


Execution Tips LifeWINGS

Hidden slide

- Confirm partner customized content changes
- Change <Facilitator name> on title slide and disclosure statement
- Insert intro pic(s), if using
- Verify audio and video
- Pre-plan timing adjustments



Main Point(s):

- 1. This slide for facilitator use only as checklist guide to customize and the course and check equipment.**

Hidden slide



Facilitator Information Only Slide

The acronym TeamSTEPPS stands for Team Strategies and Tools to Enhance Performance and Patient Safety.

Facilitator needs to commit to memory and be able to verbally repeat to class when first introduce the term "TeamSTEPPS."

This is information only for Facilitator, no need to show this slide.

Facilitator needs to commit to memory and repeat verbally first time introduce acronym "TeamSTEPPS."

Welcome!

Sign-in Sheet – check if you want CME / CNE
 Name Card (back cover, use marker)
 CME (Physicians & PAs) must complete:

- ✓ Credit Declaration Form handout
- ✓ Course Evaluation / Critique (*in back of book*)

CNE (RNs and others) must complete:

- ✓ Registration form – page 1 of book
- ✓ Course Evaluation / Critique (*in back of book*)

Pagers / Phones on silent

LifeWINGS
 Better Teams. Better Systems. Better Care.

ANCC DHA

Main Point(s):

1. Admin items / directions to show participants as they are signing in, taking their seats and preparing for the class prior to start time.
2. Slide is not for presentation/facilitation portion. Click ahead to next slide when ready to begin class.
3. Revise posted information (CME/CNE) as necessary depending on location.

Have this slide up as participants are signing in and taking their seats.

Revise information as necessary depending on CME/CNE requirements at specific hospital.

Current information on the slide is **only** CME/CNE requirements **when LifeWings instructors are conducting the classes, and if requested/approved by hospital in the contract.**

Individual hospitals must have their own CME/CNE approval and process in place when hospital's Master Trainers (TTT) are conducting their own classes.

Participants will be seated with others at tables. As participants sign in for class have them sit at random tables. Don't let them sit in their cliques or familiar groups (e.g. all doctors, nurses or techs at one table) or discussion is likely to be limited, biased, disrupted, and/or stifled.

One technique to enhance class discussion is to label tables ahead of time with number or letter and then assign participants a table as they arrive to ensure multidisciplinary mix (similar to wedding reception table assignments). If have hospital contact helping you with sign-in, have them assign individuals a table number ahead of time since they can find individuals' disciplines and likely know of any cliques that need to be split up. This will greatly enhance all exercise discussion with contributions from different disciplines, experience levels, points of views, etc.

Click ahead to next slide when ready to start the class.



Main Point(s):

1. Welcome attendees.
2. Introduce yourself and establish credibility.

Intro Module:

Time: 25 minutes

When participant completes the module they will:

- Understand that although healthcare professionals are well trained anyone can make a mistake
- Understand that they can trap & mitigate those errors through TeamSTEPPS (Team Strategies & Tools to Enhance Performance & Patient Safety) skills and a safety system.
- Understand that TeamSTEPPS is working in Healthcare – there are proven results.
- Have the desire & need to know more – willing to listen!

Slide

Time: 1-3 minutes depending on your introduction.

BE SURE TO CHANGE THE FACILITATOR'S NAME TO YOURS!!

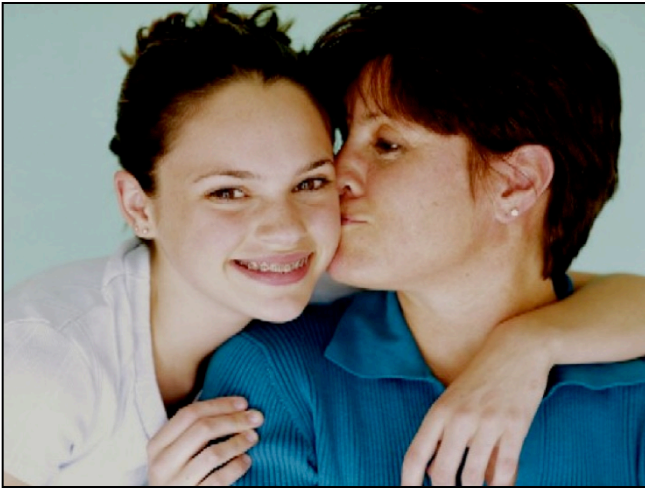
Add hospital/organizations logo on title page if you have it.

Brief introduction of yourself including your aviation and clinical experience. Include how long you have been working with LifeWings, why you do it, why you believe in TeamSTEPPS/LifeWings, use personal story, etc.

When done:

Sample Transition: *I'd like to understand your hospital's culture a little better so consider this scenario... <click>*

(Time for Jane story: 2 minutes for story itself, 4 minutes total, including all interaction from facilitation questions.)

**Main Point(s):**

1. Begin to tell Jane's story - Introduce Jane.
 - 13 years old with leukemia
 - Several rounds of chemotherapy
 - Developed severe life-threatening allergy to latex
 - Mother receives call – in remission
 - Mother & Jane go to celebrate
 - They are involved in serious auto accident

Time: 15 sec

Introduction of Jane story**Sample “script”/facilitation:**

Jane was a 13-year-old girl who had been diagnosed with cancer and went through several rounds of chemo. As a result of the chemo she had developed a severe latex allergy that resulted in a rapid loss of blood pressure and heart palpitations. Her mother received the phone call that confirmed Jane's cancer was in remission.

Sample Transition: *To celebrate, Jane and her mother went shopping at the mall. Unfortunately their trip was cut short by an accident. . <click>*



Main Point(s):

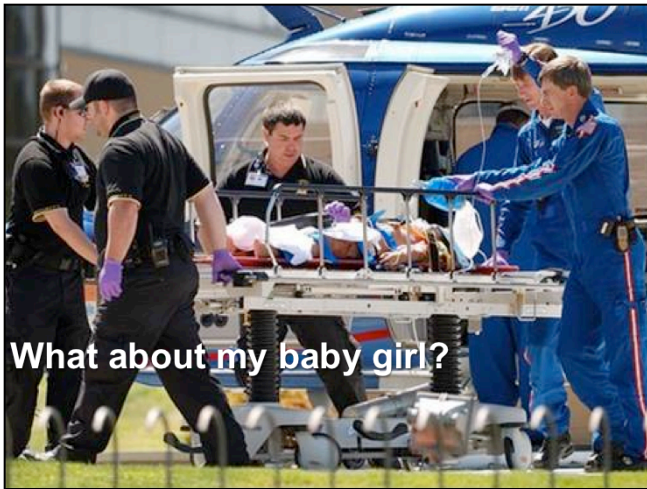
1. Continue “Jane Story” - jaws of life needed to extract Jane.

Time: 5 sec

Sample “script”/facilitation:

... First responders had to use the Jaws of Life to remove Jane from the car and assessed her injuries as life threatening.

Sample Transition: *Fearing internal injuries...* <click>



Time: 10 sec

Sample “script”/facilitation:

...was prepping her for the flight in the ambulance while her mother was lying next to her. Jane's Mother grabbed the flight nurse's arm and asked “What about my baby?” to which the flight nurse responded, “We will take care of her. She's in good hands.” Jane's mother replied back, “Please let everyone know that she had cancer that is in remission but developed a severe, life threatening allergy to latex!”

Sample Transition: *The flight nurse marked the chart and off they went.... <click>*

Note: You may be more comfortable with “What about my daughter?”

Main Point(s):

1. Continue “Jane Story” – Jane's mother tells the flight nurse about Jane's cancer, chemo, and severe latex allergy.



Time: 10 sec

Main Point(s):

1. Continue “Jane Story” - paramedics rush Jane into emergency/trauma.
2. Introduce Rebecca - new surgical RN or tech in orientation who is observing and hears the flight nurse mention the latex allergy.

Sample “script”/facilitation:

...Upon arrival at the hospital, Jane is rushed to the Emergency/Trauma floor where the trauma team assess her. The team fears internal injuries and sends her for an exploratory cat scan that reveals a ruptured spleen requiring immediate emergency surgery. The team begins to prep her for surgery.

Observing the activity as Jane arrives at the hospital is Rebecca, a new student nurse at the hospital. Rebecca has only been there for two weeks and is still in training. As part of her orientation training to the hospital she was assigned to observe the trauma process from the patient's arrival through surgery. Her preceptor is extremely busy so directs her to observe on her own, to simply listen, watch, and learn.

Sample Transition: *Rebecca was pretty sure she heard the flight nurse say something about a latex allergy, but when she arrives in the OR... <click>*



Time: 15 sec

Main Point(s):

1. Continue “Jane Story” - Rebecca sees OR team has set up using latex, she decides to speak up during the timeout.
2. Patient rolled in with Surgeon following right behind.
3. Surgeon says no timeout. Rebecca is not sure what to do.

Sample “script”/facilitation:

...she sees the team assembled utilizing latex. She wants to speak up and mentally prepares herself to let them know during the timeout.

Suddenly they begin to roll in the patient (already under anesthesia) with the surgeon along side her. The surgeon is the chair of the trauma department and is known for her autocratic style, very demanding, intolerant of delays or incompetence. The surgeon announces that they have to get right to work - no need or time to do a timeout.

Rebecca does not know what to do at this point - she hopes that somebody will recognize the mistake.

Sample Transition: *What do you think?... <click>*

What do you think?

If you were the surgeon would you want Rebecca to speak up?

Based on the culture you believe exists at your hospital, will Rebecca speak up?

...Why or Why Not?



Main Point(s): Use this series of slides if showing specific hospital's Safety Climate Survey (SCS) results for questions about speaking up.

1. Establish through question #1 that everyone wants a team member with critical information to speak up.
2. Through question #2 show that there is doubt as to whether Rebecca will speak up.

Time: 1 minute

Sample “script”/facilitation:

1. *What do you think? If you were the surgeon or the leader for any situation, do you want team members to speak up with critical information?*

Everyone will respond, “Yes!” - that is the answer you want! You have now found common ground with all attendees and can always bring them back to their answer later in the course.

2. *Based on the culture you believe exists here at _____ hospital, will Rebecca speak up?, Why or why not?*

If they answer “yes” you'll want to create doubt by first asking “Why?” Forces them to re-evaluate. Usually they will say “yes” because they are thinking of themselves, more experienced nurses, strong personalities, overconfident, hard to admit not willing to speak up, etc. Respond with something like, “*You bet, more experienced and strong personalities will speak up, but what about the more timid or new team member, or the ones that have tried to speak up but were shut down?*” Continue until they begin to say it depends; they begin to show doubt that everyone will speak up.

