UNMH Labor and Delivery

LoboSTEPPS Training

L&D TeamSTEPPS Change Team

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TeamSTEPPS Instructor Guide. [TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020. Rockville (MD): Agency for Healthcare Research and Quality; September 2006.

TeamSTEPPS Training Objectives

- Review teamwork basic principles
- Analyze cases to identify teamwork breakdowns
- Identify teamwork strategies that can reduce errors
- Describe a Team Trained Just Culture

Culture of Safety & Creating a *Just Culture*

- An organization that holds safety – protection from harm – as its core value and belief.
- A ”Just Culture” focuses on the accountability of a system not the individual.
- Build open and honest reporting mechanisms. i.e Patient Safety portal

We are human

Everyone makes errors everyday

No one makes an error on purpose

An error is not misconduct

We make errors for a reason

Why Do Errors Occur?

Too busy

Working too fast

Interruptions

Fatigue

Multi-tasking

Failure to follow-up

Poor hand-offs

Multi-disciplinary care; poor communication between disciplines

The Science of Teamwork

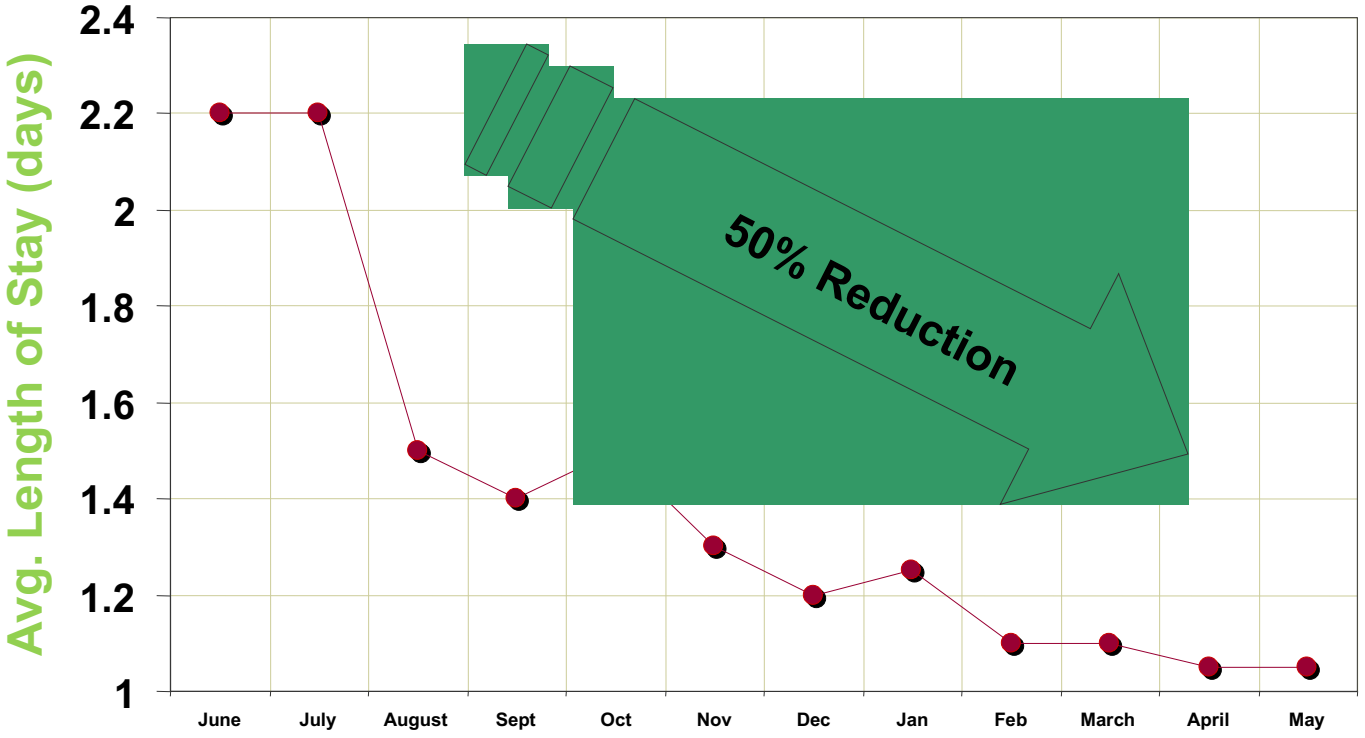
Based on 40 years of research

Defines a team

Identifies skills for team performance

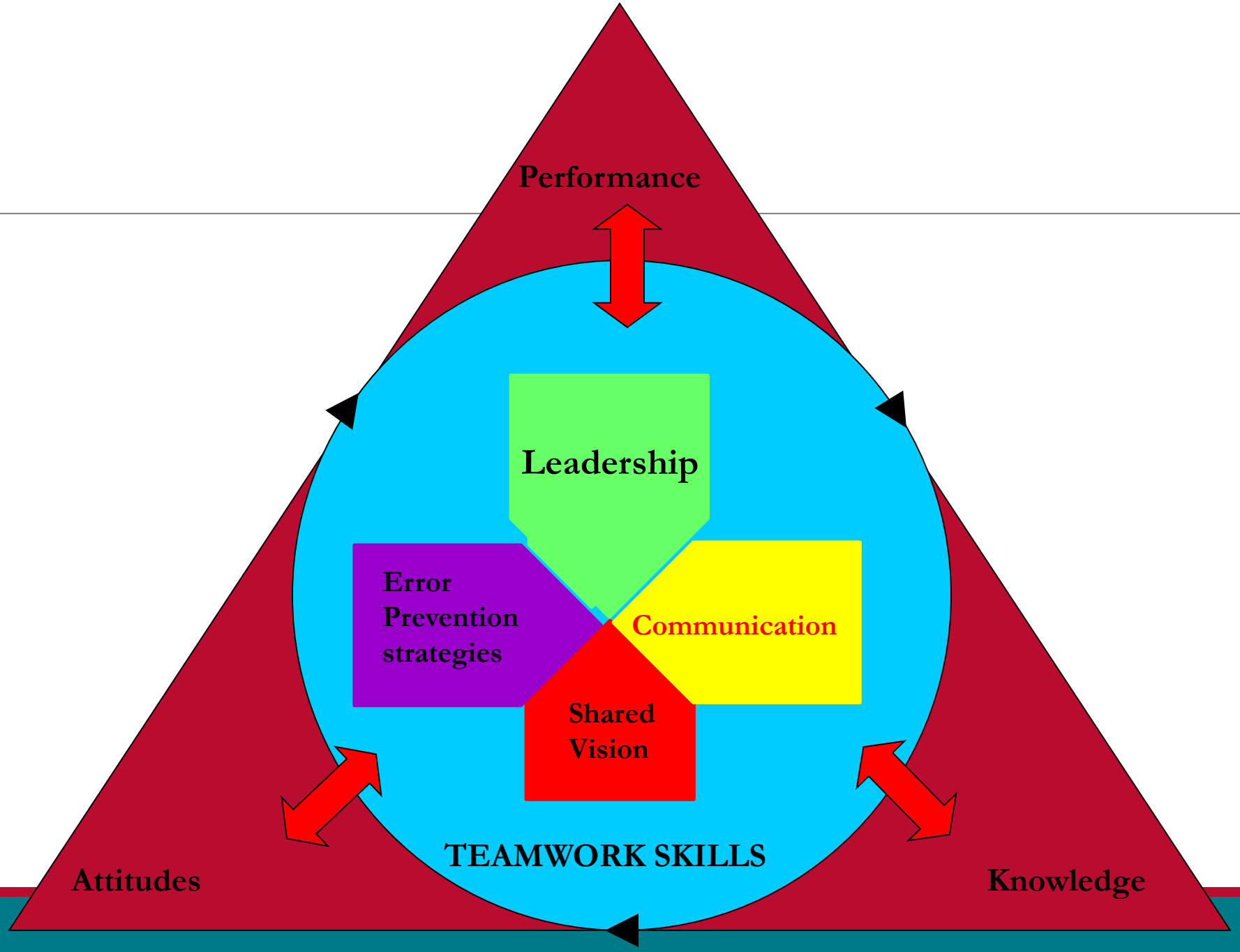
Establishes support systems necessary for implementation

