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Implementation of a Debrief "Takeaway" board

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Abstract

My original focus of my project was to implement Team STEPPS, to help improve the communication and teamwork within our entire perinatal service department. However, as I started I ran into barriers with time and with other projects put out by our management that needed to take president. It is then that I decided to narrow my focus on one aspect of Team STEPPS which we are already implementing, and that is debriefs. As a member of the Perinatal Patient Safety Program (PPSP), I was able to learn about all the takeaway's we received from debriefs that had occurred, and I felt that all staff should be privy to this information. It is important for all staff to understand the importance of debriefs and what the positive things are that occur during events and most importantly what are the opportunities/suggestions we can take away and improve on after all critical events/near misses. I had to start my project by presenting the idea to the PPSP group, which consist of the head of the perinatal service department, our manager, an assistant manager, nurses from each department, the head of Pediatrics and OB, a midwife, and our secretaries. After approval I had to read through each debrief done in the past and create a list of positives, opportunities, and suggestions. After the creation I had to bring the suggestions to our ANM and our manager for approval. Once approved I placed a poster size "debrief learnings" in our dictation room where all staff can see, I discussed importance to educated all ANM's so they can educate staff through huddles of what the purpose is, and also left feedback opportunities for staff to tell me their concerns, questions, or benefits of the board.

Clinical Leadership Theme

Through my project I am utilizing **Nursing Leadership,** one of the CNL curriculum elements (AACN, 2013)**.** I am going to use Team STEPPS to help be an advocate for not only my patients but also my staff. I am working to change the culture within our unit to help decrease errors and improve communication and teamwork. I have worked to identify this as a need in my unit, and as a CNL I will continue to work and improve our units' injustices to help increase morale and overall improve the care we provide.

Statement of the Problem

We are lacking communication and trust within our unit. According to our People Pulse results I was able to see that our staff did not feel safe speaking up when they see an error because they were afraid of punitive action taken against them. As a staff nurse I have also seen thee disconnect between staff and management, and I want to make a change because I want our staff to feel excited to come to work. With the utilization of Team STEPPS we can help build teamwork and communication to lessen the hierarchical gap between providers and nurses. I have become aware that the entire implementation of Team STEPPS will take a long to accomplish, so I have decide to focus on a small goal within the Team STEPPS concept that I can create change with: the debrief process. The purpose of my project will be to work with the current debrief process, identify any current issues with the format, and lastly provide our staff monthly with information obtained from previous debriefs that occurred. From each debrief that occurs I will compile the positives, the opportunities, and the suggestions they made for

management to work on and place it on a poster board for all staff to read and make suggestions on.

Project overview

Our culture on our unit is lacking in communication and teamwork, again shown by the results of our People Pulse. It has become clear that promoting teamwork within a unit is a top priority, which is why “Joint Commission has included teamwork training as part of its patient safety curriculum” as well as the Institute of Medicine making teamwork “one of its five core competencies for health care professionals” (Gururaja et. al., 2008). My goal is to improve communication and teamwork by using the tools that Team STEPPS provides. One of these tools is the use of debriefs to allow our staff to review critical cases or near misses to improve patient care and improve our current processes. Currently the feeling on the unit is that Assistant Managers are doing debriefs as a checklist, to just “get it done”, and it really should be a tool that is utilized to help all staff learn from mistakes that were made and more importantly recognize staff for things that went well. As much as we focus on the negative it will be important when discussing debriefs that I make all staff aware that they can be done to reward the positive as well. My specific aim will be to educate staff on the importance of debriefs and what and why they should occur, as well as create monthly “takeaways” and post them for all staff to learn from every situation. I hope to start the “monthly take away chart” next month and improve how often debriefs are occurring by 90% before December 2015. As I work on this I will be slowly implementing what Team STEPPS is and show staff that debriefs is just one tool that is provided to us to help create a better culture on the unit and improve communication and teamwork. All of

which will help the global aim of implementing Team STEPPS by March 2016 to increase patient safety and decrease patient errors.

