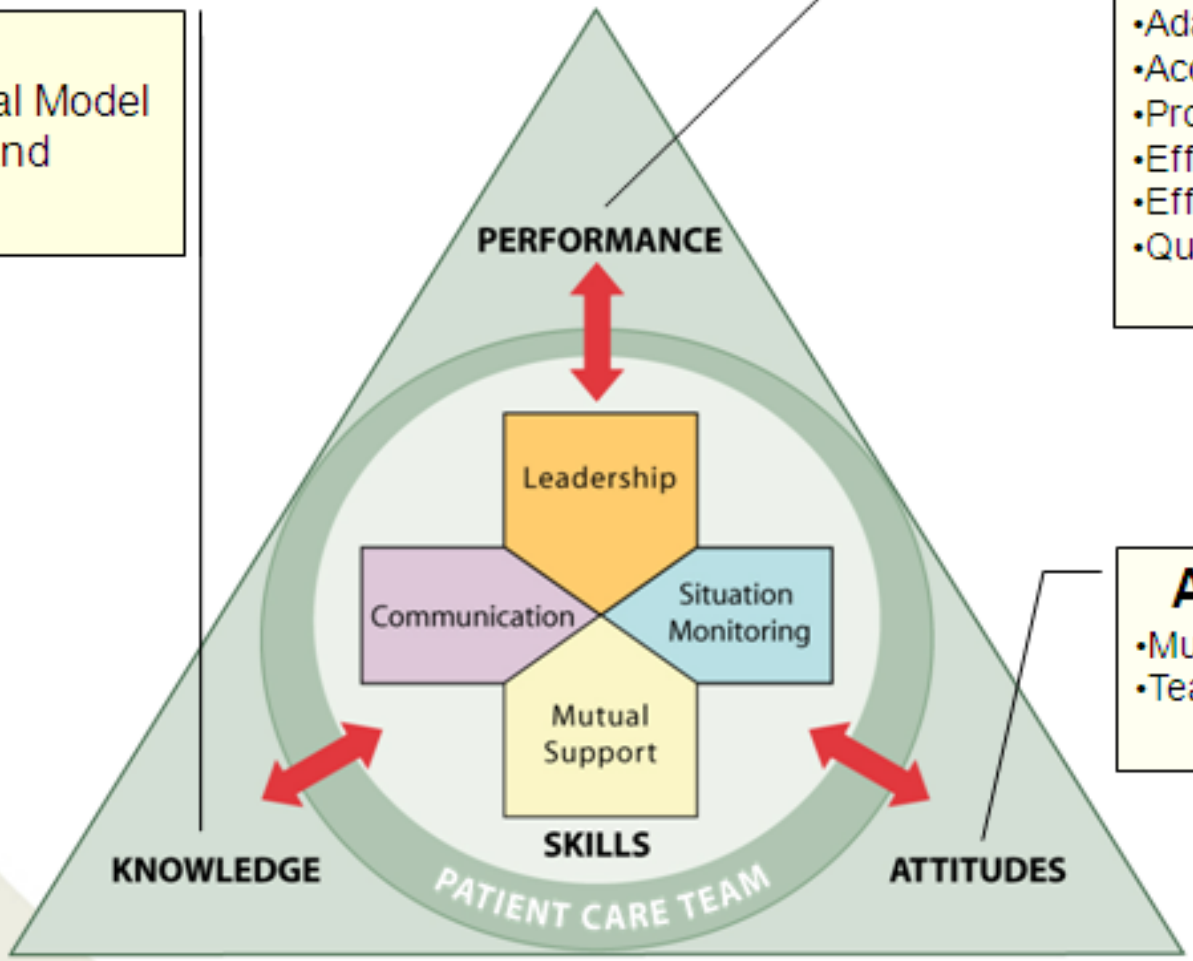
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Team Performance and Outcomes…..

Knowledge
- Shared Mental Model
- **Teamwork** and
- **Clinical**



Performance
- Adaptability
- Accuracy
- Productivity
- Efficiency
- Effectiveness
- Quality & Safety