Length of ICU Stay After Team Training



(Pronovost, 2003)

Journal of Critical Care Medicine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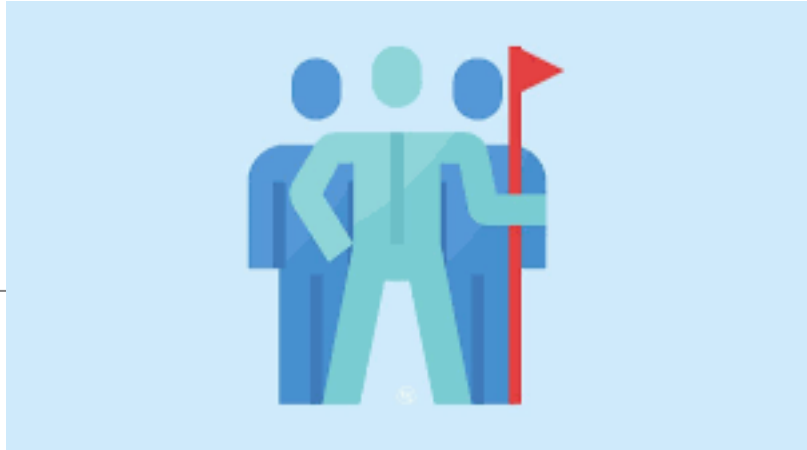
Leadership is Not:



- “Being the boss”
- Having the final word
- Doing everything
- Something only the clinicians do

Teamwork research shows strong leadership is key for high reliability teams to function well.

- Establish and maintain clear roles
- Ensure teamwork events occur
- Prioritize and make decisions
- Manage resources
- Model and facilitate teamwork skills
- Facilitate conflict resolution
- Are easily approachable, flexible, responsive to input of other team members
- Work to develop trust and to motivate staff

A Good Team Member:

- Knows the roles of team members and team goals
- Offers pertinent information for group decision making
- Participates in agreed upon communication events
- Is easily approachable
- Supports other team members

VOLUME 264
NUMBER 81

50 cents
75 cents beyond
30 miles from Boston

*

The Boston Globe

FRIDAY, SEPTEMBER 19, 2003

STORM DRAIN

TODAY: *Mostly cloudy, humid, showers, windy, 71*

TOMORROW: *Warmer, calmer, some sun, 76-81*

HIGH TIDE: *6:08 a.m., 6:19 p.m.*

FULL REPORT: PAGE B8

Doctors were unsure of roles as boy died at Children's

By Anne Barnard
GLOBE STAFF

The 5-year-old boy had just had electrodes implanted in his skull to track his epilepsy when a massive seizure struck. Though he was in intensive care at Children's Hospital in Boston, one of the world's top pediatric centers, no one ordered the aggressive treatment that could have saved his life.

The seizure racked the boy's 44-pound body for an hour and a half – with none of his doctors making the decision to give him the aggressive medications normally used in such episodes – until he stopped breathing. He died two days later, on Mother's Day.

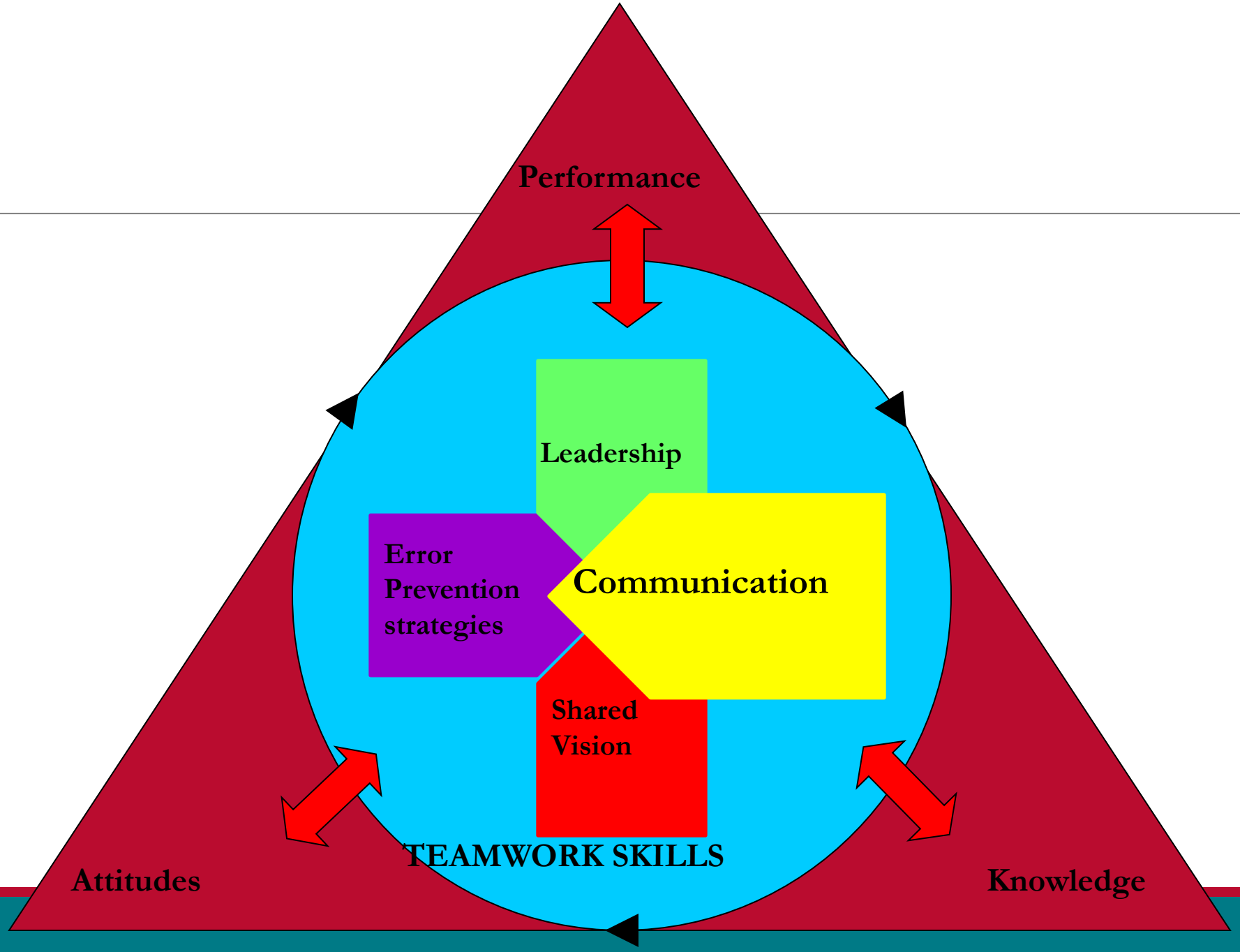
The May 9 episode, investigated by the state and described in a 24-page report released yesterday, revealed serious problems with communication and accountability at one of the city's flagship hospitals, public health officials said. It also triggered a review of all hospital operations by state and federal officials. Paul Dreyer, who investigates medical errors for the Massachusetts Department of Public Health, called the event "one of the worst we've ever seen."