Sample Transition: *Let's look at results of a couple of questions from your most recent safety climate survey...<click>*



Time: 1 minute

Sample “script”/facilitation:

Here are your results from your last Safety Climate Survey in response to the statement “Staff will freely speak up if they see something that may negatively affect patient care.” What do you think?

Who are they likely speaking up to? Who are you most comfortable speaking up to? Expect answers that they will speak up to their own discipline – that's who they are often most comfortable with. But who often needs to know about the problem? The decision-maker, someone with hierarchy.

Compare their results to benchmark. Usually results on this survey questions are pretty good, compared to benchmark, but room for improvement. Many in the audience may be surprised the green not closer to 100%, especially in units where staff and providers.

Sample Transition: *What about speaking up to or questioning a decision-maker / “higher on the totem pole”?...<click>*

Optional Slide - Project Lead will decide if want to use series of slides with SCS results applicable to speaking up – PL modify this slide with actual results.

Main Point(s):

- 1. Show results for staff freely speaking up.**
- 2. Often results for this question are near benchmarking, but many participants may still be surprised not 100%.**
- 3. For the green answers, who are they most likely to speak up to? Another RN or Tech.**



Optional Slide - Project Lead will decide if want to use series of slides with SCS results applicable to speaking up – PL modify this slide with actual results.

Main Points

1. Show survey results for speaking up to someone of higher authority.
2. Compare between results on prior slide and this one – highlights problem in healthcare: individuals not comfortable or trained to speak up to someone with higher authority.

Time: 1 minute

Sample “script”/facilitation:

Here are your results from your last Safety Climate Survey in response to the statement “Staff fee free to question the decisions or actions of those with more authority” Quite a bit different from the last question. What does this tell you? In the case of Rebecca, who does she need to speak up to right now? Yes, the surgeon.

Normally we see significant reduction in positive responses, increase in negative responses.

Sample Transition: *If Rebecca does speak up to the surgeon, what will she say?*

...<click>

What do you think?

If you were the surgeon would you want Rebecca to speak up?

Based on the culture you believe exists at your hospital, will Rebecca speak up?

...Why or Why Not?

If she does speak up, what will she say?



Main Point(s): Use this series of slides if showing specific hospital's Safety Climate Survey (SCS) results for questions about speaking up.

1. Through questions #3 show that even if she does speak up, unsure if she will say the most effective words. Currently there is no standardized format to communicate effectively in these kinds of situations.

Time: 2 minutes

Sample “script”/facilitation:

If Rebecca does speak up to the surgeon, what will she say?

Many in class will answer: **“Stop, she has a latex allergy.”** But in reality, that is highly unlikely. She'll probably say something like, **“Are you sure about the latex? I thought I heard something about a latex allergy....etc.”** We call that **“beating around the bush.”** rather than getting straight to the point. Facilitate a discussion about this. Many will say she won't go directly to the Surgeon, instead she'll say something to her preceptor - as facilitator ask, **“Who needs to know the information right now?”** Answer: the Surgeon! Finally, ask **“Do you have a system or process in place that provides a standardized format for communication to use in these situations to ensure that individuals say the correct or most effective words?”**

When all questions have been presented and discussed, summarize the discussion and then tie it into Tenerife:

So what I'm hearing is that if a team member has critical concern or information,

1. *You want them to speak up,*
2. *But there is doubt as to whether that will always happen - it depends on the individuals involved in situation.*
3. *And even if they do speak up, we are not sure if they will communicate effectively (we hope they will, we think they should, and we may have a rough idea of what they'll say.)*

Do you have a system in place to ensure that not only everyone will speak up, but they'll speak up in a predictable and effective way?

Sample Transition: *That's interesting, because we in aviation experienced the same situation and here's how we found out that we needed a safety system ...<click>*



Option for Introductory Story: Jane story - OB patient allergic to Penicillin / Ancef

Main Point(s):

1. Continue “Jane Story” - jaws of life needed to extract Jane.

Time: 5 sec

Sample “script”/facilitation:

... First responders had to use the Jaws of Life to remove Jane from the car and assessed her injuries as life threatening.

Sample Transition: *Fearing internal injuries...* <click>



Time: 5 sec

Option for Introductory Story: Jane story - OB patient allergic to Penicillin / Ancef

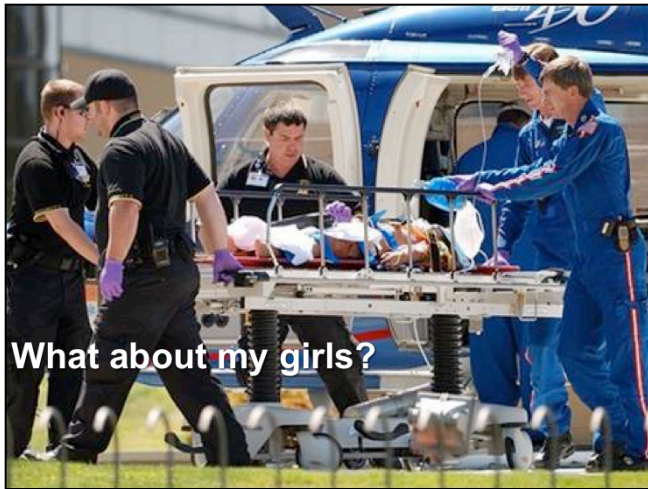
Main Point(s):

1. Continue “Jane Story” - fearing internal injuries and for the baby, Life Flight is called in to take Jane to level 1 trauma center.

Sample “script”/facilitation:

....Fearing internal injuries, they called Life Flight to transport her to a level one trauma center.

Sample Transition: As the flight nurse<click>



What about my girls?

Time: 10 sec

Sample “script”/facilitation:

...was prepping her for the flight in the ambulance while her husband was being treated by the medics. The husband grabs the flight nurse's arm and asks, “What about my girls? – Are they going to be okay - my wife and baby girl we’re expecting any day?” to which the flight nurse responded, “We will take care of them. Your wife's in good hands.” The husband replies, “Please let everyone know that she has a severe allergy to penicillin and cephalosporins, such as Ancef.

Note: You may be more comfortable with “What about my wife?”

Sample Transition: *The flight nurse marked the chart and off they went.... <click>*

Option for Introductory Story: Jane story - OB patient allergic to Penicillin / Ancef

Main Point(s):

1. Continue “Jane Story” – Jane's husband tells the flight nurse about Jane's allergy to penicillin / Ancef.



Time: 10 secs

Option for Introductory Story: Jane story - OB patient allergic to Penicillin / Ancef

Main Point(s):

- 1. Continue “Jane Story” - paramedics rush Jane into emergency/trauma.**
- 2. Introduce Rebecca - new surgical RN or tech in orientation who is observing and hears the flight nurse mention the latex allergy.**

Sample “script”/facilitation:

...Upon arrival at the hospital, Jane is rushed to the Emergency/Trauma floor where the trauma team assess her. The team fears injuries to both mom and baby, consults with the attending OB, and ultimately decides she needs an immediate emergency C-section.. The team begins to prep her for surgery.

Observing the activity as Jane arrives at the hospital is Rebecca, a new nurse (or tech) at the hospital, still in orientation. Rebecca has only been there for two weeks and is still in training. As part of her orientation training to the hospital she was assigned to observe the trauma process from the patient's arrival through surgery. Her preceptor is extremely busy so directs her to observe on her own, to simply listen, watch, and learn.

Sample Transition: *Rebecca was pretty sure she heard the flight nurse say something about an allergy to Ancef (or drug allergy), but when she arrives in the OR... <click>*



**Option for Introductory Story: Jane story -
OB patient allergic to Penicillin / Ancef**

Main Point(s):

- 1. Continue “Jane Story” - Rebecca sees staff prepping the Ancef (cefazolin).**

Time: 5 secs

Sample “script”/facilitation:

Rebecca sees the staff prepping to administer Ancef (cefazolin) as the prophylactic antibiotic in Jane's surgery.

NOTE: On this topic, the most extreme quibblers among the hot-grounder crowd might be anesthesiologists. There's some dispute in the literature about evidence supporting cephalosporin allergies in penicillin-sensitive patients. Substitute drugs carry their own risks, and some cephalosporins may be safer than others because their chemical structure has less in common with penicillin. But, if the allergy is severe and it's YOUR DAUGHTER on the table...



**Option for Introductory Story: Jane story -
OB patient allergic to Penicillin / Ancef**

Main Point(s):

- 1. Surgeon says no timeout. Rebecca is not sure what to do.**

Time: 5 secs


Sample “script”/facilitation:

As Rebecca is trying to figure out what to do or say, the patient is brought into the OR with the surgeon along side her. Rebecca immediately recognizes the surgeon as the chair of the trauma department and is known for her autocratic style, very demanding, intolerant of delays or incompetence. Rebecca has been warned to “tread lightly” around this surgeon. The surgeon then adamantly announces that they have to get right to work - no need or time to do a timeout.

What do you think?

If this were an ultra-safe hospital, what do you expect to happen?

- What will Rebecca do?
- What will Dr. K do?



Optional “What do think” ?s for Introductory Story: Labor; non-reassuring strip

Main Point(s):

1. Establish through question #1 that they expect Rebecca to speak up, and Dr. K to listen – do what’s safest for Jane & baby no matter what.


Time: 30 secs

This series of 3 “What do you think?” slides go only with the Jane story where “mom is 44, 5th child, does not want a C-section” story.

1. What do you think? If this were an ultra-safe hospital, what do you expect to happen? What will Rebecca do? What will Dr. K do?

What do you think?

What if something like this happened here, with your version of Rebecca and Dr. K?



- A. Rebecca will definitely speak up
- B. Rebecca might speak up (depends on a number of factors)
- C. Rebecca likely will not speak up
- D. Rebecca will definitely not speak up

Optional “What do think” ?s for Introductory Story: Labor; non-reassuring strip

Main Point(s):

1. Through question #2 show that there is doubt as to whether Rebecca will speak up.

Time: 30 secs

This series of 3 “What do you think?” slides go only with the Jane story where “mom is 44, 5th child, does not want a C-section” story.

2. *What if something like this happened here, with your version of Rebecca and Dr. K? Which one will most likely happen?*
 - A. *Rebecca will definitely speak up?*
 - B. *Rebecca might speak up (depends on ...)?*
 - C. *Rebecca likely will not speak up?*
 - D. *Rebecca will definitely not speak up?*

Facilitate from class reasons for which one they chose. If chose B, what does it depend on?

What do you think?

How would you rate your culture?