Attitudes
- Mutual Trust
- Team Orientation

Evidence-Based Benefits

25 Years Behavioral Research

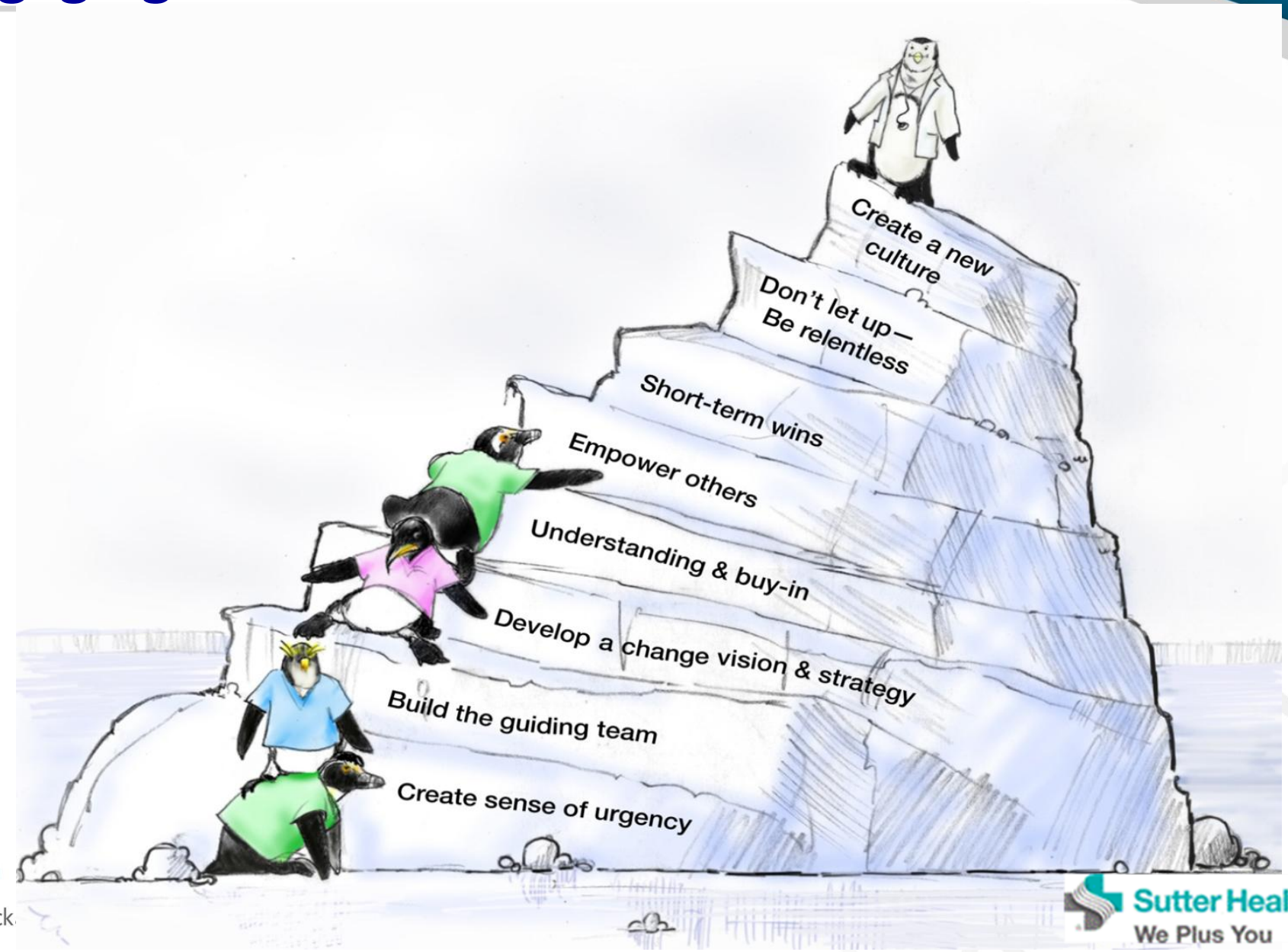
- Reduce clinical errors
- Improve patient outcomes
- Improve process outcomes
- Increase patient satisfaction
- Increase staff satisfaction
- Reduce malpractice claims