Hospital president Dr. James Mandell issued a strongly worded apology yesterday: "Children's Hospital accepts full responsibility for the outcome . . . and extends its deepest apologies."

The investigation portrays a situation where lines of authority were deeply tangled, and where no one person had accountability for the patient. Following the boy's death, each of the doctors who initially worked on the case – two at the bedside and one consulting by phone – told investigators they thought one of the others was in charge. The senior doctors who supervise them also disagreed over which department should have led the treatment, with brain surgeons, epilepsy specialists, and critical-care doctors each saying the other groups were responsible.

Amid the intense activity around the patient, none of the doctors or nurses apparently kept watch over the patient's airway – rule number one in any medical emergency. When an attending intensive-care physician arrived more than an hour into the seizure, she told investigators, she

CHILDREN'S HOSPITAL, Page A24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Did you know?

Words account for only 7% of message[1]

Tone of voice accounts for 38%

Body language accounts for 55%

1) Mehrabian, 1971

"Communication is the response you get to a message you sent, regardless of the intent"

-(anon)

Tips for Tiger connect

1. Always assume MRI (most respectful interpretation) when communicating via Tiger Connect!

2. If possible first communication amongst any inter disciplinary team should be face to face

1. Avoid over Texting, plan of care should be face to face

Our Toolbox of Team Communication

Communication Events

- Ad hoc huddles
- Coordination meeting
- Hand-offs
- Safety Huddle
- Pre-op verification
- Time-outs
- Delivery/Surgery Summary
- Debriefs
- Pattern Check
- OB STAT
- OB Trigger

Tools/Templates

- Shift Forecast
- SBAR
- Safety Huddle template
- Pre-op verification template
- Time-out template
- Post-delivery/surgical template
- OB STAT diagram
- OB Trigger diagram
- Hemorrhage risk assessment
- MEWS
- DESC

Defining Our Teams

Core Team:

Team that provides direct patient care

Coordinating:

Leadership structure to manage oversight/safety for entire unit-

OB STAT/OB Trigger Teams:

For emergencies/ Emergency Back-up

Daily schedule of events

Time	Event	Purpose	Location
7:00 am	RN Shift change Clinician Sign-out	RN assignments Clinicians change of shift sign-outs OB STAT and OB Trigger roles re-assigned	Sol, Luna, Conference room
7:45 am	Coordinating team meeting	Review events, staffing, update Shift Forecast Board, ensure all roles assigned	Nursing station
10:00 am	Safety huddle	Situation awareness for all staff	SOL
5:30 -7:00 pm	Clinican Sign-out	Clinicians change of shift sign-outs OB STAT and OB Trigger roles re-assigned	Sol, Luna
7:00 pm	RN shift change	RN assignments	Conference room
7:45 pm	Coordinating team meeting	Review events, staffing, update Shift Forecast Board, ensure all roles assigned	Nursing station
10:00 pm	Safety huddle	Situation awareness for all staff	SOL

Core Team Responsibilities

- Provide excellent patient care
- Meet regularly
- Update coordinating team on changes in workload, plans of care, resources, etc.
- Address all safety concerns
- Provide all patients with a well-defined plan and share this plan with team members
- Ensure that all roles are filled

Tools for Communication with Core Team: *Shift Forecast*

- Identifies clinicians on shift
- Identifies staff roles
- Identifies elective work (inductions, OR procedures)
- Identify Backup attendings/call RNs

Tools for Communication: *Coordination meeting* 7:45 am/pm

- OB, MCH and CNM attending
- Anesthesia Attending
- RN supervisor

PURPOSE

- Review schedule of events
- Need to call/change schedule of events
- Bed availability

Coordinating Team Role

- Communicate with the core team
- Maintain global situation awareness and monitor for safety
- Process, integrate and disseminate information gathered from outside units
- Organizing the patient flow
  - Prioritize Cesarean deliveries and inductions
  - Delegate resources
- Manage conflict

Tools for Communication: *Safety Huddle*-10:00 am/pm

- Multi-disciplinary
- Occur at 2x per day and ad hoc when staff is overloaded or unclear of plans
- RN is presenting
  - RN to huddle with clinician prior to safety huddle review plan of care
- Require staff to:
    - Update patient care plans
    - Identify safety concerns
    - Prioritize workload

Safety Huddle:

New Time-10 am Sol

Required Team Members:

Charge Nurse

OB Tech

Primary RNs

Anesthesia Attending

Anesthesia Resident

Triage CNM* TBD

Triage RN

CNM

OB Attending

OB Residents

MCH Attending

MCH Residents

MCH Fellow

MFM

NICU* TBD

Safety Huddle Template

- Introductions/Roles
  - Clinicians/students first
  - RNs introduce themselves when presenting
- RN Presents:
  - Patient data: Age, g/p, GA, reason for admission, language for patient
  - Category of the strip
  - Hemorrhage risk
  - Risk factors
  - Plan of care
- Review of OB Triage (if 2 nurses in triage one to come over for huddle)
- Review antepartum patients with MFM
- Review provider availability
- Review workload for the day
- Review unit resources

Clear and Succinct Requests: SBAR

Situation: Describe the situation

Background: Give the background regarding the patient

Assessment: Most recent and all relevant assessment data to include prior values or trends e.g. blood glucose values

Request: Can the other person accommodate the request/ concern?

Nursing Script for Safety Huddle

ID: *Patient is a __ yr old (Age) GxPx (Gravida/Parity) at ____ gestational age who was admitted for _____.*

Pregnancy complications: *Briefly list complications during pregnancy or labor*

Rh status: *Patient is Rh ____ (positive or negative)*

GBS Status: *Patient is GBS _____ (Positive or negative). Patient is _____ (On/Off) Penicillin*

Dilation: *Patient is currently at ____ dilation, her last exam was at _____.*

Membrane Status: *Membranes are _____ (Intact, Ruptured) and ROM occurred at_____ (Date/time).*

Pitocin: *Patient is currently _____(On or Not on) Pitocin. Pitocin is currently at _____.*

Fetal Tracing: *Baby has been overall category _____. Interventions done during previous shift for fetal indication include_____.*

Hemorrhage risk: *Patient has a hemorrhage score of _____*

Pain control: *Patient _____ (Has/Interested in/planning/not planning) epidural*

Lobo Notes: *Include important information about patient social situation, mental status, ect that floor should be aware of*

Plan of care for the day: *Discussed plan of care with Dr. _____ and are planning to proceed with _____.*

Patient	MD	RN	Age	GA	G/P	CX	MISC
SMITH	OB	Julie	27	35	2/1	2/80/-1	SROM, Twins, TOLAC, Yellow
WHITE	CNM	Erin	32	38	4/3	8/100/+1	Pit, BMI 50, Macrosomia Green
GREEN	CNM	Erin	21	41	1/0	9/100/0	Pit, Triple I, Yellow
WATERS	MCH	Annie	41	34	1/1	N/A	PP, Pre-e SF, Mg, Yellow

Tools for Communication:
Pre-Op Verification-All Procedures

- Occurs before all procedures
- **ALL** team members **REQUIRED** to attend
- Differs from team meetings; event focused
- Use briefing template
- For all OR procedures* occurs prior to going to OR

PRE-OP VERIFICATION

Pre-Operative Verification

Any Team Member:

Is everyone ready to pause for the Verification?

Have all patient interviews been completed by the team?

Have any regional block(s) been completed? -if applicable

Anesthesia Provider:

I am **[Anes Provider]**, I will be providing **[Service]** during the surgery.