0 ----- 10

A. 5 or less
B. 6 to 7
C. 8 to 9
D. 10



Optional “What do think” ?s for Introductory Story: Labor; non-reassuring strip

Main Point(s):

1. Establish with question #3 the need to improve current safety culture.

Time: 2 minutes

This series of 3 “What do you think?” slides go only with the Jane story where “mom is 44, 5th child, does not want a C-section” story.

3. *On a scale of 0-10, how would you rate your culture of safety here at....? Why?*

When all questions have been presented and discussed, summarize the discussion and then connect with aviation's similar situation and lessons learned from Tenerife:

So what I'm hearing is that if a team member has critical information,

1. *You want them to speak up,*
2. *But there is doubt as to whether that will always happen - it depends on the individuals.*
3. *And even if they do speak up, we are not sure if they will communicate effectively (we hope they will, we think they should, and we may have a rough idea of what they'll say.)*

Do you have a system in place to ensure that not only everyone will speak up, but they'll speak up in a predictable and effective way?

Sample Transition: *That's interesting, because we in aviation experienced the same situation and here's how we found out that we needed a safety system ...<click>*

**Main Point(s):**

1. Begin set up of Tenerife Story –
2. Facilitators: know that overall point of Tenerife story is to show that aviation had the same issues as Healthcare: Need for speaking up, Culture of intimidation / retaliation, and lack of team & communication skills / system ensuring all team members will speak up & effectively communicate with critical information.

Time: 15 secs

Sample “script”/facilitation:

A significant event for aviation occurred in 1977 on Tenerife, an island in the Canary Islands.

Sample Transition: *Due to some errors and miscommunication, two 747's (large aircraft) ended up on the same runway in very thick fog: one 747 was taking off without appropriate clearance, and another 747 was taxiing to the nearest turnoff..... <click>*



Main Point(s):

1. KLM Capt.. van Zanten was “high ranking,” one of most experienced pilots who trained others, very concerned with punctuality, not tolerant of delay or errors, intimidating in tone he set and position he held, etc.
2. Copilot and Flight Engineer in cockpit with Capt. van Zanten tried, but were unable to effectively communicate critical information: they needed to stop because the other 747 was still on the runway and they did not have takeoff clearance.

Time: 30 sec

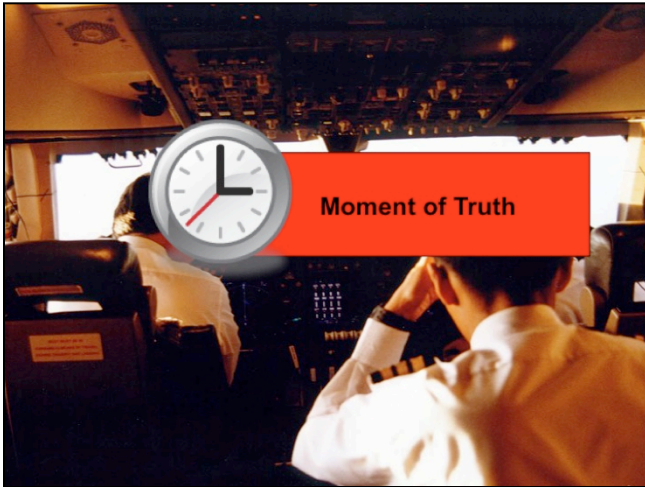
Sample “script”/facilitation:

.....Due to some errors and miscommunication, two 747's (FYI - very large aircraft - double decker airplane, upper floor is cockpit and first class, lower floor is coach, can carry over 400 passengers). ended up on the same runway in very thick fog, one 747 was taking off without appropriate clearance, and another was taxiing on the runway to the nearest turnoff.

The captain of the 747 taking off is Capt. Van Zanten. He is a captain's captain, and has risen to the top of the pyramid of aviation. He is the Chief of Training for the 747 at KLM (Major Dutch airline), their most experienced pilot, and he has trained nearly every other pilot who currently flies the 747 for KLM. Like the surgeon we just described, he is very good and focused, not tolerable of delays, interruptions or what he interprets to be incompetency.

The other crewmembers (copilot and flight engineer) in the cockpit with Capt. van Zanten had critical information about the situation (other 747 still on the runway and no clearance for takeoff), tried to say something (hinting and hoping) but were unable to effectively communicate this to Captain van Zanten due to the culture, hierarchy and lack of training to communicate in these situations.

Sample Transition: Captain van Zanten continued with the takeoff.....<click>

**Optional Slide for Tenerife Story****Main Point(s):**

1. **Moment of truth for copilot and engineer to speak up in a direct manner to Capt. van Zanten, no matter how intimidated.**

Time: 15 sec

Sample “script”/facilitation:

...This is the moment of truth for the copilot and engineer to directly tell the Captain, “Stop! There is another 747 still on the runway!” But they do not try again – they’ve tried already, to no avail. Their communication was ineffective.

Sample Transition: *Captain van Zanten continued with the takeoff.....<click>*



Main Point(s):

1. Captain van Zanten sees the other 747 (PanAm) but is too slow to take off and too fast to stop.
2. Captain van Zanten tries to “leapfrog” up over the PanAm 747.

Time: 10 sec

Sample “script”/facilitation:

Captain van Zanten continued with the takeoff, seeing the other aircraft in the fog only when he was too close and too fast to stop.

Sample Transition: *He tried to pull up over the other aircraft.....<click>*



Main Point(s):

1. The two 747's collide.

Time: 5 sec

Sample "script"/facilitation:

...but was unable to avoid the collision...<click>

**Main Point(s):**

1. Tragedy (583 dead) occurred not because of weather, broken equipment or lack of flying skills, but because of human error and lack of trained teamwork skills supported by a safety system.

Time: 30 sec

Sample "script"/facilitation:

... and as a result, 583 people died.... why?

Yes, poor communication, insufficient assertion and effective communication by the KLM crew, failure to heed concerns voiced by team members... human error

The aircraft were not broken crew had sufficient technical skills. They were lacking teamwork skills. Just like Rebecca, crew members had critical information that the leader needed but were uncomfortable speaking up to their most experienced Capt. and were not trained to speak up in a standardized format.

Sample Transition: *From analyzing this accident and several other deadly accidents, aviation realized... <click>...(next slide: 70% of their accidents were a result of human error, due to human limitations such as these)*

**Main Point(s):**

1. Human error is inevitable and we must expect it.
2. Solution: stop blaming individuals. Instead, fix the system to manage error: prevent, catch, and mitigate error.
3. Train team skills and implement hardwired safety systems.

Time: 30 seconds

Samples for “script”/facilitation:

“Aviation realized the technical skills, whether piloting skills or clinical skills, are necessary but not sufficient. While it's emotionally satisfying to blame the individual, what we really needed to do was to train specific team skills, and then hold people accountable for using the skills through the system. This proved to be not only more enlightening, but far more effective. Which approach to human error do you experience in healthcare today?”

Sample Transition: *That's interesting because<click>”*

Or...

...no matter how well trained, motivated and professional, if humans are involved, error is inevitable. It was insufficient to simply expect humans to be error-free - they have physiological and psychological limitations such as fatigue, workload, memory lapses, etc.

So aviation's solution was to first stop blaming the individual, instead fix the system by building a resilient one that anticipates and tolerates individual error, and then traps and mitigates the impact of that error.

Individuals must be trained in team skills and then to use those skills in a hardwired safety system, ensuring that errors are caught and corrected, no matter the personality or experience level of the team members.

Just for your information, Aviation's program is called Crew Resource Management or CRM. Healthcare's equivalent is TeamSTEPS: Team Strategies and Tools to Enhance Performance and Patient Safety.

Sample Transition: *Is aviation's solution adaptable to healthcare? To answer that let's compare the root cause of error between aviation and healthcare... <click>*

Similar Root Causes for Error LifeWINGS

Aviation	Healthcare
70 – 80% of airline accidents are related to interpersonal communications <small>(Sexton & Helmreich, 99)</small>	70 – 80% of adverse events involve communication failure. <small>(VA National Center for Patient Safety, 2007)</small> 72% of reported sentinel events identified human factors as root cause <small>(The Joint Commission, 2014)</small>

Main Point(s):

- 1. Healthcare and Aviation have similar root causes for error: 70-80% accidents caused by human communication error.**

Time: 15 seconds

Sample “script”/facilitation:

...Let's compare the root cause of error between aviation and healthcare

What is the percentage of errors in aviation due to problems with team interaction? (take inputs) 70-80%.

What about healthcare? (take inputs) Exactly the same. (VA National Center for Patient Safety, Executive Summary, 2007) 72% root cause of sentinel events: human factors – The Joint Commission Sentinel Events Data, 2004-2014. 72% is specific data for year of 2014, Data is from reported sentinel events.

Both Aviation and Healthcare share the same primary cause of accidents - namely “inevitable human error.”

Sample Transition: *In order to look closer at human error... <click>*

**Main Point(s):**

Effectively setup Challenge - move fast!

GOAL IS TO SET THEM UP TO FAIL (simulating what they experience on the floor) **AND GET THE WRONG ANSWER!**

1. Identify each table as a team.
2. Tell them you will show series of numbers, they just need to add them up.
3. Relate problem to patient outcome.
4. Not allowed to use pen, pencil, paper, pda, etc.
5. Move fast – Don't give them time to introduce themselves, pick a leader, come up with plan, etc.

First team challenge

Goal is to set them up to Fail - Set them up to get the wrong answer.

Time: 3 minutes for numbers exercise - in the intro section, you will only have them run through this once. They will do it again in Block 4 using all the skills and a checklist to brief their team.

Setup time: about 30 seconds. Do not allow them time to introduce themselves, identify a leader, or come up with a plan - move fast to prevent this.

(All classes will be seated at tables. As participants sign in have them sit at random tables. Don't let them sit in their cliques or known groups. Label tables by number ahead of time and then assign participants a table number. If a hospital representative is helping you with sign-in, have them assign individuals a table number.) Tell them each table is a team.

Sample "script"/facilitation:

...we are going to start off with a team challenge. Each table is a team.

*I am going to show you a series of numbers on the screen, your task is to simply add up the numbers and come up with the sum or total. **Technique: tell them fifth grade math, easy.***

I will then come to your group and want only one of you to give me the answer.