Rationale

When looking at our People Pulse I have found that trust and communication are vital needs within our unit. The survey found that 73% of staff do not believe the work culture makes it easy to learn from errors and congruently 55% of staff feel they cannot speak up about errors or mistakes made on their unit (Kaiser Permanente, 2014). These results, along with the SWOT I created, show me that there needs to be a culture change throughout our entire unit to help staff feel supported when speaking up and allow people to feel safe. I know that with the implementation of Team STEPPS we can help fix these problems within our unit. The cost for my small project will cost very little because I will discuss debriefs at the staff meeting this July, and will create a survey on my own prior to this to find out the general feeling about debriefs and what staff would like to keep and change of the current process. I will also be personally creating the “takeaway” board to educate staff on learnings from each debrief every month. I will review each debrief at the Perinatal Patient Safety Project meetings, with management so we do not disclose any personal patient information, or anything that would make staff uncomfortable. With regards to Team STEPPS that is a much bigger project to overtake, however, the benefit is that the key stakeholders (CNO, COO, Perinatal Service Director, and Perinatal Manager) have already signed off on the project and realize the need not only within perinatal services but all of Kaiser Permanent Antioch.

Methodology

When reviewing all of the change theories to utilize I feel that Quinn's Theory can help me most with my project. I feel that my project is moving a little slower than I would like, since other things have come up on our unit that management feels needs more attention at the moment. Quinn's Theory helped me move past the barriers and find a part of Team STEPPS that I can start putting into place now. It helped remind me that if we do not change our culture we are opening ourselves up to mistakes, burnout, and continued perspective on nurses that feel unsupported and trapped (University of San Francisco). Until we utilize Team STEPPS and show our staff that we recognize need for change within our culture, than nothing will work. I think it's important that Quinn's theory also touches on being a transformational leader, reminding me that for deep change to occur I need to start within myself. I need to continue educated staff on the WHY, and teach them that we can become a more cohesive team. It is important to make this change and understand that it is also "imperative to 'rock the boat,' and those that do so are true leaders and advocates" who are standing up for change to benefit staff and patients (Antill, 2015). I feel that after I start the debrief board on "takeaway's" I will need to continue after implementation. I think that is important as a CNL to maintain sustainability, I will have to continue to work with our staff to continue implementing Team STEPPS, enhancing the debrief tool is only a small goal in a bigger project. The best way to follow effectiveness is to create survey staff and continue to gather their feedback on the project so they feel they are all aprt of the change.

Data Source/ Literature Review

Through my project I am continuing assessing the effects of the debrief board and asking staff for input and feedback. Gupta et.al worked to implement Team STEPPS in the interventional ultrasound department to help improve communication and teamwork (2015). After gathering a

pre-implementation survey from all team members with the use of the hospitals Safety Attitudes Questionnaire, they implemented Team STEPPS with the use of master trainers. As a result researchers found that teamwork scores improved from a mean of 67.9 to 87.8 and safety climate scores improved from a mean of 76.5 to 88.3 after implementation, showing that Team STEPPS can significantly help improve teamwork and safety on a unit. Similarly, Maguire et. al., (2014) showed that Team STEPPS can help improve human factors and minimize medical errors. It will be important for my team and me to recognize the importance of human factors. Norris et. al., (2012), showed that through creating a plan, anticipating what can go wrong, understanding the system as whole, listening to people’s concerns, and getting people involved in the conversation of safety than you can improve outcomes and enhance quality and safety of care.

Prior to the implementation it will be important to make sure we are involving frontline staff throughout each step (Kerridge, 2012). Which is why I believe it is important to obtain the thoughts of all staff about how they feel debriefs currently are going and what changes they would like to see. Levett-Jones & Lapkin (2014), did a study to review and identify the effectiveness of debriefing as it relates to simulation based learning. Unlike the article by Severson et al., this article was peer reviewed by two independent reviewers using a standardized critical appraisal instrument form the Joanna Briggs Institute. They gathered 10 randomized controlled trials that involved different debriefing techniques and reviewed pre and post-tests. They found that debriefing help significantly in improving on technical and non-technical skills. However, they found that video playback in simulation and debriefing learning did not show any clinical improvement like the article by Severson et al. stated. This research only concluded that some type of debriefing is beneficial but which system if the best to improve outcomes is still unknown. Severson et. al., (2014) also found that the use of debriefs was beneficial to help