Would you please tell us your name and Date of Birth? **[Pt/Rep Responds]**

__Confirm identity with patient's ID band__.

Would you please tell us what we're doing for you today and which side we're working on (if applicable)? **[Pt/Rep Responds]**

Has the procedure site been marked and verified(if applicable)? **[Confirm/Verify]**

What allergies do you have? **[List]**

The pre-anesthesia assessment has been reviewed.

Circulating Nurse:

I am **[Nurse]**, I will be the nurse in the Operating Room.

I have verified that the consent is signed and matches the stated procedure.

Hemorrhage risk is **[List]** I will bring the following uterotonics to the OR **[List]**

The H&P has been updated and signed.

I have confirmed that **[Surgeon/Provider]** is in house and available.

The OR room, images, equipment, and implants are ready for this procedure.

Surgeon/Provider:

I am **[Surgeon/Provider]**, I will be the surgeon in the Operating Room.

Indications for the procedure are **[List]**

Pertinent medical history includes **[List]**

If anyone has concerns or sees anything unsafe, please speak up immediately. What concerns do you have?

The Pre-Operative Verification is complete. We're ready to transport to the OR.

(Patient/Representative role may be filled by a RN/LIP, if needed)

Surgical Time-out

OR TIME-OUT

Surgeon: Is everyone ready to pause for the Time-Out?
I am **[Attending Surgeon]**. I will be the surgeon.
This is **[Patient Name]** consented for **[Procedure/ Site/ Side]**.
The patient's **[Site]** has been marked and the marking was visualized. (If applicable)
Radiographic images showing laterality are visible in the room. (If applicable)

Circulator: I am **[Nurse]**. I will be the Circulator.
We have confirmed **[Name/ DOB/ MR#]** with the patient's ID band.
I verify that the consent is signed and matches the stated procedure.
The Fire Risk assessment includes: **[List]**.
VTE prophylaxis (SCDs) are on before induction and working. (If applicable)
Additional considerations are: **[List]**.
I am **[Anesthesia Provider]**. My attending is **[Anesthesiologist]**.

Anesthesia: The patient's allergies are: **[List]**.
The antibiotics administered were **[List]**, given at **[Time]**.
The anesthetic plan for **[Patient Name]** is: **[Type/ Local/Regional]**.
The patient's weight is: **[List]**. I have a Pediatric Code Sheet. (If applicable)
The patient T&S and blood products are: **[List]**. (If applicable)
The Emergency Manual is present and located **[List]**.
Additional considerations are: **[List]**.
I am **[Scrubbed Person]**. I will be the Surgical Tech.

Surg Tech: The implants are: **[List Type and Availability]**.
I have accounted for the critical/ one-of-a-kind instruments. **[List]**
I have confirmed sterilization indicators for all trays as passing.
Additional considerations are: **[List]**.

Surgeon: If anyone has concerns or sees anything unsafe, please speak up immediately.
What concerns do you have?
After the patient is draped, we will verify the site one final time.
Additional considerations/ instructions/ contingencies are: **[List]**.
The Time Out is complete at **[Time]**.

*Additional Time-Outs will be completed for each procedure/position change.

Tools for Communication:
Birth or Procedure Summary-all deliveries

- After all deliveries and procedures in OR
- In OR MUST be completed *before* the surgical attending leaves the OR and must be done
- After vaginal deliveries should be done after laceration repairs

Birth and Procedure Summary Template

- Procedure performed
- Specimens
- Needle and Sponge count correct and verbalized
- Labs sent/need follow-up
- QBL
- Any concerns regarding patient's recovery
- Any "Lobo notes" needed

Tools for Communication: *Debriefing*

- *DISCUSS elements of Teamwork, this is NOT a chart review*
- Was communication clear and effective?
- Were roles and responsibilities understood by team members?
- Was a Situation Awareness maintained?
- Was workload evenly distributed?
- Did we ask for and offer assistance when needed?
- What went well and what could have been done better?
- What should be changed or improved for next time?

Debrief form

Located in cabinet behind the nursing station

Can be initiated by anyone on the Team

Should be completed before end of shift

Reviewed in Patient Safety Event Review committees

DEBRIEF FORM : Patient Clinical Summary

- A debrief should be initiated as soon as possible after any of the event types listed below or for any maternal or neonatal event that warrents discussion.
- The debrief should include as many team members involved in the case as possible.
- Any member of the L&D team can initiate a debrief.
- The RN Supervisor will help coordinate the debrief and will submit the completed form to the L&D Unit Director.
- Debrief forms will be reviewed by a multi-disciplinary team on a monthly basis.

Name of person completing form	
Patient Initials	
Patient MRN	
Date of Event	
Location of Event	
PSI submitted	☐Yes Date Submitted: ☐No If no, why not: ***Following the debrief, please submit a PSI if the team identifies larger systems issues that need to be addressed.***
Event Type	☐Severe PPH ☐ Activation of Massive Transfusion ☐Hysterectomy ☐Eclampsia ☐ Emergent/STAT C/S ☐ Shoulder Dystocia ☐ Catastrophic Uterine Rupture ☐ Maternal ICU Admission ☐ Maternal Mortality ☐ Neonatal death. ☐ Other:_____
Team Present for debrief (Check all that apply)	☐ Primary RN ☐ RN Supervisor ☐ OB Attending ☐ MCH Attending ☐ Aneses. Attenidng ☐ CNM ☐ OB Residents. ☐ FM Residents ☐ Anes Resident ☐ Neonatology ☐ MCH Fellow. ☐ MCH Backup ☐ Transfusion. ☐ OB/Surg Tech. ☐ Other RNs ☐ Unit Clerk ☐ Other:

Think about how the obstetric emergency was managed:

Identify what went well: (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: _____

Identify opportunities for improvement: "human factors" (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: _____

Identify opportunities for improvement: "systems issue" (Check if yes)

- ☐ Equipment
- ☐ Medication
- ☐ Blood product availability
- ☐ Inadequate support (in unit or other areas of the hospital)
- ☐ Delays in transporting the patient (within hospital or to another facility)
- ☐ Other: _____

Tools for Communication: *Ad Hoc Huddles*

- Quick exchange between two (or more) members of the team
- Method for closing the loop
- Tools for effective huddle:
  - SBAR
  - Check-back
- Clarifying the plan

Tools for Communication: *OB Trigger Team*

Tools for Communication: *OB Trigger Team*

WHY OB Trigger Team

- ✓ Create a way to respond quickly to urgent clinical scenarios before escalate to OB STAT
- ✓ Similar to the Sepsis Response Team in rest of hospital
- ✓ Promote Teamwork/task sharing

WHO is on the OB Trigger team

- Trigger 1 (R3 or R4 or MCH fellow)
- Trigger 2 (R1 or R2)
- Trigger Attending
- RN Supervisor

Roles will be assigned by coordinating team at shift change (7am and 6pm)

Tools for Communication: *OB Trigger Team*

- Can be called by anyone! Will activate a team that is expected to respond within 15 mins.
- When an OB trigger is called, resident team is expected to go to the patient's bedside
- Residents will lead the team so that the patient has the best possible outcome
- If PGY-1 or 2, the supervising resident must be informed about the case
- Attending Physician must be called within one hour of the event and communication of such must be documented on the Triggers Multidisciplinary Event Note.
- Documentation includes Assessment, Plan
- OB QSO reviews all triggers