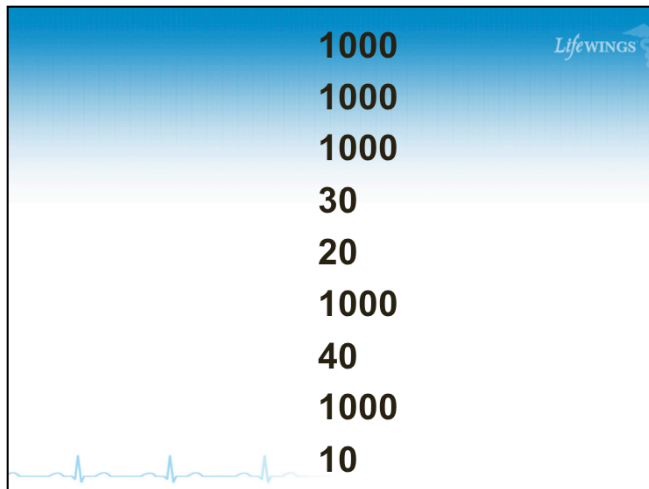
Imagine that these numbers are your patient in a life or death emergency situation so you'll need the answer or decide on the "treatment" immediately. If you get the answer wrong, your patient dies!

The ground rules are: No pens, pencils, notes, calculators, PDA's, or any other type of adding Tool. "it must be done in your head."

if they ask a question, answer, "great question but I can't answer that" or "I don't know."

It is critical that you begin right away or you won't get the results you need to make your point!!

Sample Transition: Here comes your patient...<click>

**Facilitators remember:**

- You must check timing of auto build of numbers on your computer and adjust if necessary since may change with different versions of PowerPoint.
- Numbers are automatic and next slide will automatically appear. **DO NOT** click your mouse on this slide or you will stop the sequence.
- Look for and stop anyone who is recording the numbers in any way.
- Cause distraction by moving & talking.

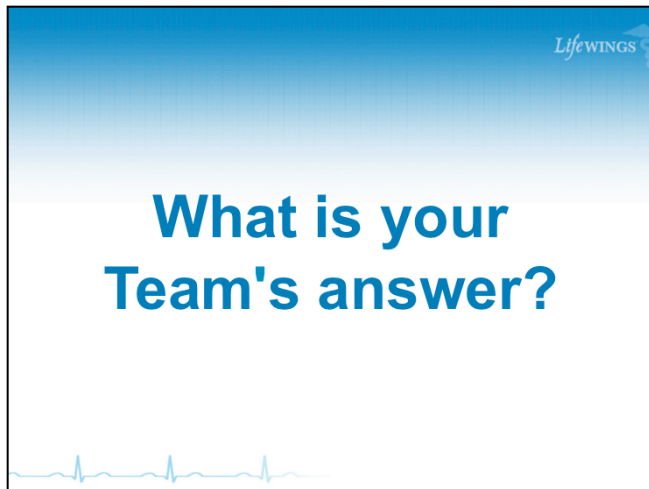
PROCEDURE: TEST the numbers and how quickly they auto build on your computer to determine timing - you may have to adjust since timing may change between versions of PowerPoint. Timing should be the same between the first and second showing (Block 4) of numbers.

Numbers are automatic and next slide will automatically appear **DO NOT** click your mouse on this slide or you will stop the sequence.

Cause distraction by continuing to talk and give verbose / repetitive directions as the numbers come up. Walk around knowing it bothers them – can walk in front of the slide a couple of times, but no don't overdo. Remember, you want them to get the wrong answer! You're simulating what they experience out there on the floor.

As the numbers appear, ensure that you are moving around the class to listen to the teams. Most often, there is someone on a team, not the leader, that will have the correct answer, and try to relay it, usually unsuccessfully. Who ever steps up to be the leader, will usually call out their answer to the team, squashing any other inputs, and then directly give you their (the leader's own addition) own initial answer when queried.

When last number builds, next slide will automatically build.

**Main Point(s):**

1. Get teams' answers quickly.
2. Show uncertainty of correct sum and directly relate that patient's safety is at risk.
3. Move to next slide to debrief their first attempt at this problem - emphasize confusion and different answers as you debrief.
4. Do not tell them if correct or wrong – or what the correct answer is.

Go to each group and ask for their answer - put pressure on them to answer quickly. Be quick about it.

Most groups will answer “6000” (5100 is correct but don’t tell them!). If even one group has a different answer from the rest, ask “Who's right?” - remind them that the team or teams with the wrong answer will kill their patient. Even if all groups have the same answer (right or wrong), ask them if they are willing to bet their patient's lives on their answer. If one or all get 5100, do not tell them they got it right - create doubt, “Are you sure? Would you bet your patient's life, or your salary, etc...?”

I'm not going to give you the answer, yet, because you will have another opportunity to do this again towards the end of this class. By that point you will have some skills and techniques to apply to this problem.


Sample Transition: *to help us determine what happened so we can improve next time, let's debrief what occurred ...<click>*

Team Challenge
Performance Feedback

LifeWINGS

- Communication
- Team Management
- Recognizing Warning Signs
- Decision Making
- Debrief

These skills require training and a safety system in place



Main Point(s):

1. Debrief the team challenge.
2. As build each bullet separately, ask precise questions about how well they did during that exercise.

Time: 2.5 minutes

Sample “script”/facilitation: Multiple examples of questions you might ask for each bullet – do not ask all of them, choose just one or two questions per bullet.

Let's discuss this team challenge. First, what about...

...<click> Communication. **Examples of questions you might ask:** *How well did you communicate? What barriers did you have to effective communication? Did anyone have a different answer than the rest of the group? How well did you communicate that?*

...<click> Team management: **Examples of questions you might ask:** *What were some of the challenges you faced as a team? How was your team managed? What was missing from your team? Who was your leader? Did you have one? What was your role? Was it clear? Was the problem clear? Did you know what to expect? Were you comfortable with your team members? Did you even know their names or their abilities? Were you operating as a team or as individuals?.*

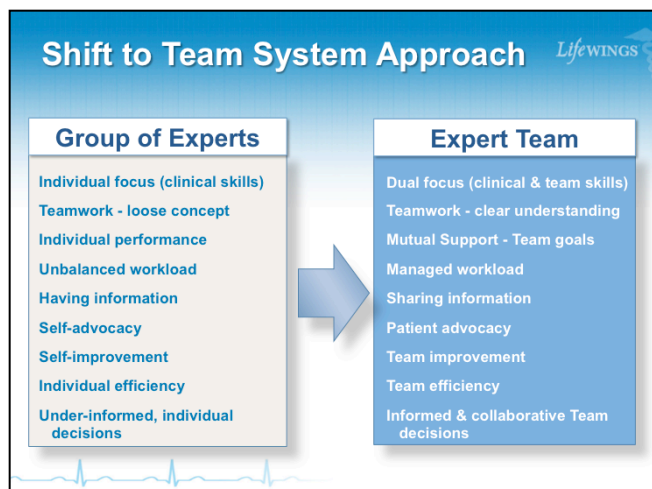
...<click> Recognizing warning signs. **Examples of questions you might ask:** *What warning signs did you have that this was an adverse situation? What was adverse about the situation? (fast, no time to prep, distraction with you talking, confusion, took away Tools / resources, etc.) What was strange about the way I presented the numbers? (left alignment.) Would you have been more likely to get the right answer if I had alerted you of this before you saw the numbers*

...<click> Decision making. **Examples of questions you might ask:** *Was it clear who the leader was or what the problem was? Did any self appointed leader shout out, “It's 6000, what do you think? Why is that a problem? (poisoning the well - individuals don't give their ideas because leader has already made up their mind.)*

...<click> Debrief. *That's what we are doing right now. What are we learning from this debrief or discussion we are having right now? When we do this exercise again, near the end of this class, are there changes you'd like to make based on our discussion?*

...<click> *These are the specific skills taught in aviation to manage error.*

Sample Transition: *These skills are now also being taught in healthcare...<click>*



Main Point(s):

- 1. Paradigm shift from individual to team system approach creates the safety net necessary to prevent, catch, and mitigate the inevitable human error.**

Time: 30 seconds

Sample “script”/facilitation:

...with the goal of the paradigm shift from groups of Experts to an Expert Team,

TeamSTEPPS will create the necessary paradigm shift from a healthcare system merely dependent on individual performance and hoping it is correct all the time, to one that relies on the team working together effectively to produce a safety net that prevents, traps and mitigates inevitable human error. The result will be a resilient and reliable system.

You can point out a few items on each (items most relevant to your hospital) but do not cover every item listed – too time consuming.

These organizations believe that the training you're going through today is a great start, but in order to make lasting changes, a successful TeamSTEPPS program must include certain elements.

Sample Transition: *Let's look at what those are by looking at our your own TeamSTEPPS program....<click>*

**Main Point(s):**

1. **Site Assessment** : floor observations, what do you do well /what can be improved.
2. **Leadership Development**: LC five hours (same as this course) + <# of days> LDI to discuss how to support/break down barriers for front-line implementation.
3. **Skills-based Training** – customized training of team & communication skills participant's can apply immediately.

Time: 30 seconds

Sample “script”/facilitation:

First, a site assessment was conducted. LifeWings (or your own TeamSTEPPS trained individuals) spent <# of days> on the floor in your unit to observe and learn what you do well and what can be improved. They took note of your current processes and got a feel for how individuals interact, communicate and coordinate. The findings established a baseline for the program and were used to tailor today's class curriculum. ...<click>

Next, Leadership first attended this very same course for 5 hours, then spent <# of days> to discuss their role and necessary policy to ensure the program is successful. They spent significant time identifying current barriers and how they can best support you, the front-line, in making changes you identify and implement. ...<click>

Now we are in the Skills-Based Training phase where all individuals in your unit will attend this same class. Everyone will be trained in practical team and communication skills to be applied immediately.

Sample Transition: *We will spend the rest of today's class making our way up ...<click>*

**Main Point(s):**

1. Very briefly introduce the TeamSTEPPS skills that will be covered in today's skills workshop.
2. All skills discussed today focus on high reliability, reduced errors, and increased patient safety & quality of care.

Time: 30 seconds

Facilitators: You are NOT pre-teaching each module here - you are merely giving them a quick look/brief & concise overview at what skills are going to be discussed during the workshop. In your quick overview you will show how each skill builds on the previous one.

...up the pyramid of TeamSTEPPS skills.

...<click> "We will begin by discussing some prescriptive "To-do's" that will enable individuals to rapidly form a cohesive team where they have a shared mental model and the open flow of communication.

...<click> Even the most well formed teams can encounter prevalent communication barriers but simple techniques can easily overcome them.