improve communication and teamwork, although their research was not as thorough. Research continues to prove that the implementation of Team STEPPS helps to improve communication and increase teamwork both of which work to improve patient safety. Knudson (2013) shows that since 2000 there have more than 95,000 medication errors and since 2001 150,000 patients have fallen victim to unsafe medical practices. This article goes on to state that with the implementation of speaking up, creating checklists, bridging the gap between frontline staff and management, and sticking to evidence based practice (all of which are tools of Team STEPPS) we can decrease these numbers. To make all of these improvements we need to change the culture, which is what Team STEPPS will help us do, and I am planning on using one tool, debrief, to help start this process. Without improving the quality of teamwork and communication within a unit we are placing our patients at increased risk. According to research miscommunication is one of the leading causes of medical errors, most of which are preventable (Digitale, 2014). With the implementation of my project we are likely to improve communication and decrease medical errors, as other hospitals have already seen through implementing Team STEPPS. According to the Journal of American Medical Association, Boston Children’s was able to decrease medical error from 33.8 to 18.3 per 100 admissions, directly linking it to Team STEPPS (ARHQ, 2014). Currently the median cost of medical errors is roughly 1000$, and that is the low end of the spectrum (David et. al, 2013). I know that it is costly to add Team STEPPS into our unit, however the cost to benefit ratio is significant. We can directly improve patient safety, improve the quality of work for our staff, and most importantly decrease morbidity and mortality within our unit. As a CNL I am identifying clinical cost outcomes to improve safety to our patients and enhance the quality care given.

Timeline

I am still in the planning phase of my project (see appendix A) and am currently in the process of discussing with my assistant manager and gathering data from past debriefs. I plan on this phase to only take 3 weeks to gather information and educate staff before implementation. During the implementation phase I will continue to address the staff and place the first debrief “takeaway” board in the staff dictation. It will be important that as the first one is up, to discuss with staff positive and negative about the board, and to gather their input for the next board. I will use thee debriefs from the last 4 months and write collective learnings about each case. This information will help staff learn from past cases, to help improve our performance. Debriefs is one tool in Team STEPPS that we are already using but can benefit from making the process more effective. The last phase of this project, “sustainability” will last the longest, because I feel that it will be important to keep up with the project and continue to assess the needs of the unit. I would like to create the debrief board as something useful for nurses, so I will continue to make changes until it is something the staff find beneficial.

Expected Results and Nursing Relevance

I am hoping and imagine that the final outcome is that Team STEPPS becomes implemented and that the culture on our unit can improve. However, as a small term win, I want to kick off the “takeaway” board so that the nurses can utilize debrief as a tool to improve the care we give, and help hold each other accountable on our actions without there being any punitive actions against them. I believe if we can gain the nurses confidence and understanding of what we are doing, then the whole process of implementing Team STEPPS will be easier. As an advocate for the profession I want to let staff understand why there is a need for culture change, and why we need to review debriefs and change how they are being done. Change can come with push-back so I

need to make sure I involve all staff before implementation occurs, and I need to understand their point of view and their needs as well as the needs of our patients.

Summary Report

My goal of this project was to create a debrief takeaway board that can be utilized to educate staff on the learnings and common themes that come up within every debrief that is done. Through this our staff will be able to recognize the good that is being done during critical events, the opportunities we have to improve upon our process, and the suggestions staff made to our management that they are currently working on. It is important that staff understand the importance of debriefs and that they recognize that management utilizes them as a tool to do project improvements on our unit. Through data retrieved from the People Pulse and from discussions with staff there is a huge disconnect with communication between management and staff, and a lack of teamwork. Debriefs should be used to help bridge that gap. A tool to be used so staff can openly talk about a specific situations and improvements that need to be made, tools that they need to make the outcome better, and positive feedback given so we can provide the best care to our patients.

Each month I will continue to read through each debrief and take out the positives staff identify, the opportunity for improvement, and the suggestions made by staff for things like staffing ratio, equipment need etc. that management can work on. In the first one I was able to go back a couple months and also post information about what a debrief is and why they are important so staff can understand, then created the first “Debrief Takeaway board” (Appendix B) and posted it in our staff dictation room. Besides posting the information I created a private sheet where staff can write suggestions (Appendix C) and ways to improve the board so they feel they have a say in it as well, and gave them a box to place comments in so they can remain private

(Appendix D). So the project has been a success, the staff and management have been satisfied with the results.

The only changes I was able to make to the project was moving up the implementation 2 weeks so that I can go through a whole PDSA cycle prior to the end of the course. Going through a whole PDSA cycle made me feel more confident about the effects of my project and the continued sustainability. However, I am continuing to gather suggestions prior to the next month’s learnings, and will go through another PDSA prior to moving onto SDSA. I am proud to say that this project is already making staff feel more engaged, and I have received great feedback some positive and some opportunities to improve upon to make the poster more efficient. I believe that sustaining this project will be doable because not only will I act as the champion in creating the monthly poster, but I will also be gathering continuous feedback from staff so everyone feels that they have a stake in it. As a CNL I will work to continue to help this project grow, and keep patient safety and process improvement/enhancement at the top of the list of why debriefs are so important. I think this project will only enhance my main goal of implementing Team STEPPS into our unit, which I start on soon with my team!

