The Perfect Trifecta – CUSP/TeamSTEPPS/Change Management

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Introduction

Previously conducted programs identified gaps in knowledge that led to the creation of an integrated program utilizing Comprehensive Unit-based Safety Program (CUSP), Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), Model for Improvement and change management strategies.

Teamwork results from the March 2015 Safety Culture Assessment (average percent positive) were 50% for all inpatient units. Safety climate results were 59%.

Results from our safety culture assessment and employee engagement survey confirmed the need for formal training and development in the area of teamwork and safety culture. Based on these results it was decided to transition multiple programs into a single integrated program. In order for our teams to focus on working towards zero preventable harm, we needed to equip them with the right knowledge, tools and support to move towards the goal.

Three units (Pediatric ICU, Pediatric Medicine & Neurosurgery/ General Surgery) were identified to conduct the new program. Their average percent positive scores for teamwork were 62% and for safety climate were 72%.

The goal is to build a culture of teamwork and patient safety within Johns Hopkins All Children’s Hospital. This will be accomplished by strengthening the healthcare teams’ knowledge and skills in the science of safety and improvement and creating unit-based teams.

Objectives

- To train identified teams on CUSP and TeamSTEPPS® concepts to improve collaboration and communication within the team and across the organization.
- To provide structure for unit-based teams to identify and implement patient safety improvement projects.
- To develop knowledge and skills to implement change.

Materials and Methods

- Flipped classroom approach (classwork at home and homework in class)
- Self-paced/on-line pre-work
- Experiential/active learning sessions

Results

The Safety Culture Assessment was conducted again in March 2017 and the average percent positive scores for the 3 units for teamwork were 62% and for safety climate were 65%. These domain scores give a “big picture” and it was decided to look more closely at the item scores for individual questions.

The results for the Teamwork item scores for percent that responded “agree or strongly agree” are as follows for 2015/2017:
- Speaking up if a problem with patient care is perceived is not difficult – 68%/71%
- Work setting disagreements are resolved appropriately – 65%/71%
- Easy for personnel to ask questions when they do not understand – 88%/87%
- People in this work setting work together as a well coordinated team – 84%/86%

The results for the Safety Culture item scores for percent that responded “agree or strongly agree” are as follows for 2015/2017:
- In this work setting it is not difficult to discuss errors – 65%/70%
- I know the proper channels to direct questions regarding patient safety – 94%/91%
- I am encouraged to report any patient safety concern I may have – 87%/86%
- Medical errors are handled appropriately in this work setting – 88%/82%

Conclusion

When analyzing the results from the Safety Culture Assessment, the item scores for individual questions provided meaningful information when conducting debriefings with the frontline staff and for analyzing trends. It is planned to add Error Prevention into the curriculum for the next program. The next Safety Culture Assessment will be done in 2019.

References

Agency for Healthcare Research and Quality, Department of Defense. TeamSTEPPS. Available at: http://www.ahrq.gov/teamstepps/curriculum-materials.html