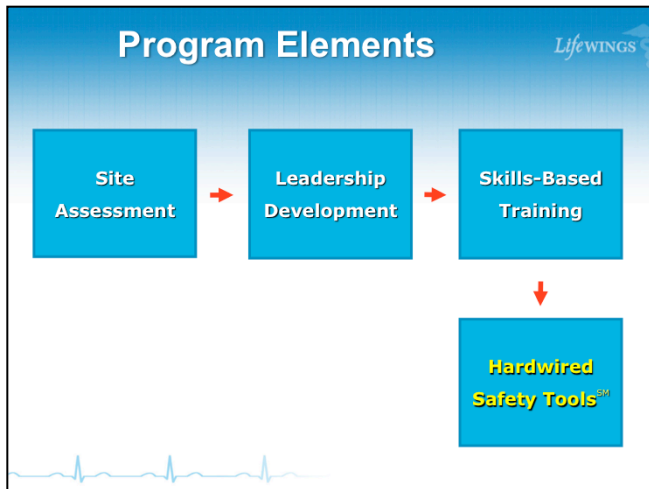
...<click> We can enable that team to look or Cross-Check for specific performance markers that indicate a developing adverse situation, and then through assertion, effectively communicate those concerns to their team and get a decision to address the issue.

...<click> Team decision-making strategies to avoid common pitfalls require that we use all of these skills, and to

...<click> ensure that we're continuously improving it's essential that we are providing feedback to our team members, especially in the form of a team debrief.

...<click> All of these skill sets form the core of a new paradigm for patient care that results in high reliability, reduced errors, and improved quality and safety. "

Sample Transition: *You will receive training on all of these skills today as part of your hospital's TeamSTEPPS program...<click>*



Main Point(s):

- 1. Hardwired Safety ToolsSM: Standardized tools & practices ensure the Team & Communication skills are applied, no matter who is involved – higher reliability, patient safety & quality of care.**

Time: 15 seconds

Sample “script”/facilitation:

...The hard part is actually putting them into practice back in your unit and ensuring that everyone is using them.

...<click> That is where the Hardwired Safety ToolsSM come into the picture.

Transition: What exactly are Hardwired Safety ToolsSM?...<click>

**Main Point(s):**

1. **Define Hardwired Safety ToolsSM:** well-defined protocols such as checklists and structured communications that “hardwire” or require the team & communication skills are put into practice.

Time: 30 seconds.

Sample “script”/facilitation:

The term Hardwired Safety ToolsSM evokes many images as we see here. In healthcare, Hardwired Safety ToolsSM are simply well-defined protocols such as checklists and structured communications that “hardwire” the team skills into daily practices and processes.

By targeting the application of teamwork and communication principals, the Tools are specifically designed for situations where you are experiencing team shortfalls or specific patient safety concerns. These Tools are written so that the standard remains well-defined and does not dissolve over time into token compliance.

The Tools are the sharp end of the system that will ensure a reliable and safe standard of care.

Bottom line, when the Tools are well designed and properly implemented, they will:

- *Ensure that the team skills are in fact performed in a repeatable and reliable manner no matter who is on the team.*
- *Overcome human limitations to prevent, trap and mitigate error.*
- *Make it easy to do the right thing and difficult to do the wrong thing.*
- *Ultimately they allow you and your team to focus your attention on the patient and providing safe and quality care.*

Technique: *“Cardiovascular training for 30 minutes, 3-4 times a week will improve your health by lowering your blood pressure and cholesterol. Everyone understands that, right?” Okay good, now does that mean everyone in this room is now at a high level of fitness?” Of course not; learning is great but until we bridge that knowing-doing gap we don't get any of the real benefits of that knowledge. The Hardwired Safety ToolsSM we're going to discuss are very similar to a workout with a trainer - the Tools, just like the trainer, ensure the behavior or skill is actually performed.”*

“And just as you would still walk from time to time during the course of your day, deriving further aerobic benefit beyond your workout; you should still use the teamwork skills we've discussed throughout the course of your work day as you deliver care and cure to your patients.”

Sample Transition: *Here are key Hardwired Safety Tools that we will focus on....<click>*

Key Hardwired Safety Tools LifeWINGS®

- Team Briefings
- Transfer of Care Reports
- Team Debriefings
- Concern Reports
- Checklists



Main Point(s):

1. Introduce different types of HST's available to healthcare.
2. Point out that Tools must be developed and customized by unit members (the front line users) for their own unit.

Time on Slide: 30 seconds

Sample “script”/facilitation:

...Here are the key tools we will focus on. These tools simply hardwire the TeamSTEPPS skills we discuss today into your standardized processes to ensure higher reliability – makes it easy to do the right thing, difficult to do the wrong thing. Hardwired Safety Tools are not “cookbook medicine” but rather tools to assist in ensuring critical items are not missed during critical processes.

This list is not all inclusive. It does list the core or key Hardwired Safety Tools that will directly target known teamwork and communications deficiencies in healthcare organizations.

There are other Hardwired Safety Tools we’ve seen innovative teams develop to address their unique issues.

Where do these Tools come from? Who do you think should develop the tools you use on the floor? (wait for answer – most will answer “us.”) Yes, you the user should be the ones developing and implementing the tools. You know best what is needed and what will work. Only then do we see tools implemented that are both useable and reliably used. LifeWings does not develop these Tools. Front-line staff and providers, the users, develop these Tools to work specifically in their own unit and to address their specific issues.

Staff and providers from your front-line will participate in a 3-day workshop <say date if know them> where they will first identify your unit specific team and patient safety challenges, develop tools to address those issues and then go through a detailed planning process to ensure each tool is effectively implemented. More details about that workshop at the end of this class. If you’d like to be a part of that workshop, please let me know after class or contact <name>. Even if you can’t attend all 3 days we welcome you to stop by and be a part of the change ideas.

More to come on this near the end of today’s course.

Sample Transition: As we go through the class today...<click>

Page 4 - Record Your Thoughts & Turn In at End of Class LifeWINGS

- Team & Communication Challenges
- Patient Safety Concerns
- Ideas for Tools



Time on Slide: 30 seconds

Main Point(s):

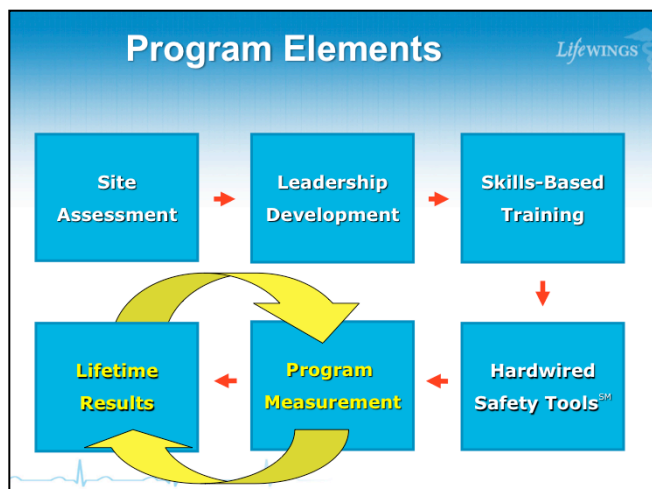
1. Encourage participants to record their ideas on Page 4 as they go through the class:
 - Team & Communication Challenges they encounter on a daily basis.
 - Patient Safety Concerns they have in their unit and Ideas for Tools to address those issues.
2. Turn in page 4 at the end of class.

Sample “script”/facilitation:

... As we go through the class today we will show you numerous examples of Hardwired Safety ToolsSM and ask you to think of what Tools would address your own unit's teamwork and communication shortfalls.

Please turn to page 4 in your book. During the class, you will think of your own specific team & communication challenges, patient safety concerns and ideas for Hardwired Safety ToolsSM to address those challenges and concerns. Please jot your thoughts down on this page as they come to mind. That way we'll have your input for the Hardwired Safety Tools Workshop even if you are not able to directly participate.

Sample Transition: Once the tools are developed and fully implemented... <click>



Main Point(s):

1. Program measurement – measure changes in behaviors, performance, attitudes, satisfaction and outcomes as a result of the program/tools implemented.
2. Lifetime Results – based on measures, revise and tweak the system and tools as necessary to make permanent culture & process change.

Time: 1.5 minutes

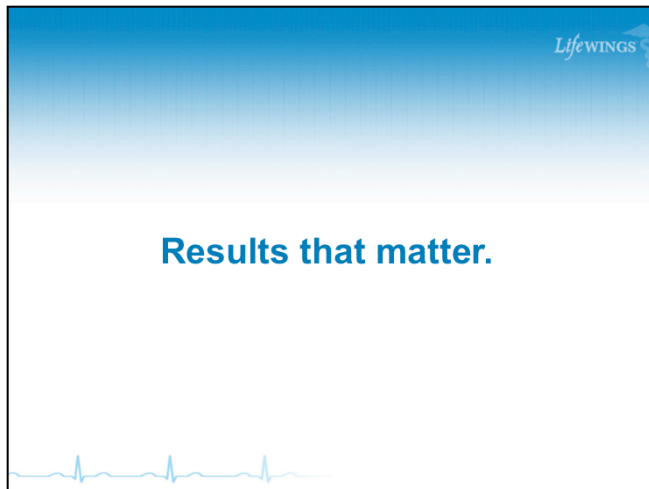
Sample “script”/facilitation:

Once your Tools are developed and fully implemented ...<click>

...your department will measure attitudes, skill's knowledge and performance, behaviors and outcomes to determine the effectiveness of the TeamSTEPPS program and Tools, and achieve ...<click> ...lifetime results through the continuing effort to appropriately adjust/tweak the Tools, program and system, as well as create new Tools as the need is identified.

Ultimately you will own your hospital and department's TeamSTEPPS tools and program. How well you incorporate into your practices is very much dependent on you and your colleagues, with Leadership’s continual support. (If hospital has transitioned from LifeWings to hospital's own trainers conducting program events, let participants know.)

Transition: *What results have other hospital units realized when they’ve completed a similar program?...<click>*



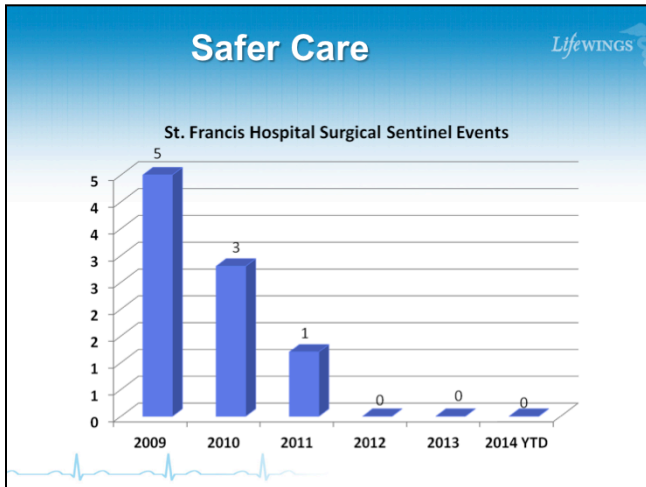
- Main Point(s):** Choose 2-3 slides of results appropriate for specific hospital/unit/participants.
- 1. Show some results from this program. Results that really make a difference to staff, providers and patients.**

Time on Slide: 5 secs

Sample “script”/facilitation:

What results have organizations seen from this program? Results that matter.