References

Agency for Healthcare Research and Quality. (2014). JAMA study finds TeamSTEPPS associated with reduction in medical errors. *AHRQ newsletter.* Retrieved from http://www.ahrq.gov/news/newsletters/e-newsletter/411.html#1 (Links to an external site.)

American Association of Colleges of Nursing. (2013). Competencies and curricular expectations for clinical nurse leader education and practice. Retrieved from http://www.aacn.nche.edu/cnl/CNL-Competencies-October-2013.pdf (Links to an external site.)

Antill, C. (2015). Rocking the boat: the link between transformational leadership and advocacy. British Journal Of Healthcare Assistants, 9(2), 93-99.

David, G., Gunnarsson, C. L., Waters, H. C., Horblyuk, R., & Kaplan, H. S. (2014). Economic measurements of medical errors using a hospital claim database. *US National Library of Medicine & National Institute of Health*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23538182

Digitale, E. (2014). Better communication between caregivers reduces medical errors, study finds. *Stanford Medicine*. Retrieved from https://med.stanford.edu/news/all-news/2014/12/better-communication-between-caregivers-reduces-medical-errors

Gupta, R. T., Sexton, B. J., Milne, J., Frush, D. P. (2015). Practice and Quality Improvement:

Successful Implementation of Team STEPPS Tools into an Academic Interventional Ultrasound Practice. American Journal of Roentgenology. Retrieved from http://www.ajronline.org/doi/abs/10.2214/AJR.14.12775

Kaiser Permanente. (2014) People Pulse Survey.

Kerridge, J. (2012). Leading change: 2 -- planning. Nursing Times, 108(5), 23-25.

Knudson, L. (2013). Medical mishaps call for change in health care culture. AORN Journal, 97(2), C1.doi:10.1016/S0001-2092(12)01432-9

Levett-Jones, T., & Lapkin, S. (2014). A systematic review of the effectiveness of simulation debriefing in health professional education. Nurse Education Today, 34(6), e58-63. doi:10.1016/j.nedt.2013.09.020

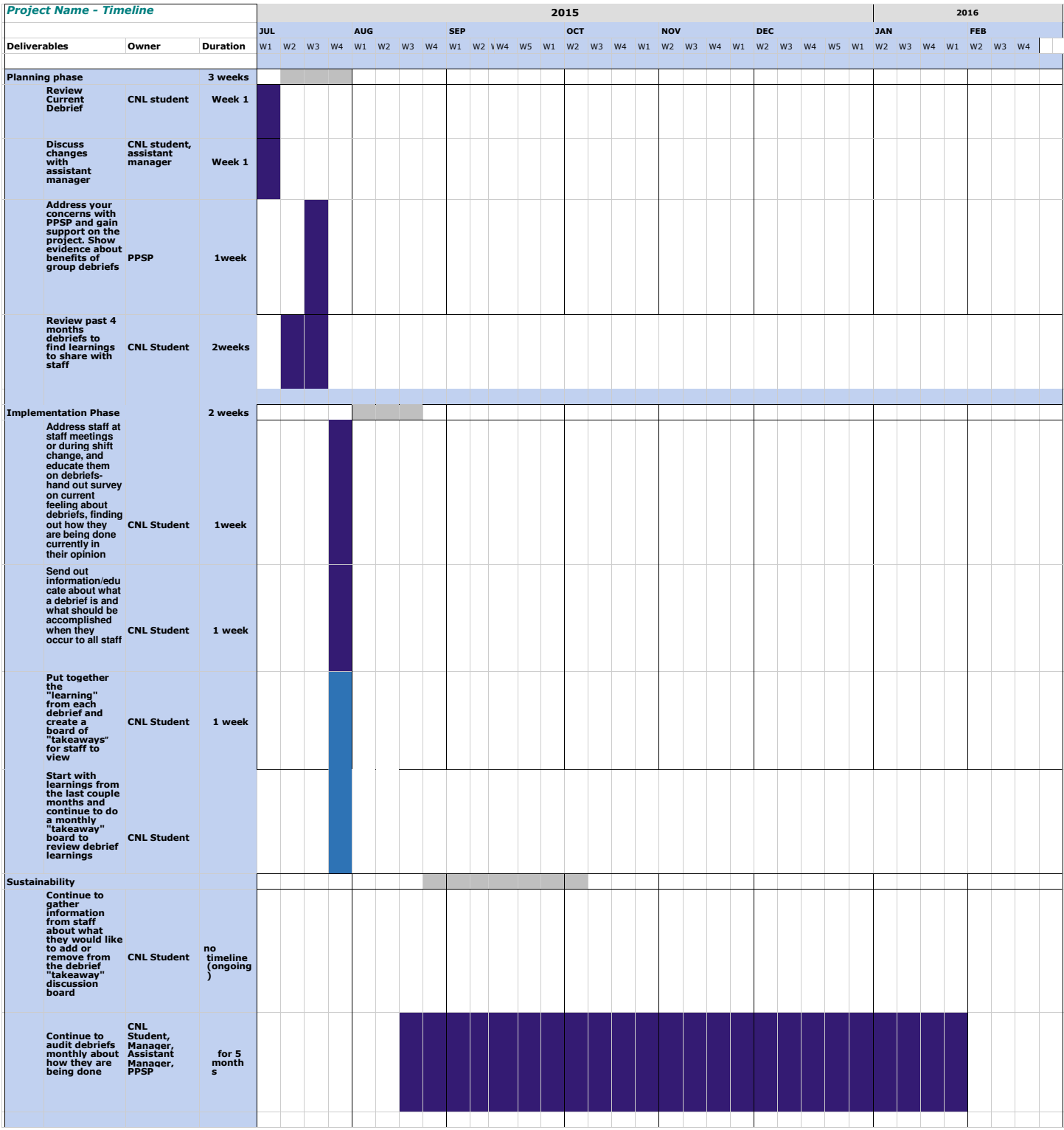
Maguire, M. B., Bremner, M. N., Yanosky, D. J. (2014). Reliability and Validity Testing of Pilot Data from the Team STEPPS Performance Observation Tool. Nursing and Care. Retrieved from http://dx.doi.org/10.4172/2167-1168.1000202