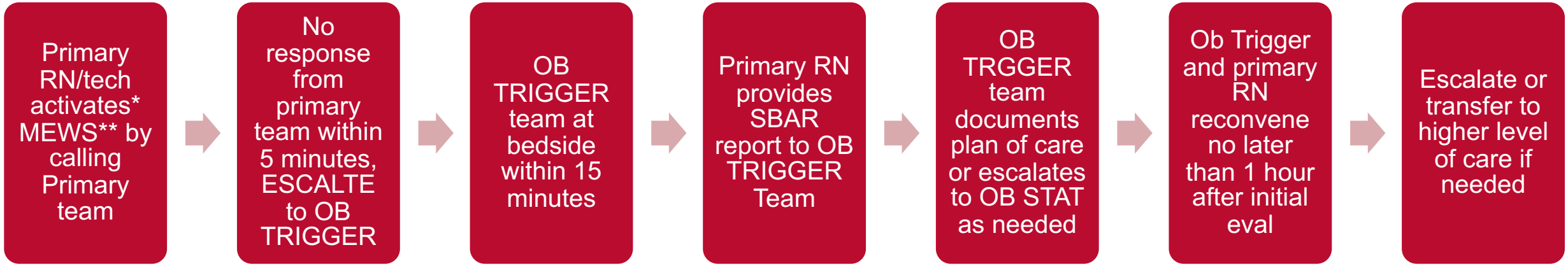
Maternal Early Warning Signs

Vital Signs- new onset	Labs	Other
HR <45 or >120	Fibrinogen <200	Unremitting headache, unrelieved by pain medication
SBP <80 or >160	Hgb <8 or HCT <24	Pain >7, unrelieved by pain medication
DBP >110	Platelets <100,000	Shortness of breath or Chest pain
RR <10 or >30	Glucose <50 or >200	Family Concerns
Urine output <30cc/hr for >2 hours		Agitation/confusion*
O2 saturation <92%		Staff or Provider concern**

**Not for patients admitted for opioid withdrawal, please follow separate pathway for patients admitted for medication for opioid use disorder*

*** For example increased bleeding or other events based on clinical judgment*

Work Flow for activation of Maternal Early Warning Signs



SEND OB TRIGGER AS PRIOITY PAGE

*If tech activates MEWS, tech notifies the primary RN *and* primary team.

**For lab MEWS criteria, may be activated by a provider or RN or support staff

Tools for Communication: *OB STAT*

What is the purpose of the OB STAT Team?

- Designed to ensure that there are adequate resources for emergent situations
- Requires structured roles
- Pre-defined individuals respond to emergencies
  - All attendings will receive page for situation awareness and should respond
  - One attending designated as OB STAT leader
  - Coordinating team designates OB STAT leader at shift change
  - Update Shift Forecast in coordinating meeting
- Ensures rest of unit remains staffed
- Floor considerations if OB STAT called:
  - Turn off pitocin if c-hyst
  - Evaluate if pitocin should be shut off when OB-STAT called

WHEN TO ACTIVATE OB STAT

OB STAT should be activated for *any* OB Emergency

- ✓ Seizure
- ✓ Hemorrhage requiring emergent transfer to the OR
- ✓ Emergent C/S (i.e. cord prolapse, fetal bradycardia, failed vacuum, advanced cervical dilation in breech)
- ✓ Precipitous delivery
- ✓ Shoulder Dystocia
- ✓ Maternal Respiratory failure
- ✓ Maternal Cardiac Arrest (Tell 333 to activate DR. HEART and OB STAT)
- ✓ Other life threatening maternal or fetal events

How to call a Maternal Code at UNM

- Emergency alarm is activated
- 333 paged by primary RN or RN supervisor (or designee)
- Will need to say you are activating an OB STAT and Dr. Heart
- All available staff until OB STAT and Code Team Arrives
- Code team assumes care of code