…Ultimately change the culture

Advancing care and safety through teamwork

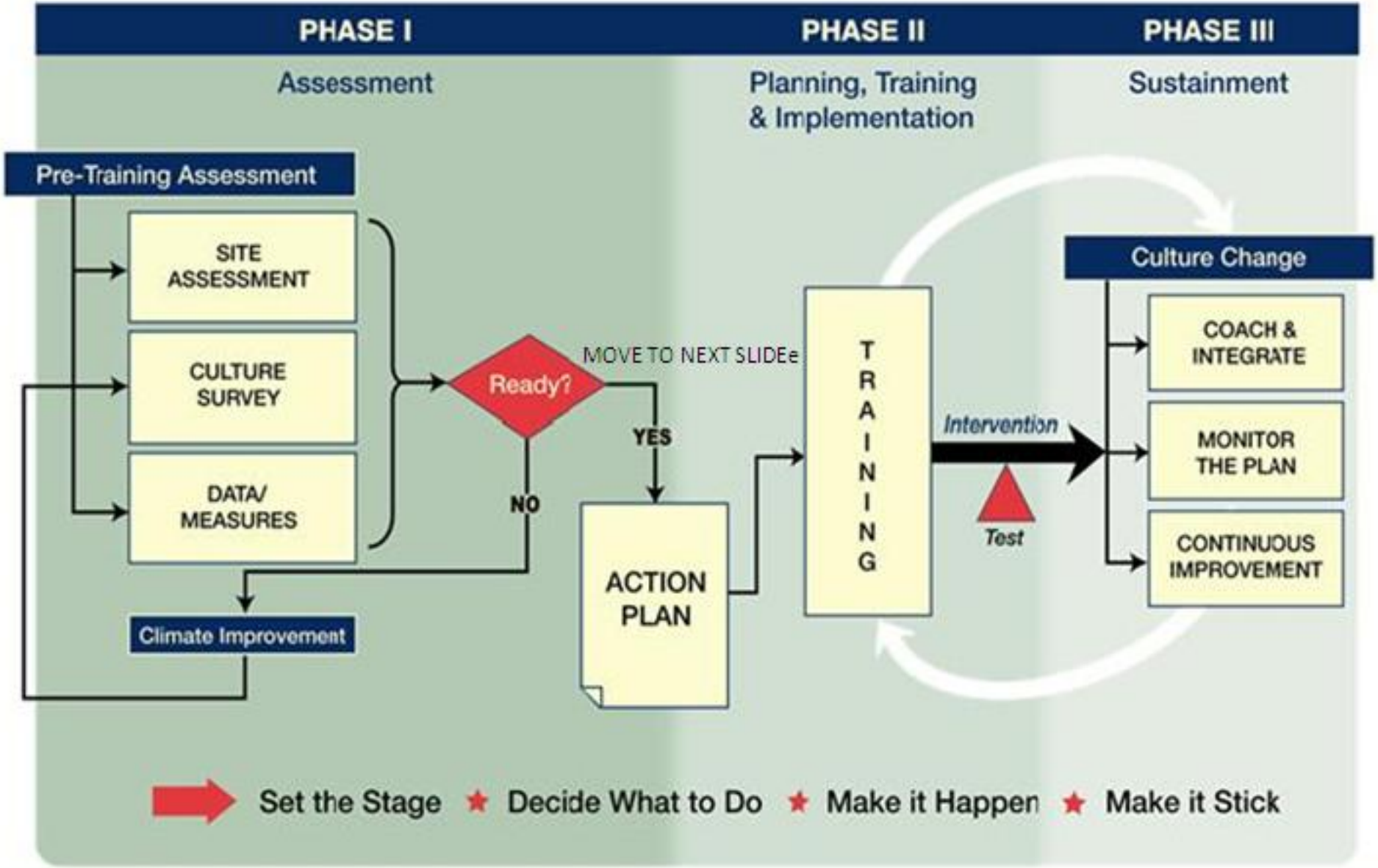
Engaging in TeamSTEPPS®



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TeamSTEPPS® Shift Towards a Culture of Safety



Pocket Guide

TeamSTEPPS

Strategies & Tools to Enhance Performance and Patient Safety

TRICARE

PATIENT SAFETY

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care · www.ahrq.gov

Debrief Checklist

The team should address the following questions during a debrief:

- ☐ Communication clear?
- ☐ Roles and responsibilities understood?
- ☐ Situation awareness maintained?
- ☐ Workload distribution equitable?
- ☐ Task assistance requested or offered?
- ☐ Were errors made or avoided? Availability of resources?
- ☐ What went well, what should change, what should improve?



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



High-Performing Teams

Teams that perform well:

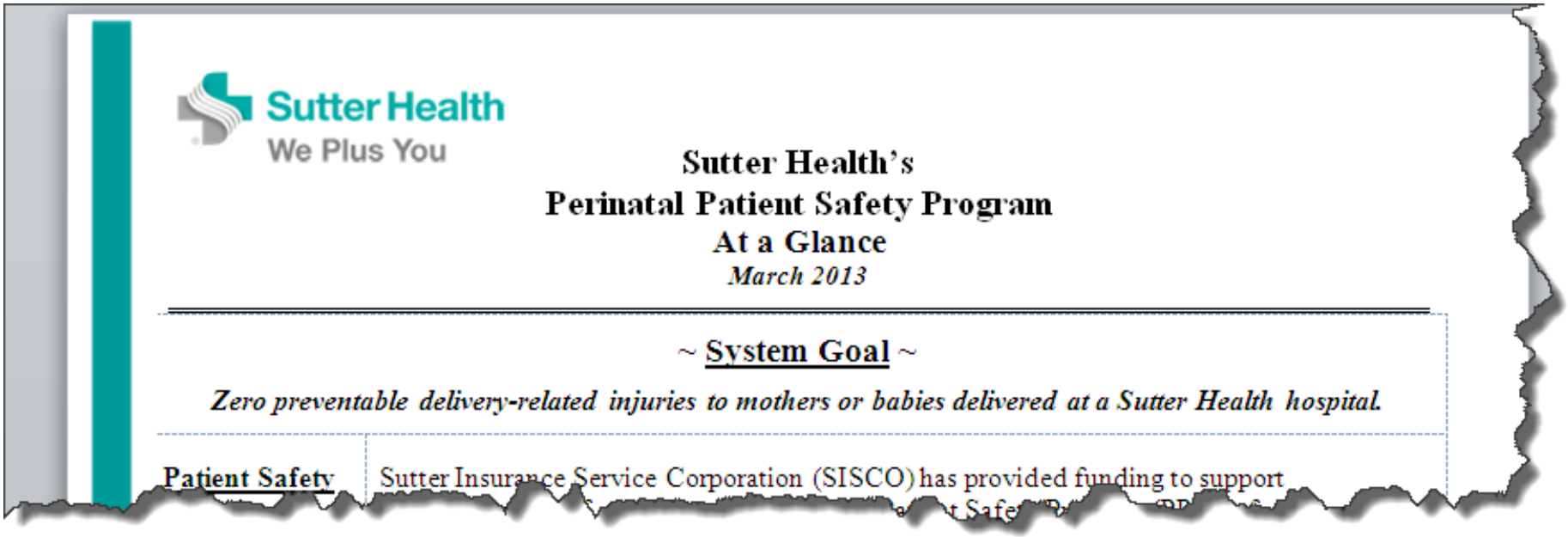
- Hold **shared mental models**
- Have clear **roles and responsibilities**
- Have clear, valued, and shared **vision**
- Optimize **resources**
- Have strong **team leadership**
- Engage in a regular **discipline of feedback**
- Develop a strong sense of **collective trust** and confidence
- Create mechanisms to **cooperate and coordinate**
- Manage and optimize performance **outcomes**