Norris, B., Currie, L., & Lecko, C. (2012). The importance of applying human factors to nursing practice. Nursing Standard, 26(32), 36-40.

Severson, M. A., Maxson, P. M., Wrobleski, D. S., & Dozois, E. J. (2014). Simulation-Based Team Training and Debriefing to Enhance Nursing and Physician Collaboration. Journal of Continuing Education in Nursing, 45(7), 297-305. doi:10.3928/00220124-20140620-03

Towers Watson, 2014. People Pulse Survey: Kaiser Permanente.

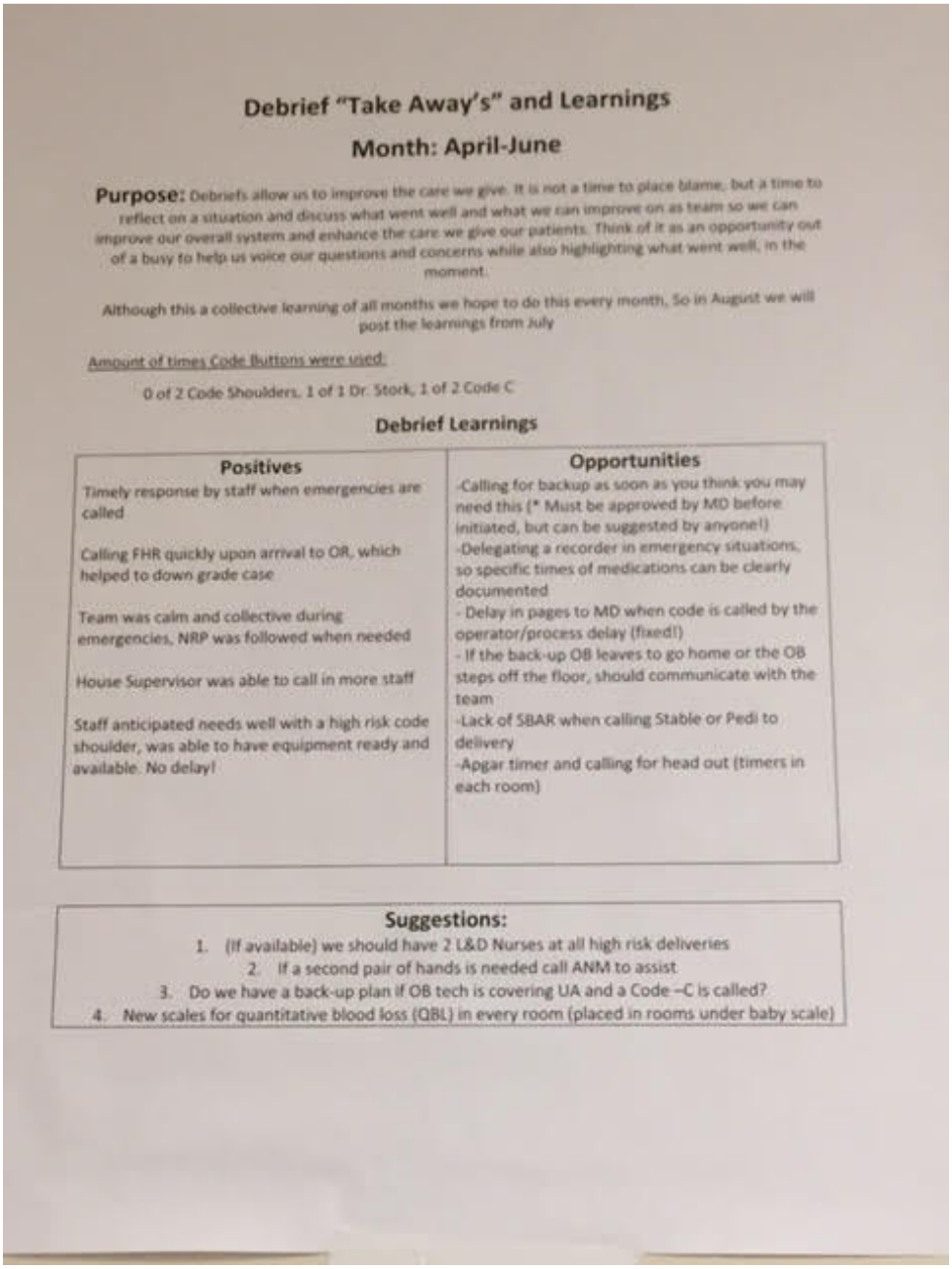
University of San Francisco. (n.d) N651-Module 5 PowerPoint. Retrieved from https://usfca.instructure.com/courses/1552955/pages/module-5-introduction-and-readings?module_item_id=16186993



Appendix A: Timeline for the Project

Appendix B

"Debrief Takeaway and Learnings" Poster



Debrief "Take Away's" and Learnings

Month: April-June

Purpose: Debriefs allow us to improve the care we give. It is not a time to place blame, but a time to reflect on a situation and discuss what went well and what we can improve on as team so we can improve our overall system and enhance the care we give our patients. Think of it as an opportunity out of a busy to help us voice our questions and concerns while also highlighting what went well, in the moment.

Although this a collective learning of all months we hope to do this every month, So in August we will post the learnings from July

Amount of times Code Buttons were used:

0 of 2 Code Shoulders, 1 of 1 Dr. Stork, 1 of 2 Code C

Debrief Learnings

Positives	Opportunities