Sample Transition: *Here are a few examples...<click>*



Choose only 2-3 data slides in this series. Choose data appropriate for project/ target audience.

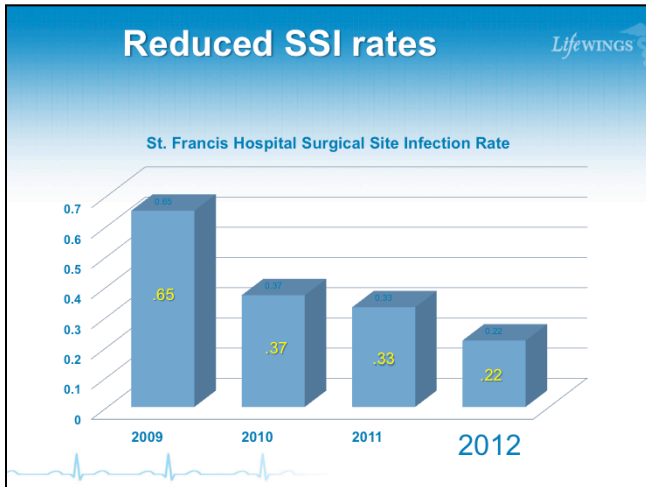
Main Point(s):

- 1. Discuss the results of a successful TeamSTEPPS implementation. This hospital had experienced 5 sentinel events in the OR, after starting the project in 2010, the rate plummeted and they ended up over 4 years sentinel event free.**

Time: 30 seconds

These are the results from a hospital about the same size as Piedmont. They had been experiencing about 5 sentinel events per year in their ORs. After starting the TeamSTEPPS implementation in 2010, they had one event in January of 2011 and are still sentinel event free to this day, a period of over 50 consecutive months without a serious safety event. Their mortality rates and SSI rate were significantly reduced as well.

If this is your last results slide, Sample Transition: *Just a few examples of results others have seen. Most important to you will be the results and changes you experience here at <hospital>...<click>*

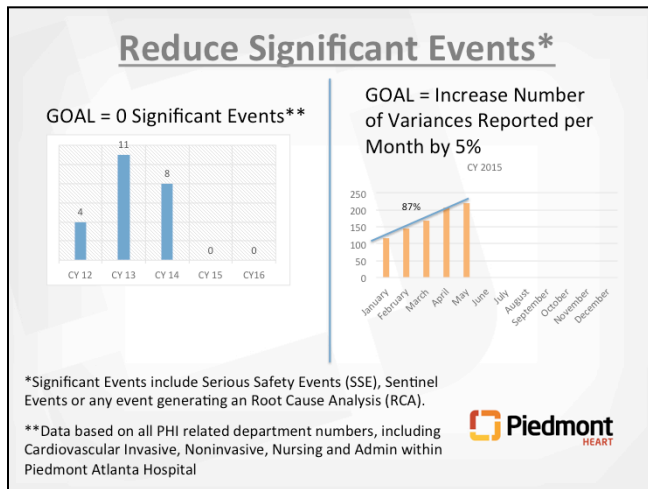


Choose only 2-3 data slides in this series. Choose data appropriate for project/target audience.

Main Point(s):

- 1. St. Francis reduced surgical site infection rate.**

If this is your last results slide, Sample Transition: *Just a few examples of results others have seen. Most important to you will be the results and changes you experience here at <hospital>...<click>*

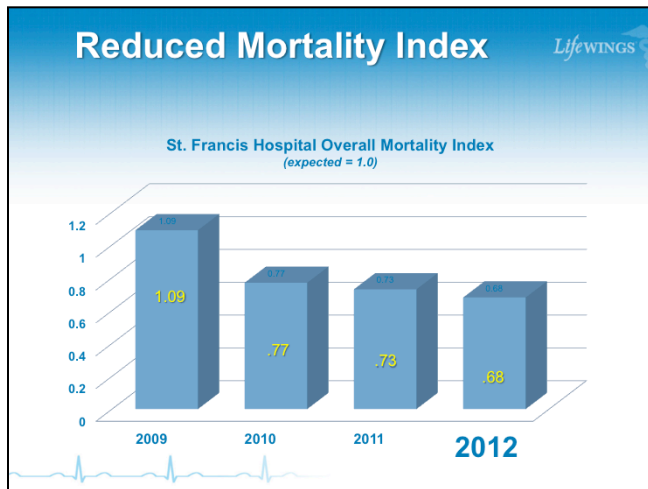


Choose only 2-3 data slides in this series. Choose data appropriate for project/ target audience.

Main Point(s):

- 1. Piedmont Heart reduced significant events and increased number of reported variances.**

If this is your last results slide, Sample Transition: *Just a few examples of results others have seen. Most important to you will be the results and changes you experience here at <hospital>...<click>*

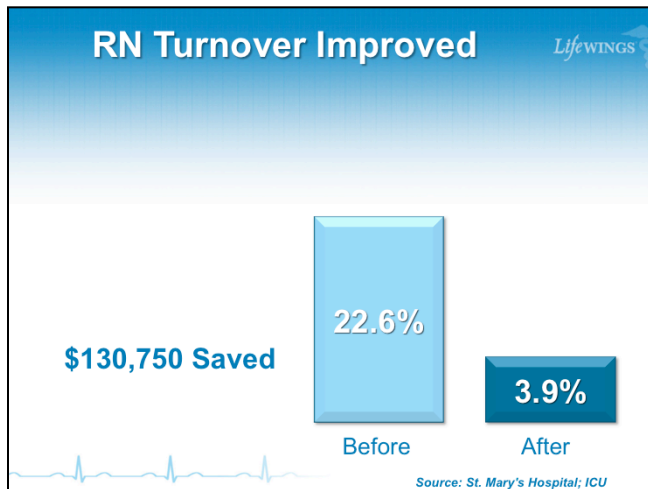


Choose only 2-3 data slides in this series. Choose data appropriate for project/target audience.

Main Point(s):

- 1. St. Francis reduced overall mortality index.**

If this is your last results slide, Sample Transition: *Just a few examples of results others have seen. Most important to you will be the results and changes you experience here at <hospital>...<click>*

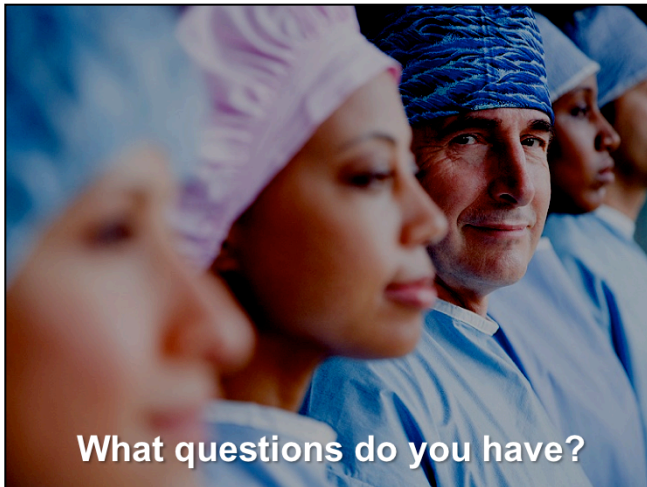


Choose only 2-3 data slides in this series. Choose data appropriate for project/target audience.

Main Point(s):

1. St Mary's Hospital, ICU, reduced RN turnover and saved \$130,750.

If this is your last results slide, Sample Transition: *Just a few examples of results others have seen. Most important to you will be the results and changes you experience here at <hospital>...<click>*



Main Point(s):

1. Ask specifically “What questions do you have....”
2. Take questions.

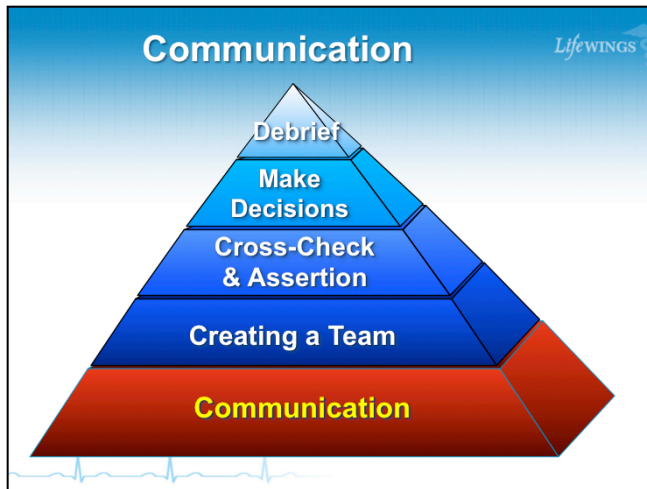
Time: 15 seconds, or more, depending on questions.

Sample “script”/Facilitation:

...What questions do you have about what we have covered so far and what you can expect from today's class?

Answer any questions the class might have.

Sample Transition: *Before we delve into the first skill, ...<click>.*

**Main Point(s):**

1. Briefly describe what the “Communication” module is going to cover (big picture).

Module time: 35 minutes

Facilitators objective:

When student completes the module they will:

1. Discuss common communication barriers they experience.
2. Understand techniques to overcome those barriers.
3. Practice using standardized format to communicate.
4. Discuss handoffs and how to make most effective.
5. Understand examples of Hardwired Safety ToolsSM for the communication skills.

Slide

Time: 30 seconds

Sample “script”/facilitation:

At the foundation of our pyramid is Communication. We will identify barriers to communication and then discuss skills and techniques to overcome those barriers.

Sample Transition:

We know communication can be very difficult in healthcare, why?....<click>

Communication Failures LifeWINGS

- 80% serious medical errors involve miscommunication between caregivers during transfer of patients. Joint Commission Center for Transforming Health Care
- The average 500-bed U.S. hospital loses \$4 million a year as a result of communication inefficiencies. Journal of Healthcare Management 2010;55(4)265-82
- From the 2015 Crico Strategies Comparative Benchmarking System Report:
 - Communication factor in 30% of 23,658 malpractice cases 2009-2013
 - Communication failures contributed to patient harm in 7,149 cases; losses incurred = \$1.7B

"The single biggest problem in communication is the illusion that it has taken place."
- George Bernard Shaw

Optional Slide

If use, choose which data applicable to current partner/unit.