(Salas et al. 2004)

Barriers to Team Performance

- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Varying communication styles
- Conflict
- Lack of coordination and follow-up
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity

Sutter Health Perinatal Patient Safety Program



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Sutter Health's
Perinatal Patient Safety Program
At a Glance
March 2013

~ **System Goal** ~

Zero preventable delivery-related injuries to mothers or babies delivered at a Sutter Health hospital.

Patient Safety	Sutter Insurance Service Corporation (SISCO) has provided funding to support

Leading from the C-Suite: Without leadership there is no change!





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Quality Delivery System (Lean) Adoption

- **In 2011 SLH began our journey to implement Lean as our operating system at the hospital.**
- **We invested in the necessary culture changes :**
  - +15 leaders attended Certification training (8 days of classes in Lean)
  - All leaders (30+) attended an 8 hour training
  - Hired a full time QDS Specialist – a Med/Surg RN at SLH for 9+ years
  - 4 service lines performing active improvement work
    - Inpatient, Surgery , Emergency Services, Family Medicine Clinic
  - Ran numerous Kaizen workshops and events
- **The results were impressive:**
  - Reduced staff walking time
  - Improved communication
  - Engaged frontline staff in developing and implementing the solutions
  - Created high visibility within the organization

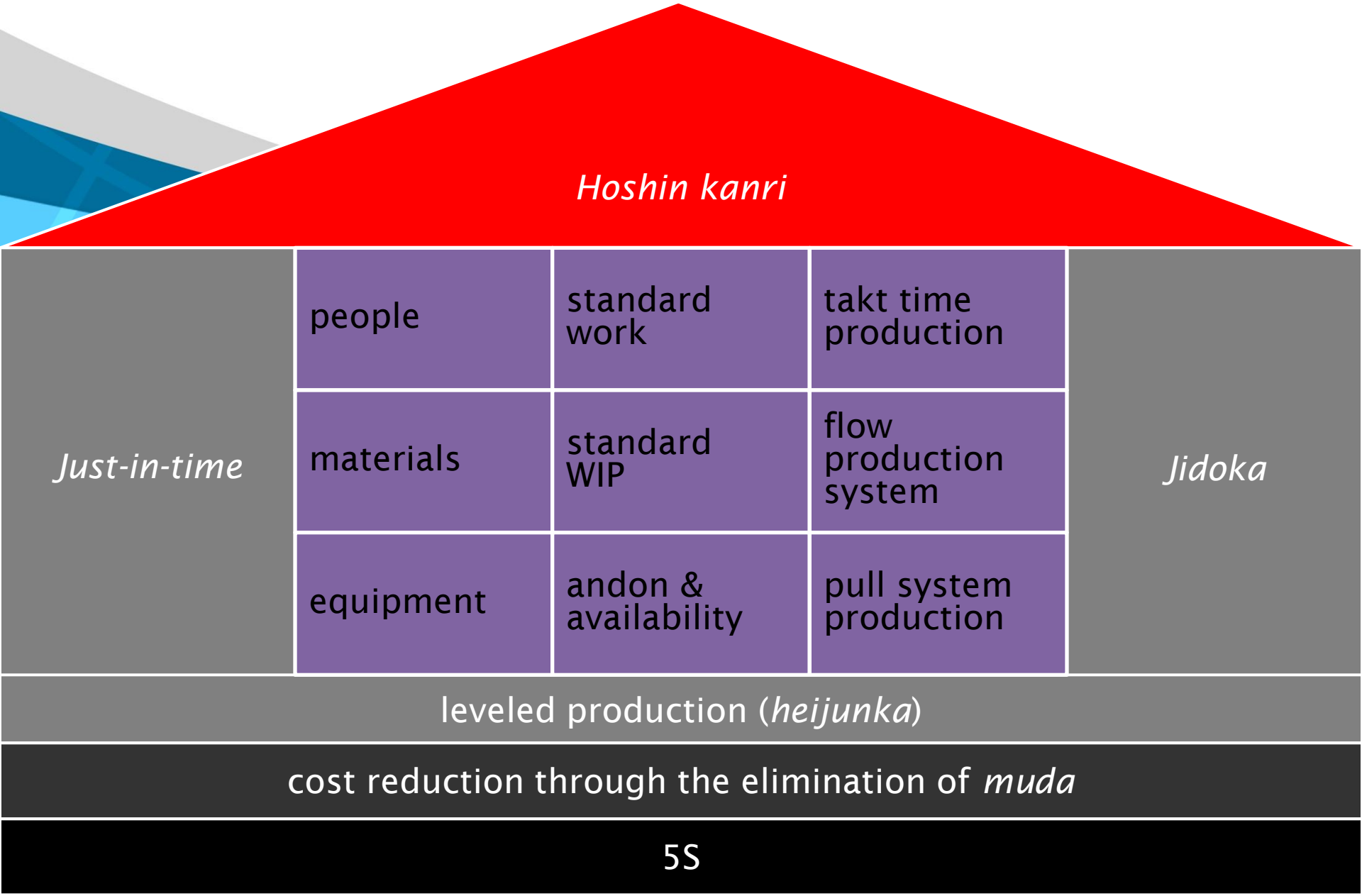


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Toyota management system



But, it wasn't enough

- **While we continued to make improvements in the open service lines, the changes were not being embedded in our culture**
- **Frontline staff were still fearful in raising safety concerns**
- **Accidents and errors still happened**

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We still have a long way to go

- **AHRQ Culture of Safety Survey results had declined year to year (Spring of '12 to Spring of '13)**
- **Experience of Work (EOW) employee engagement / satisfaction survey results declined (Fall of '11 to Fall of '12)**
- **Provider satisfaction survey results had declined**
- **Root Cause Analysis (RCA) results indicated that adverse events were directly tied to failures in communication**

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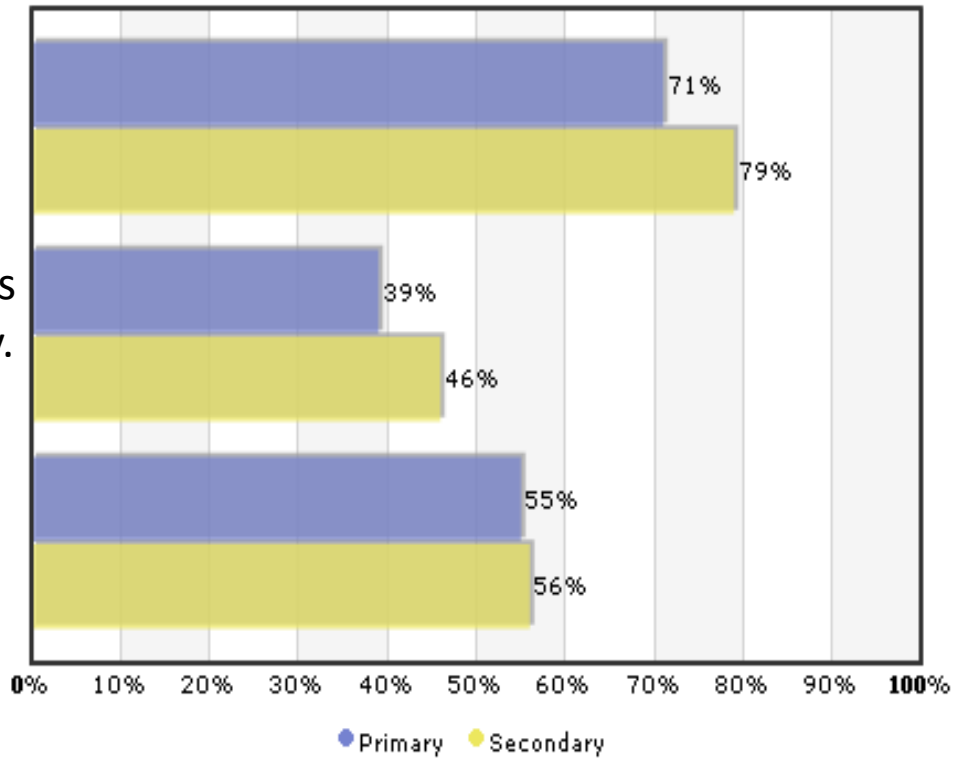
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Motivation for Changing our Culture

AHRQ survey results indicated that the overall perceptions of safety declined from 58% positive to 53% positive

- Staff will freely speak up if they see something that may negatively affect patient care.
- Staff feel free to question the decisions or actions of those with more authority.
- Staff are afraid to ask questions when something does not seem right.