Who will receive OB STAT Page

RN Supervisor

Resource RN

Emergency RN

L&D Tech

Anesthesia Attending

Anesthesia Resident

OB Attending*

CNM attending

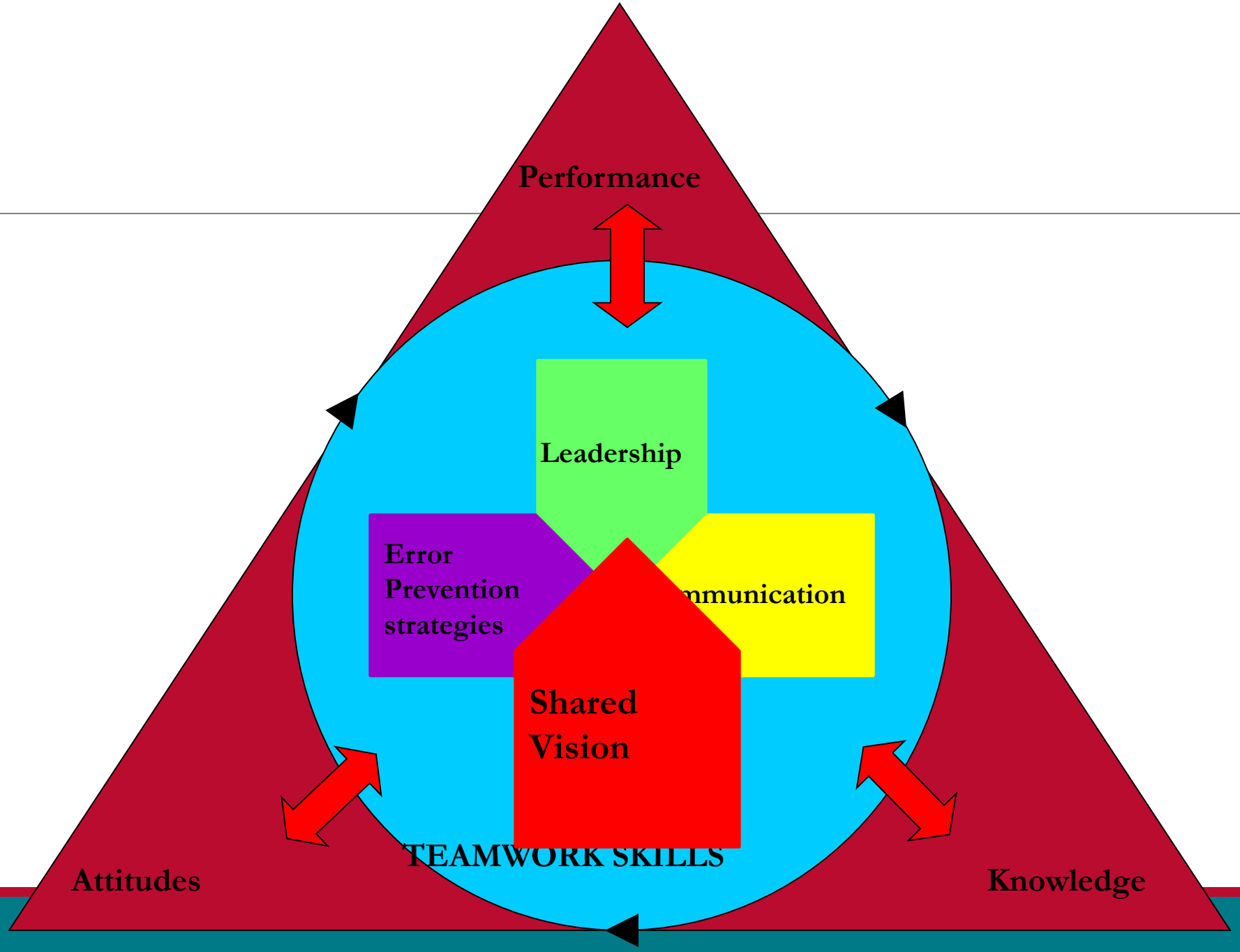
MCH/FM-OB attending*

GYN Ward Attending

Resident/MCH Fellow 1**

Resident/MCH Fellow 2**

* Primary attending to manage the OB STAT, primarily OB Attending and is assigned by coordinating team
**Resident roles assigned will be coordinating team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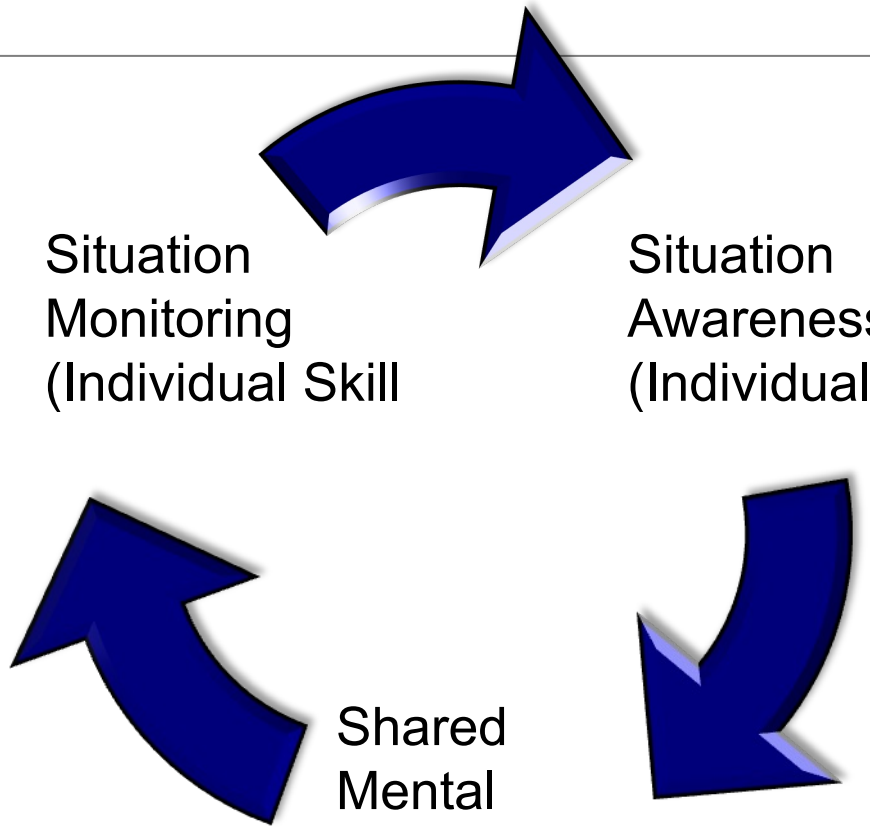
Shared Vision: A Continuous Process



Situation Monitoring

The process of actively scanning and assessing elements of the situation to gain or maintain an accurate understanding of the situation in which the team is functioning.

"Paying attention"

What Do You Monitor?

Status
Team members
Environment
Progress of plans

STEP

Elements of Situation Monitoring

- Non-hierarchical
- Expected of all team members
- Respectfully executed
- Patient centered
- Identify deviations from the original plans

Situation Awareness

- Knowing your environment and being aware of what is happening
- Results from situation monitoring

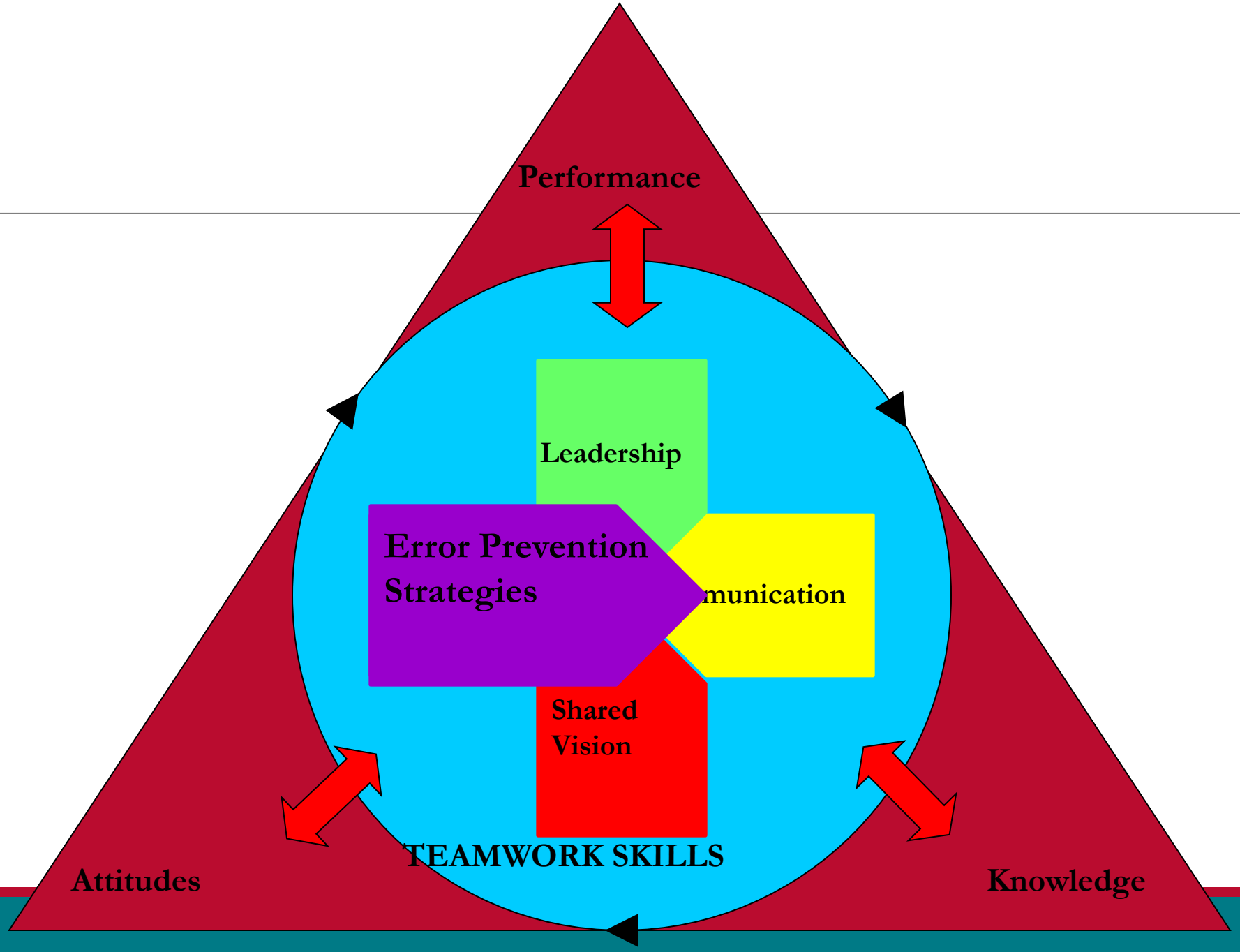
The Shift Forecast is a useful tool for situation awareness.

Shared Mental Model

- All caregivers are aware of the pertinent information and understand the plan of care
- All team members are able to assess risks to the plan of care.
- All team members are aware of availability of resources.

How We Work: Establishing Plan of Care (It Takes A Village)

- Plan of care created by clinician
- An individual's situation monitoring identifies change in patient status
- Change in status is communicated between providers and nurse through huddles creating SA
- Sharing plan with team during meetings allow for a shared mental model for all caregivers.