Main Point(s):

1. Data showing communication failures occurring in healthcare.

Optional Slide – Choose specific data from this slide if you want/applicable to current partner/unit or go to this report and extract appropriate data. This data extracted from "Malpractice Risks in Communication Failures" 2015 Annual Benchmarking Report from Crico Strategies, a division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated. rmfstategies.com

Large amount of data in this report – slide has only fraction of data. Report breaks their data of malpractice cases into Overview, General Medicine, OB, Nursing, Surgery, and Lessons from Closed Malpractice Cases including "What works." There are also several case studies.

If use this slide, **Sample Transition:** *Why are we experiencing these communication failures in healthcare?...* <click>

A Quote from one LifeWings board member:

"Time spent developing the techniques and habits that improve communication during encounters with patients and exchanges with colleagues is considerably less stressful than time spent defending care complicated by communication failures."

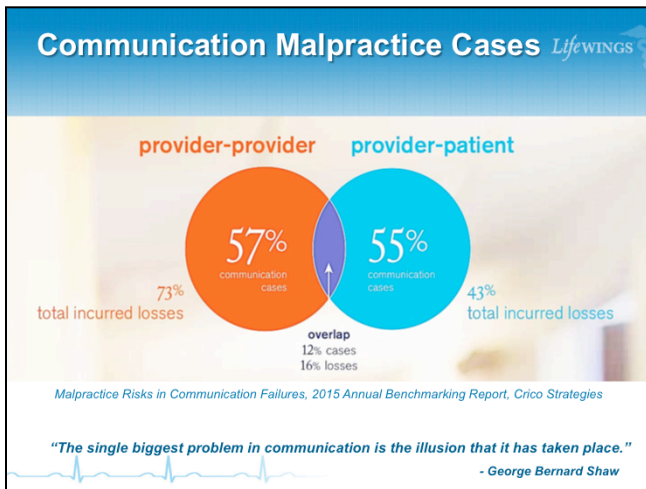
From the Crico Report:

We may not typically think of communication as a clinical skill, but health care providers and patients are frequently exposed to the tragic consequences of inadequate communication of critical information. Our 2015 Comparative Benchmarking System (CBS) Report investigates how specific weaknesses in communication impact patient safety. When information falls through the cracks, diagnoses are confounded, procedures are complicated, and subsequent care is compromised.

CRICO has analyzed more than 23,000 medical malpractice claims and suits in which patients suffered some degree of harm; three out of every 10 cases include at least one specific breakdown in communication. Our 2015 CBS Report looks at 7,149 cases in which facts, figures, or findings got lost between the individuals who had that information and those who needed it—across the spectrum of health care services and settings. These cases shine light on the who, what, when, and where of miscommunication. Consequently, they identify specific opportunities to improve skills and systems in order to bridge those knowledge gaps and keep everyone involved in a patient’s care promptly and fully informed.

Communication difficulties are not isolated to providers lacking “people skills” or patients with language or comprehension deficits. Nor is the problem exclusive to communication that is misspoken or misunderstood: errors often occur because information is unrecorded, misdirected, never received, never retrieved, or ignored. Every mode and system by which patients and caregivers share health-related information is vulnerable to failure.

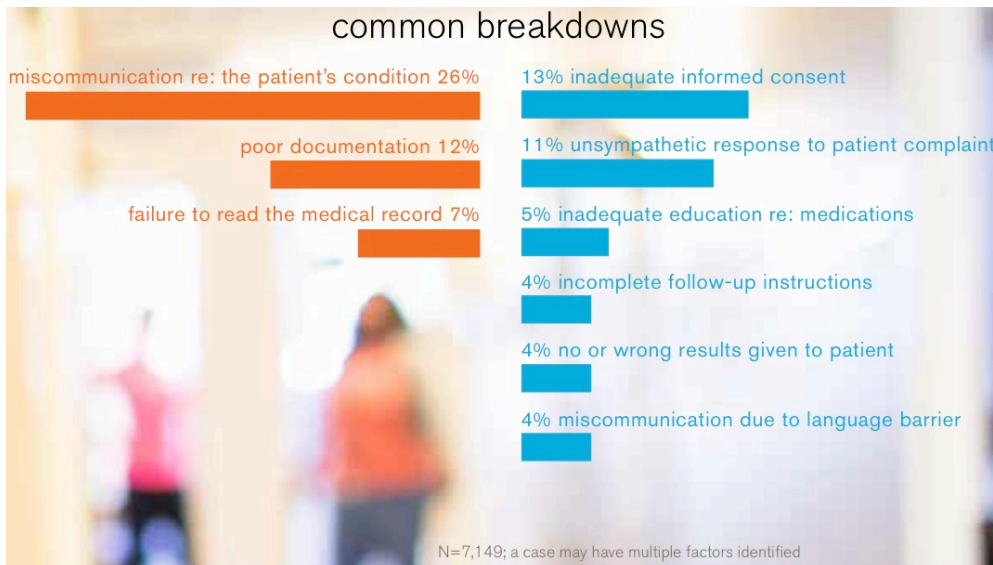
Miscommunication begets misinformation.



Optional Slide
 If use, choose which data applicable to current partner/unit.
Main Point(s):
 1. Data showing communication failures occurring in healthcare.

Optional Slide – Choose specific data from this slide if you want/applicable to current partner/unit or go to this report and extract appropriate data. This data extracted from "Malpractice Risks in Communication Failures" 2015 Annual Benchmarking Report from Crico Strategies, a division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated. rmfstategies.com

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From the Crico Report:

Miscommunication begets misinformation.

Barriers to Communication LifeWINGS

- Preconceptions, assumptions, lack of respect
- Ambiguous terms & structure
- Workload, stress & fatigue
- Distraction & noise
- Fear & hierarchy
- Turfs / silos


Main Point(s):

1. Identify barriers to communication.
2. Facilitate what participants are experiencing that prevents them from communicating effectively.
3. Customize where you focus the discussion based on site assessment, LDI, class inputs, etc.

Time: 1-2 minutes with discussion

Facilitators: Use your personal technique here - you can ask what barriers they experience before you build the bullets (use the “Why?” that builds at the bottom of the last slide) or you can show bullets and then ask which of these they routinely experience.

Don't over facilitate this slide and go into great detail for each bullet. Highlight a couple especially based upon what was observed during Site Assessment, LDI or what the class points out.

Class participants may not know what a Turf and/or Silo is. Facilitate from participants the meaning and then supplement as necessary.

Turf: protective of one's own “area” or tasks – often barrier when others start asking questions that we can interpret as stepping into our territory. Often view others as the enemy rather than part of the patient care team.

Silo: barriers (much like the tall walls of a farm / grain silo) that cause us to communicate only within our own comfort zones – often see silos within units, cliques, disciplines (nurses talk to nurses, docs to docs, techs to techs, etc.)

Sample Transition: *How do we overcome these barriers to ensure our communication is effective?... <click>*

Ensure Your Communication is... LifeWINGS

Precise, concise & timely

“Sterile” in critical processes

Standardized in structure & terms

Acknowledged



Main Point(s): Key Slide with Critical Communication Skills they can start using today. Don't hurry through – discuss/facilitate items relevant to audiences situation.

1. Show how 4 skills/techniques counter communication barriers.
2. Facilitate first 3 bullets/techniques here.
3. Facilitate last bullet, Acknowledgement, on next slide.
4. Upcoming poor comm demo & SBAR exercise highlight effectiveness of these techniques.

Time: 2 minutes

Sample “script”/facilitation:

...To ensure you are avoiding communication failures; ask yourself:

Is your communication:

- *Precise, concise & timely? - or are you “beating around the bush” and letting significant time pass before speaking up.*
- *“Sterile” in critical phases / processes - What does “sterile” communication mean? (Take inputs) Sterile communication is an aviation term meaning <click> “distraction free” or relevant communication - no unnecessary/unrelated communication, interruptions, everyone involved is focused on communication for that event/process/procedure (listening or sending) and irrelevant communication / conversations are squashed or delayed. Improves sending and listening abilities, while making it more efficient. Imagine how much quicker and more precise your reports could be at shift change if you had sterile communication.*

Technique: Ask them when during the shift is a great amount of critical information being passed between care givers - they will likely answer shift change. Then ask when is the floor the noisiest? Answer - shift change. Ask how they can make their communication more “Sterile” during those times, When do you need “Sterile” communication to ensure minimum errors?

Take inputs - answers likely to be: transfers/handoffs, phone calls about pts, reports/ signouts, medication calculations / checks, when inducing patient, timeout, etc.

What can be done to achieve “Sterile” communication?

Take inputs - answers likely to be: designate quiet rooms (med room, report room, charting room, etc.) and designate quiet times (shift change, timeout, etc.) and hold others accountable, identify brevity word to stop interruption until finished with communication/thought - one hospital uses “Standby for Safety” - then individual waits, usually just a few seconds, before receiver can give them appropriate attention.

- *Standardized in structure & terms - organized, sender won't forget important info, receiver can listen better if know what to expect and in what order, able to Cross-check each other for critical info, etc. We will look at that in great detail shortly – and demonstrate how it achieves all of these critical communication skills.*
- **Technique – before explaining Standardization, ask “What is the benefit of team members following the same format for a handoff – covering the same items in the same order?”**

Sample Transition: *The last communication skill to overcome barriers is acknowledgment....<click>*

Acknowledgment
A Critical Communication Skill

Communications not acknowledged are communications that didn't happen

NASA funded research shows a direct correlation between acknowledgments and reduced errors


Main Point(s):

1. Demonstrate through the picture/scenario & building arrows why acknowledgment is critical - only way you'll know for sure that your information was in fact received, and received correctly (as the sender intended) is through acknowledgment.

Time: 30 seconds

Sample "script"/facilitation:

... acknowledgment is critical to reducing errors.

The physician on the left is relaying <click> **(Build the Red Message arrow)** a message to the physician on the right. And the response is just as we see here, just a look from the physicians sitting down - what does that mean? **(Take responses)** Could be the receiver understands, could be he doesn't understand, could be he is daydreaming and never heard the sender, etc. Who knows! So, has communication occurred without acknowledgment? **(Take responses)**

No...<click> **(Build the Green acknowledgment arrow)** you must have an acknowledgment. That is the only way you can be sure your information is passed.

Bottom line - if your communication is not acknowledged, it never happened.