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Experience of Work Survey Results

- **In 2012, only 60% of the respondents felt like they have opportunities to have their ideas adopted and put into use – a decline of 1% from 2011**
- **In 2012, only 61% of the respondents felt that the organization was doing a good job of monitoring and improving the safety of their work area – a decline of 11% from 2011**

	Percent Very Satisfied and Satisfied		
Question	2011	2012	Change
This organization is doing a good job of monitoring and improving the safety of my work area.	72%	61%	-11%
I have the opportunity to have my ideas adopted and put into use	61%	60%	-1%

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TeamSTEPPS®

- **Under the leadership of the Sutter Health System, SLH engaged the entire Family Birth Center team in learning Team STEPPS**
- **The staff and the providers were excited about the potential to use this new set of tools to move our organization forward**
- **The FBC began having daily briefs, huddles and debriefs**
- **They used CUS to talk about safety concerns (I am concerned… I am uncomfortable… This is a safety issue…..)**
- **TeamSTEPPS fit hand and glove with QDS (Lean)**
  - The absolute belief that zero errors is possible
  - Jidoka – Stop the line
  - Challenge the status quo - 5X Why
  - Hard on process / soft on people
  - Genchi Gembutsu – Go and see

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Please welcome your Sutter Lakeside Hospital Team STEPPS Champions to the Gemba!

(left to right)- Ruth Lincoln, Dr. Diane Pege, Tammy Spitzer, Nicole Winegarner, Kathy Exum, Pat Rocha, Peggy Clark, Sheila Gatton, Bill Ringer, Tammy Carter, Jodi Peters and Jose Aponte (not pictured) – Paula Fowler, Laurie DeLeon, Dr. Jonathan Davies and Jackie Rad

Team STEPPS Champions on the Gemba!!

September 20-October 1

Do you speak STEPPS? We do....Let's Talk!