Performance
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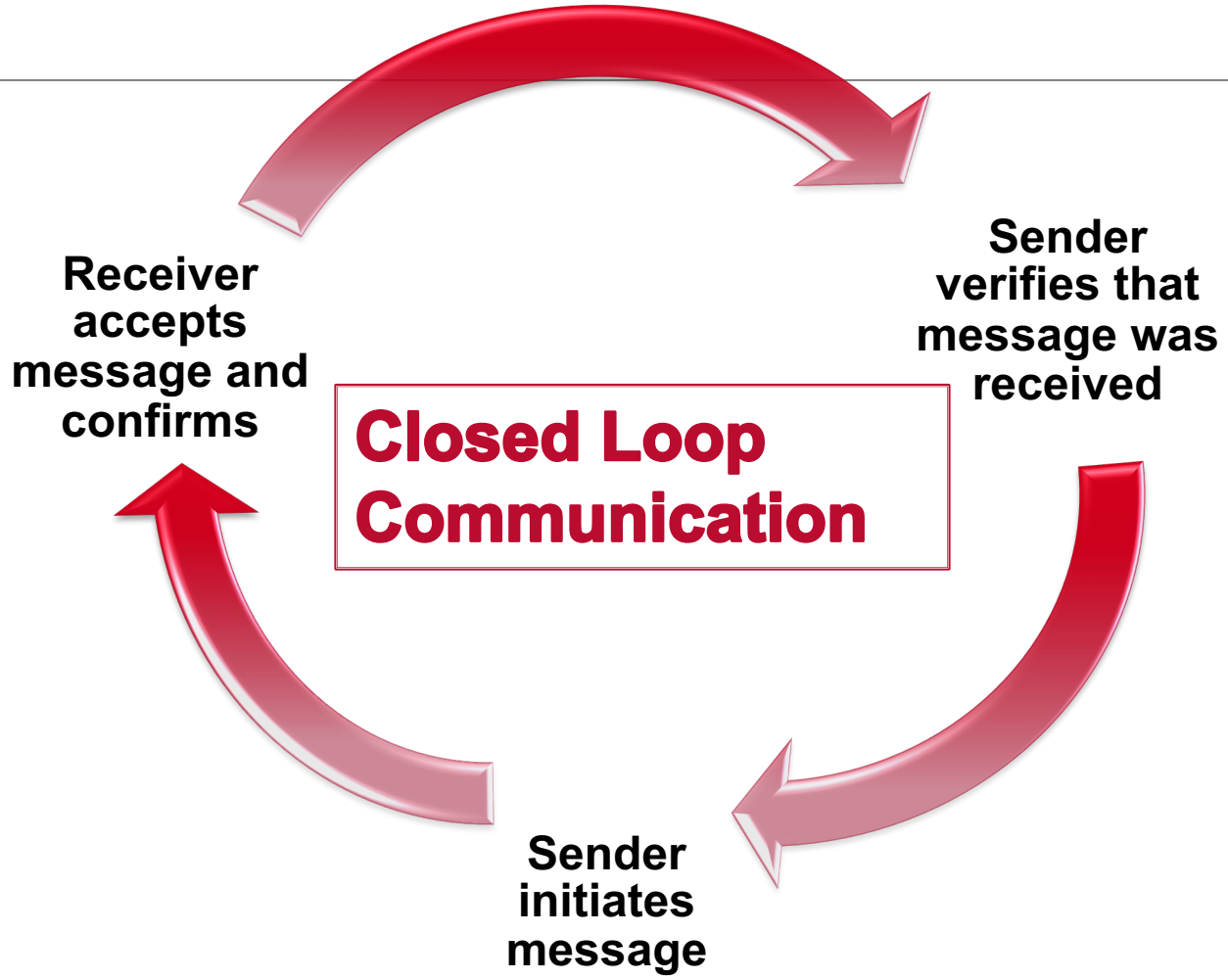
Error Prevention Strategies

- Clear transfer of information
  - Call out
  - Check back
- Advocacy and Assertion
- Management of conflict
- Management of workload

Error Prevention Strategies: ***Call out***

- Articulating important events during rapidly changing clinical situations (e.g. intubation during stat C/S with general anesthesia, making a skin incision)
- Example: “She’s a sleep, you can start,” and, “I’m starting.”

Check-Back = Closed Loop Communication



Error Prevention Strategies: ***Check Back***

- Sender clearly makes request which should be directed to a specific individual
- Receiver repeats the information (for medical orders this should be verbatim)
- Sender confirms or corrects

Dr. Smith: "Nancy, I need you to get 2 units of blood for Jane Doe."

Nancy: "I am getting 2 units of blood for Jane Doe."

Dr. Smith: "Great. Let me know when you are back."

Error Prevention Strategies: *The Two-Challenge Rule*

Voice concerns twice if necessary to confirm that communication is heard

Allows a provider to self-correct

The Two-Challenge Rule

A concern about safety must be voiced at least twice if it is not acknowledged the first time.

Dr. Smith: "Mary, please give Jane Doe penicillin for her GBS + status."

Nurse Mary: "Are you sure you want to order penicillin?"

Dr. Smith: (not looking up) "Yes, please give her penicillin."

The second time might include additional information:

Nurse Mary: "Dr. Smith, since Ms. Doe is allergic to penicillin is there another antibiotic you would like to order?" or ask why the provider believes this course of action is safe.

Advocacy and Assertion

Anyone who notes deviation from an intended plan has the responsibility to evaluate and advocate if needed.

This must be done clearly and respectfully

Two Types of Conflict

Cognitive Conflict

- A disagreement among team members about the content of their decisions and involves differences in viewpoints, ideas, and opinions.
- Can be managed through conflict resolution strategies

Affective Conflict

- A perception of interpersonal incompatibility and typically includes tension, annoyance, and animosity among group members

How Conflicts are Resolved

- Dominance
- Compromise
- Avoidance
- Accommodation
- Collaboration

Collaboration: The Best Approach

Voice concern in terms of the patient

Don’t make it personal

Stop and listen to concerns

Error Prevention Strategies:
DESC Script

D -**D**escribe the specific situation or behavior providing concrete data

E -**E**xpress how the situation makes you feel or your concerns

S -**S**uggest other alternatives and seek agreement

C- **C**onsesus should be stated in terms of impact on performance goals and consensus obtained

Feedback is a gift*
Characteristics of Good Feedback

- Timely
- Behavioral
- Specific
- Directed towards improvement
- Non-judgmental

*Dr Steve Porter

Feedback Should:

- Be private when giving feedback to an individual
- Be public in feedback when rewarding or recognizing a team
- Emphasize team process and performance
- De-emphasize interpersonal issues
- Share lessons learned

LARP SCENARIO

What Teamwork tool could be used by the RN to express concern about not being aware of plan?

32 y/oG4P2 presents to triage with vaginal bleeding at 32 weeks and is diagnosed with a placenta previa.

The physician holds a meeting the charge nurse, anesthesiologist and chief resident outside the patient's room.

The decision is made to proceed with delivery via C/S. Blood is ordered.

The primary nurse was in the room caring for the patient and was not apprised of the plan.

Tool for error prevention: DESC

D:I would like to speak to you about yesterday. Dr X, you held a core team meeting, and I was not involved.

E: It made me feel that Ms. Turner may not have confidence in me as a member of the care team.

S: In the future, if you have important things to communicate, could you make sure all members are involved and we can do the pre-op verification together?

C: I think it would be best for patients if they feel we are all on the same page. Would that be possible?

Algorithm to Enhance Culture of Safety

UNM HOSPITALS

Applies To: [UNM Hospitals, UNMCC] Responsible Department: Effective Date:

Title: **Algorithm to enhance culture of safety**					**Procedure**
Patient Age Group:	( ) N/A	( ) All Ages	( ) Newborns	( ) Pediatric	( ) Adult

DESCRIPTION/OVERVIEW

This pathway aims to optimize communication overall and in situations where perceived conflicts arise, and will be disseminated when new learners, staff, and providers are oriented to working on Labor and Delivery (L&D), OB Triage (OBT) Mother Baby Unit (MBU) and Women's Special Care (WSC).