Timely response by staff when emergencies are called Calling FHR quickly upon arrival to OR, which helped to down grade case Team was calm and collective during emergencies, NRP was followed when needed House Supervisor was able to call in more staff Staff anticipated needs well with a high risk code shoulder, was able to have equipment ready and available. No delay!	-Calling for backup as soon as you think you may need this (* Must be approved by MD before initiated, but can be suggested by anyone!) -Delegating a recorder in emergency situations, so specific times of medications can be clearly documented - Delay in pages to MD when code is called by the operator/process delay (fixed!) - If the back-up OB leaves to go home or the OB steps off the floor, should communicate with the team -Lack of SBAR when calling Stable or Pedi to delivery -Apgar timer and calling for head out (timers in each room)

Suggestions:

1. (If available) we should have 2 L&D Nurses at all high risk deliveries
2. If a second pair of hands is needed call ANM to assist
3. Do we have a back-up plan if OB tech is covering UA and a Code –C is called?
4. New scales for quantitative blood loss (QBL) in every room (placed in rooms under baby scale)

Appendix C/D:

Feedback Form given to staff and suggestion box they placed it in for privacy

Your feedback is important to us so that we can improve these debrief learnings.

This is for all staff to understand the suggestions we gather from debriefs and

what we learn from each one so we can improve our care and our process within the unit.

Things to add	What was helpful

Private suggestion box to place feedback cards