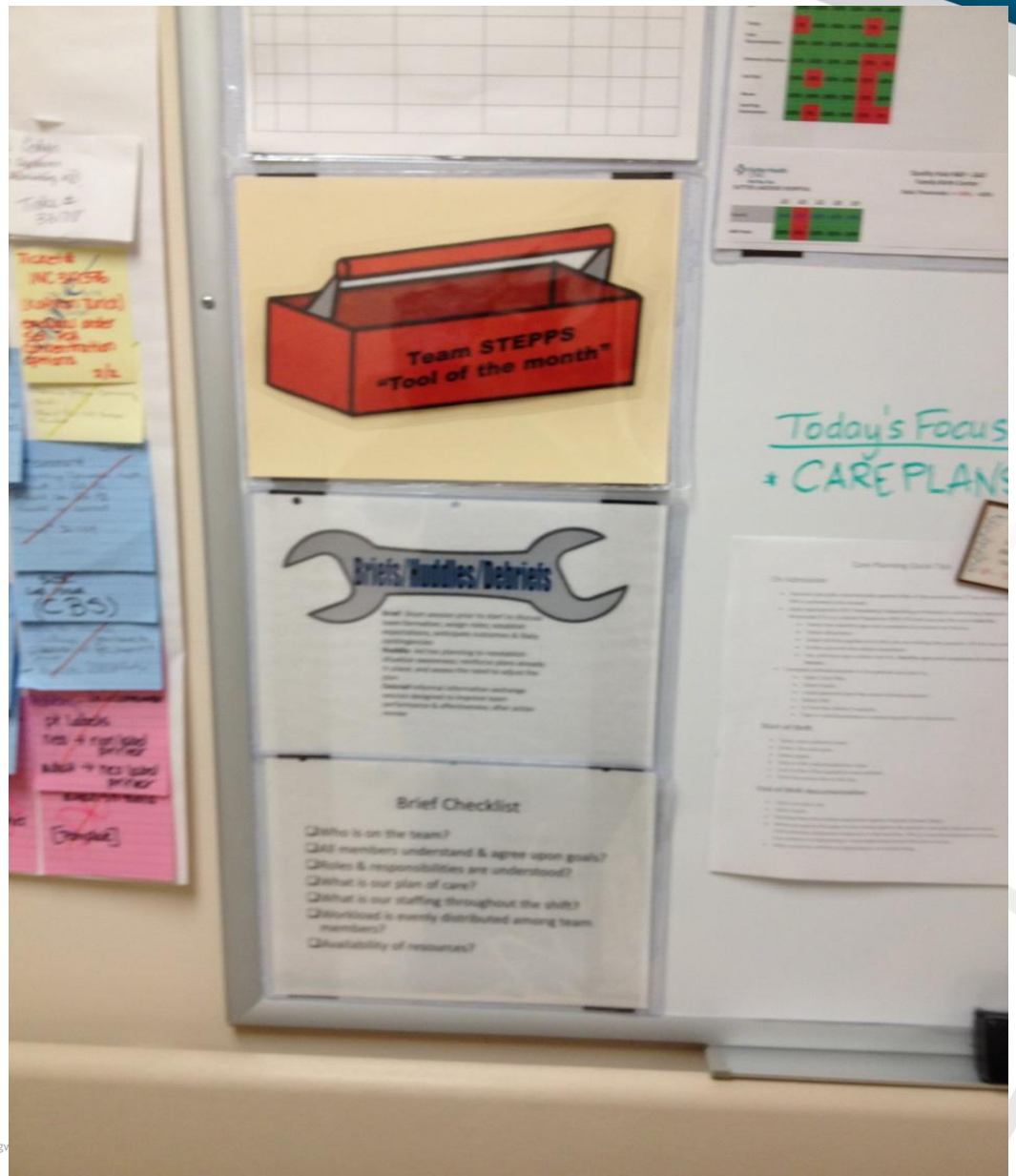
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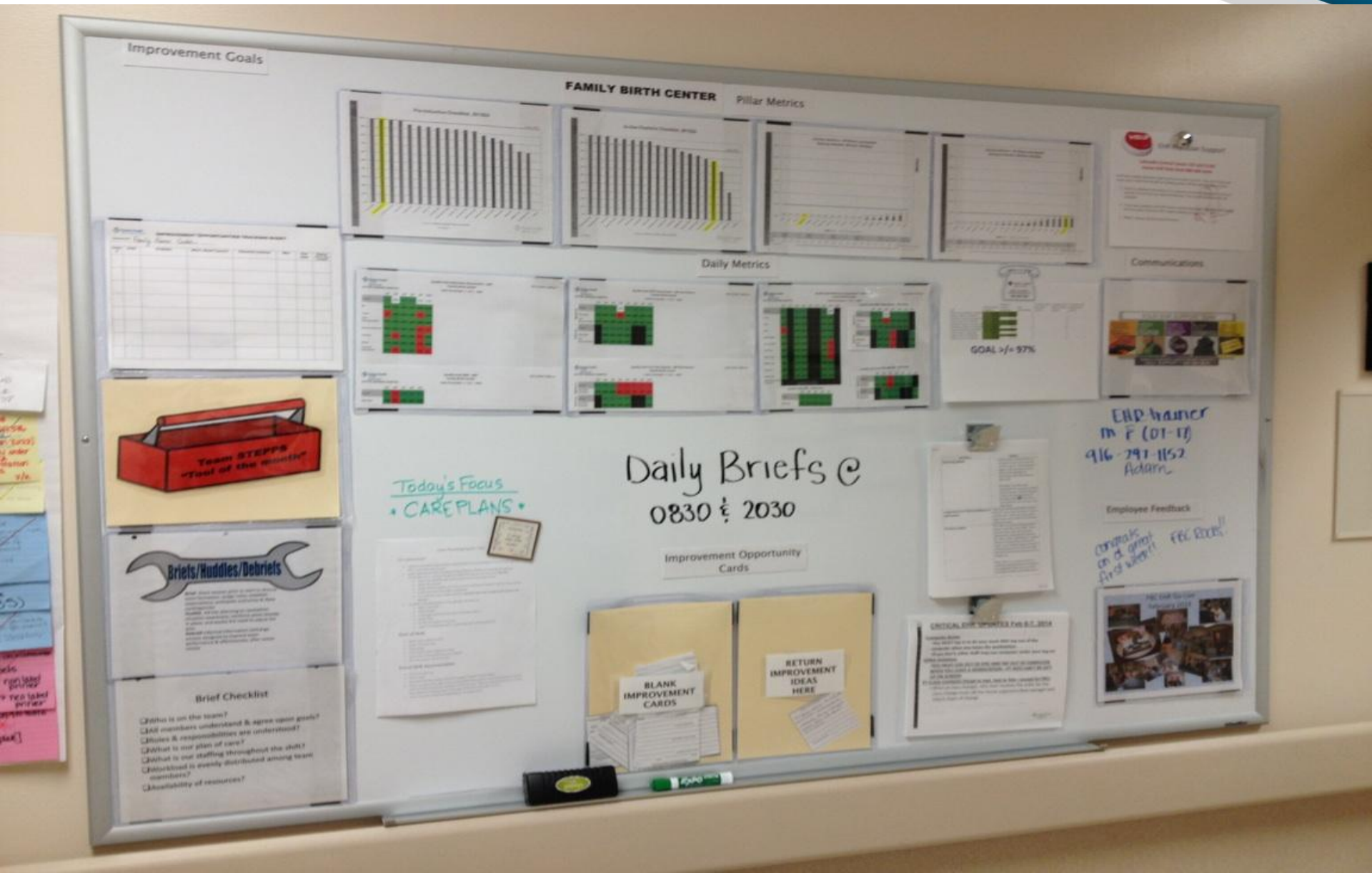
Where we are now