This communication pathway supports the emotional, cultural, and physical safety of patients and all team members, including nursing, support staff, providers, consulting services, and learners. This pathway enhances patient safety through patient-centered evidence-based care and it supports and strengthens the academic missions of training, research and community engagement.

REFERENCES

AREAS OF RESPONSIBILITY

Labor and Delivery, OB Triage, Mother Baby Unit, Women's Special Care

PROCEDURE

1. The following are the **guiding principles** for care provided on L&D, OBT, MBU, and WSC:
   a. Highest quality care for all patients;
   b. Respect for the strengths of Midwifery (CNM), Family Medicine (MCH and FM-OB), OB-GYN, and Anesthesia, the four services that provide care in all areas
   c. Respect for nursing and staff in all areas;
   d. Respect for all levels of learners in all areas;
   e. The primacy of communication is to optimize care, particularly when conflicts arise;
   f. The importance of conflict resolution with respect for all involved and respect for direct resolution at the local level whenever possible
2. This pathway outlines a stepwise escalation for conflict when concerns arise for a patient or clinical decision and applies to trainees, students, staff, nurses, attendings/faculty, patients, and families.
   a. ANY healthcare professional may consult ANY healthcare professional with urgent/strong concerns for patient safety. If uncomfortable, at any time you may involve your direct supervisor or Admin Supervisor on call.
   b. In the setting where safety concerns arise in a **non-emergent** scenario:
      i. Recommend informal resolution with a direct conversation with the people involved.
      ii. If unresolved, discuss with the RN supervisor and/or supervising attending of that patient.

Error Prevention Strategies: Summary of tools

- Call-out
- Check-back
- 2-Challenge rule
- DESC
  - Chain of command *AKA* Algorithm to Enhance the Culture of Safety

Tools for Error Prevention: Managing Workload

- Leverages team members' willingness to help one another
- Allows adaptation to changing environments
- Is the essence of teamwork
- Derives from situation monitoring
- Increases team orientation
- Improves efficiency

In support of patient safety,

Teamwork is expected!

Principles of Managing Workload: Task Assistance

- Account for experience level
- Be clear and specific
- Non-hierarchical
- Use check-back or closed-loop communication regarding task completion

Task Assistance in an OB STAT

At Nurse's Station

Unit Tech at desk

1. Receives call or alarm from labor room for OB STAT.
2. Dials 333 to activate OB STAT (add NEO Emergency if NICU needed)
3. Notifies primary RN that NICU has been alerted.
4. Schedules procedure

Charge Nurse

1. Identifies Ob STAT team members at start of shift
2. Designates which OR to be used.
3. Verifies scrub tech has gone to OR.
4. Verifies anesthesia attending has gone to patient room.
5. Verifies OB STAT team members are proceeding with tasks.

OB Emergency Resource RN

1. Assumes resource role on unit during STAT.
2. Assigns coverage for patients of other team members.
3. Pulls uterotonics and Bicitra.
4. Sage wipes, clippers if needed and bring to patient bedside (if time allows)
5. Brings jumpsuit, hat, mask and shoe covers to support person.
6. Escorts support person to recovery room and keep them informed.
7. Returns any medications left in room/waste epidural
8. Returns bed to patient room and gets stretcher

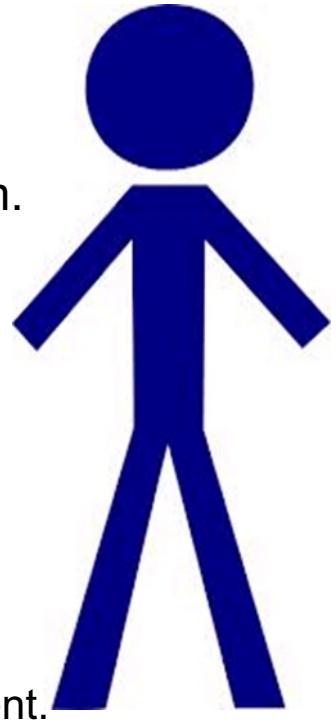
In Labor Room

Anesthesiologist

1. Disconnects epidural analgesia.
2. Administers epidural anesthetic meds.
3. Helps move patient to OR.

OB Emergency Response Nurse

1. Verifies consents are in chart.
2. Raises, then unplugs, bed in labor room.
3. Helps move patient to OR.



Primary Nurse

1. Uses OB STAT button or call light to communicate the need for OB STAT.
2. Supports patient.
3. Unplugs fetal monitor belts from patient.
4. Moves IV fluid from pole to bed.
5. Transfers patient to the OR.

Clinician

1. Communicates need for STAT C/S to patient.
2. Goes to OR to begin surgical hand scrub.
3. Does not assist nurses with tasks above.

IN OR ROOM

OB Emergency Respose nurse

1. Assists patient to OR table.
2. Places arm boards on one side of table
3. **Places Foley catheter.**
4. Applies SCDs & activates.
5. Applies Bovie PAD & activates.
   (sets at: 40/40/??)
5. Applies safety straps above knees and on thighs.

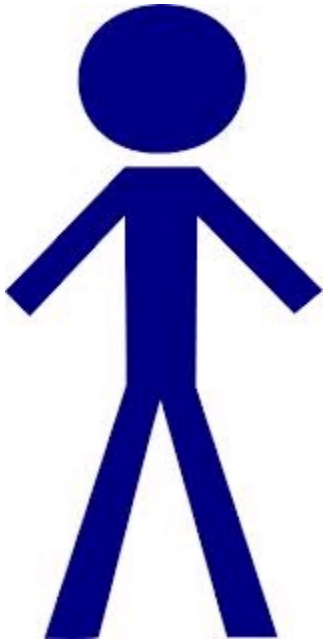
Charge Nurse

1. Moves bed out of OR after patient transfer.
2. Assures appropriate persons doing designated tasks.
3. Dismisses unneeded persons from OR.

Anesthesiologist

1 Assists patient to OR table.
3. Places all vital signs monitors on patients
4. Ensures adequate level or need for GA. (Checks for and removes gum and jewelry)

5. Administers antibiotics.



Primary nurse

1. Announces time in to OR.
1. Places arm boards on one side of table
2. Check fetal heart tones

Immediately starts abdominal ChloraPrep(30 seconds across incision location). Starts 3 minute timer. OR blot dry with OR towels if needing to proceed

3 Participates in count with scrub tech

3. Participate in Time-out per posted scripts
6. Gives report to NICU team.

NEW LoboSTEPPS tools:

- “Pattern check” = initiate huddle to review tracing
- RNs/clinicians are given pushing break after each hour if possible
- Huddle after 2 hours of second stage with Primary RN, Attending, Resident and Charge RN
  - Clinicians to write labor note to document plan of care

Outcomes of Effective Team Structure

- ✓ Effective communication
- ✓ Effective situation awareness and shared mental model
- ✓ Improved monitoring and assistance
- ✓ Trust

Toolbox of Team Communication

Communication Events

- Ad hoc huddles
- Coordination meeting
- Hand-offs
- Safety Huddle
- Pre-op verification
- Time-outs
- Delivery/Surgery Summary
- Debriefs
- Pattern Check
- OB STAT
- OB Trigger

Tools/Templates

- Shift Forecast
- SBAR
- Safety Huddle template
- Pre-op verification template
- Time-out template
- Post-delivery/surgical template
- OB STAT diagram
- OB Trigger diagram
- Hemorrhage risk assessment
- MEWS
- DESC