- All staff (300+) have attended the 4 hour introduction to TeamSTEPPS
- We have TeamSTEPPS champions from across the organization
- Our QDS Daily Management System has embedded TeamSTEPPS tools



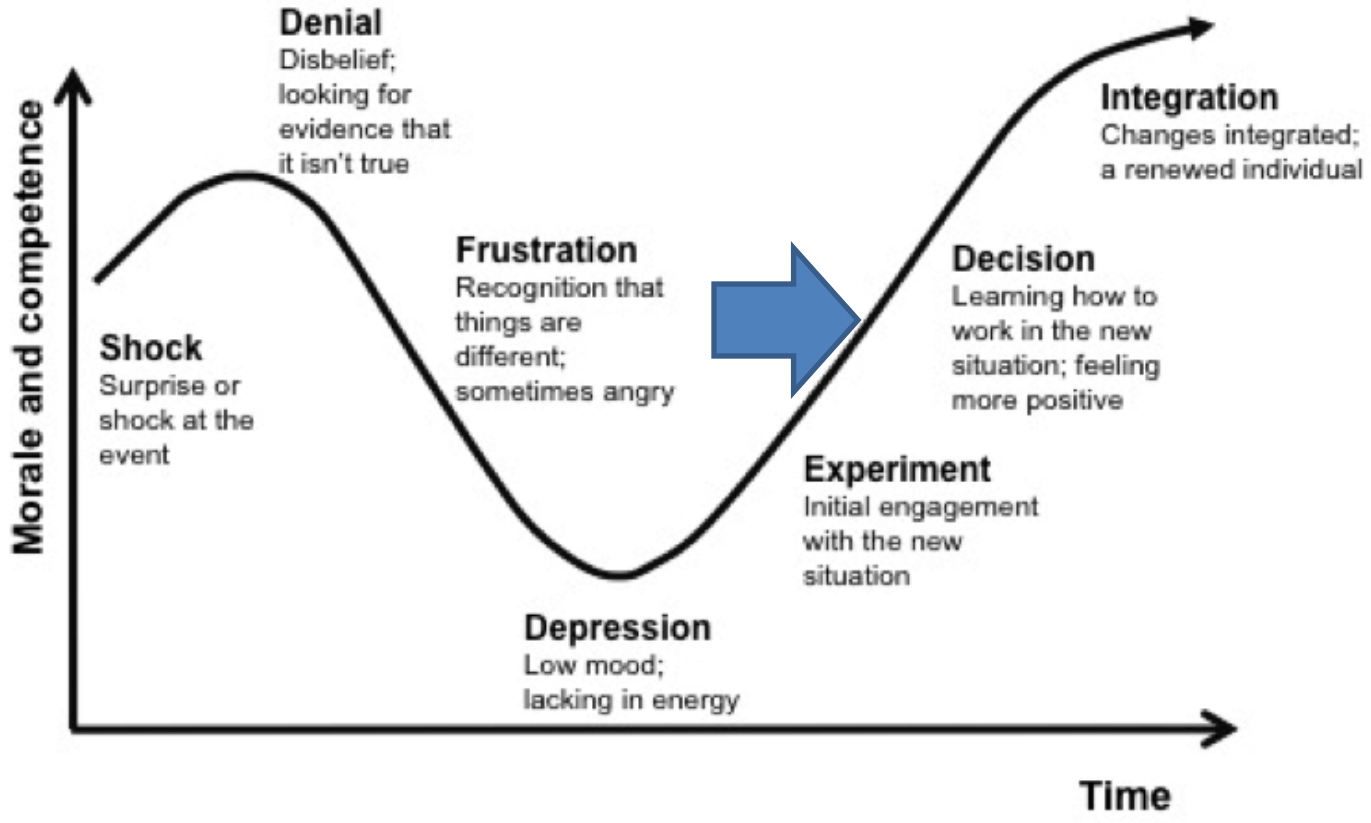
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Where we are now



Where are we now?

The Kübler-Ross change curve



Are we glad we did this?

- **Implementing TeamSTEPPS across our entire organization is helping us move to become a truly learning organization**
- **We are beginning our journey and still have a long way to go**
- **We are fully committed to making Sutter Lakeside Hospital a highly reliable system where everyone is committed to ensuring a safe place for providing care**

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2013 Experience of Work Survey Results

- **In 2012, only 60% of the respondents felt like they have opportunities to have their ideas adopted and put into use – in 2013 this improved to 65% of the respondents**
- **In 2012, only 61% of the respondents felt that the organization was doing a good job of monitoring and improving the safety of their work area – in 2013 this result improved to 74% of the respondents**

	Percent Very Satisfied and Satisfied		
Question	2012	2013	Change
This organization is doing a good job of monitoring and improving the safety of my work area.	61%	74%	13%
I have the opportunity to have my ideas adopted and put into use	60%	65%	5%

Questions?



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