Research shows a direct relationship between acknowledging communications and reducing error. **(Foushee, H.C. & Manos, K.L., 1981, September, Information transfer with the cockpit: Problems in intracockpit communications, NASA Report No. TP-1875. Moffet Field, CA: NASA-Ames Research Center)**

Joint Commission says that 66% of sentinel errors caused by incomplete communication. **(Joint Commission Sentinel Event Alert - Issue 12)**

Acknowledgments can make a significant difference.

The more communications are acknowledged, the less errors you will have.

Sample Transition: Now let's take a look at how all of these skills can improve our communication and overcome barriers...<click>

Your patient, Mr. J, was just brought in to OR 3. Mr. J had an auto accident the day before and sustained blunt chest trauma. He was admitted through the ED and transferred to a step down unit overnight. His current vital signs are: BP 90/50, HR 120, O₂ Sat 87%. You're very concerned about his blood pressure. He appears very confused and getting increasingly agitated as you talk to him to confirm the procedure. He keeps referring to his belly and stating you don't know what's going on. The OR Schedule has him listed for a bronchoscopy and left thoracotomy, but his consent states he's also having a laparotomy. You call the floor to clarify but they are in the middle of shift change and are not returning your call, so you call his physician.

Main Point(s):

- 1. OR exercise scenario information – presented in larger text, without SBAR portion, so can be seen/read by all in rooms with less than ideal conditions for viewing the screen.**

Time: 5 minutes

Sample “script”/facilitation:

...here is your first scenario.

Give pairs about 5 minutes to work through exercise. There will be a lot of discussions going on.

When it looks like all are finished with the exercise or 5 mins are up :

Techniques for “debriefing” the SBAR scenario:

- 1. Show an “approved solution” on next slide and have same individuals you used to demo the poor example, now demonstrate the good SBAR. Be advised not all scenarios in current slide deck have an approved solution – you may have to create your own if you decide to use this technique.**
 - Or -
- 2. Just show / read the approved solution on next slide, discuss main points, then have receivers debrief their partner, using approved solution as comparison.**
 - Or -
- 3. Take an SBAR solution from the class and have the class debrief using the same questions: Who called?, Was the appropriate, precise information relayed?, What do they want you to do? Was there an opportunity for questions/clarification?, etc.**

Sample Transition: *I heard some great conversations.<click>*

RN to Physician

LifeWINGS

Situation
Dr. _____, this is _____ in OR 3. I have your patient, Mr. J, who is listed for a bronchoscopy and left thoracotomy. The consent, however, states he's having a bronchoscopy, left thoracotomy, and a laparotomy.

Background
He sustained blunt chest trauma from an auto accident yesterday and has been in the step down unit overnight.

Assessment
BP 90/50, HR 120, O₂ Sat 87%. Patient is very confused and starting to get agitated.

Recommendation
Please come immediately to assess the patient and clarify the situation. What questions do you have for me?

Main Point(s):

1. "Approved solution" for Mr. J OR scenario.

Hide appropriate slides depending on your chosen technique /scenario.

Your scenario may not have approved solution slide in this slide deck – you will have to create.

Time: 2 minutes

Techniques: You can either pull an "approved" solution from the class, have them read it verbally (if you do, make sure you have already found someone with a good SBAR as they are doing the exercise) or show a follow-on slide showing an "approved solution." If you decided to use a slide with "Approved Solution" you can also have them act it out (RN reads aloud while Dr. is turned around, as if a real phone call.)

Sample "script"/facilitation:

...Let's go back to my original physician and nurse. –Or- Who heard a really good SBAR? –Or- Sally, please read your SBAR so everyone can hear it.

Set up as before, physician turn away, RN read SBAR format or have someone from the group read their own SBAR for this scenario (be sure to have chosen someone that you know has a good SBAR).

After RN reads SBAR format info, ask the physician or class:

Who is contacting you?

What information was passed about the patient? Did they pass the information you wanted this time?

What does _____ (RN's name) want you to do?.

Did the RN give you an opportunity for questions?

Which did you prefer, the first narrative or the second one? Why?

Ask the class:

What made the difference? Yes, SBAR which then promote all of the components of effective communication that overcomes the barriers: precise, concise, timely, sterile, standardized and leads to acknowledgement. .

Are you using SBAR? Why / Why Not?

Which part of the SBAR is most difficult to do? <Recommendation> Why? <because feels like you are telling them what to do> Remember it is a recommendation, not the decision. Who has the authority in this case to make the decision? <the physician>

As we just saw, when possible, standardized formats are going to significantly improve your effectiveness when communicating. Where can you standardize your commonly occurring, critical communication?

Shortly, we will see another example of standardized communication when passing critical information, but first you'll debrief your exercise.

Transition: Now, which ever one of you just received the SBAR from your partner, you will conduct a debrief.<click>

**Main Point(s):**

1. Show this slide when partners debriefing the SBAR.

Time: 1 minute

Sample “script”/facilitation:

Now let’s debrief your SBARs. Partners, whoever just received the SBAR, you will conduct a debrief with your partner by asking:

1. *What went well with your SBAR?*
2. *What can be improved?*

Receivers, be sure to let your partner answer the debrief question first, then you provide your comments.

If this is your last scenario debrief, Wrap-Up Exercise by discussion/facilitating challenges / encourage practice, use, coaching & debriefing of SBARs in real-time.

Nurses, which item in SBAR is the most difficult to do? Most will say the R/Recommendation. Ask them why? Most will say because it is like you're telling them what to do. Then ask a physician what they think – is the recommendation useful information? Why? Who still holds authority to make final decision of what to do? Physicians will say very useful, nurse is bedside, they want their critical thinking/ recommendations to help them make better decisions.

What if not using SBAR? How can you coach them?

As you have all demonstrated and discussed with each other, Standardized formats organize the transmitter's thoughts and makes sure they transmit important information – precise, concise & timely, prepares the receiver to listen - they know what's coming when and easily identify if something is missing, keeps it focused on pt issues - sterile, provides opportunity for questions / clarification, initiates acknowledgement, does the thinking for you to a certain extent when fatigued / stressed etc.

SBAR format is on your toolkit. You can use it whenever

If moving on to second scenario...

Sample Transition: *Now, let’s move on to the next scenario, partners you will switch roles... <click>*

If this is your last SBAR scenario debrief....

Sample Transition: *Consider customizing the SBAR for your specific unit and developing tools that make is easy to use, let’s look at an example... <click>*

Mrs. J was admitted to the ICU with a Type B Aortic Dissection for BP management. BP 90/50, HR 125, O₂ Sat 90% on NRB She is now complaining of lower extremity pain and numbness bilaterally Her BP has been well controlled until the past few hours when it has become labile with large swings. Her IV Labetalol has now been turned off because of hypotension. Patient is very restless and now becoming diaphoretic. Her belly appears to be getting more distended. You have sent a stat H/H. You believe she has possibly dissected and you are concerned about possible further dissection and bleeding.

S	Situation: Introduce yourself, Pt name, location, situation
B	Background: What is the patient's pertinent history, clinical background, additional information?
A	Assessment: Physical & clinical assessment of patient/situation.
R	Recommendations: What do you need / think needs to be done?

Main Point(s):

1. Adult ICU scenario for SBAR exercise.

This is the adult OR scenario. There are also L&D, NICU and ICU scenarios on other slides.

Hide appropriate slides depending on your audience.

Time: 5 minutes

Sample “script”/facilitation:

...here is your first scenario.

Give pairs about 5 minutes to work through exercise. There will be a lot of discussions going on.

When it looks like all are finished with the exercise or 5 mins are up :

Techniques for “debriefing” the SBAR scenario:

1. Show an “approved solution” on next slide and have same individuals you used to demo the poor example, now demonstrate the good SBAR. Be advised not all scenarios in current slide deck have an approved solution – you may have to create your own if you decide to use this technique.

- Or -

2. Just show / read the approved solution on next slide, discuss main points, then have receivers debrief their partner, using approved solution as comparison.

- Or -

3. Take an SBAR solution from the class and have the class debrief using the same questions: Who called?, Was the appropriate, precise information relayed?, What do they want you to do? Was there an opportunity for questions/clarification?, etc.

Sample Transition: *I heard some great conversations.<click>*

Midlevel to Physician LifeWINGS

Situation
 Dr. _____, this is _____ in ICU. I have your patient, Mrs. J, who was admitted with a Type B Aortic Dissection for BP management. She is now complaining of lower extremity pain and numbness bilaterally and I am concerned about possible further dissection and bleeding.

Background
 Her BP has been well controlled until the past few hours when it has become labile with large swings. Her IV Labetolol has now been turned off because of hypotension

Assessment
 BP 90/50, HR 125, O₂ Sat 90% on NRB. Patient is very restless and now becoming diaphoretic. Her belly appears to be getting more distended.

Recommendation
 I have sent a stat H/H and am getting further labs. I believe she has possibly dissected and need you to come in immediately. What questions do you have for me and what else would you like me to do?

Main Point(s):

1. “Approved solution” for adult ICU scenario.

Hide appropriate slides depending on your chosen technique /scenario.

Your scenario may not have approved solution slide in this slide deck – you will have to create.

Time: 2 minutes

Sample “script”/facilitation:

...Let’s go back to my original physician and nurse.

Set up as before, physician turn away, RN read SBAR format.

After RN reads SBAR format info to physician, ask the physician:

Who is contacting you?

What information was passed about the patient? Did they pass the information you wanted this time?

What does _____ (RN’s name) want you to do?.

Did the RN give you an opportunity for questions?

Which did you prefer, the first narrative or the second one? Why?

Ask the class:

What made the difference? Yes, SBAR which then promote all of the components of effective communication that overcomes the barriers: precise, concise, timely, sterile, standardized and leads to acknowledgement. .

Are you using SBAR? Why / Why Not?

As we just saw, when possible, standardized formats are going to significantly improve your effectiveness when communicating. Where can you standardize your commonly occurring, critical communication?

Shortly, we will see another example of standardized communication when passing critical information

Transition: *The last communication skill to overcome barriers is acknowledgment.....<click>*

Example of Customized SBAR

Nurse to Physician
ISBARQ

ISBARQ Clinical Communications Format	
I	Introduction: Introduce yourself. • State your name / unit
S	Situation: What is going on with the patient? • Patient name _____, location _____ • The current situation is _____
B	Background: What is the patient's pertinent history, clinical background, additional information? • Why patient admitted • Treatment / clinical course summary • Physical assessment <u>pertinent</u> to the problem • Pertinent changes • Relevant H & P
A	Assessment: What do you think is going on with this pt? • Your conclusions about the present situation
R	Recommendations: What do you think needs to be done? • What does the patient need and when?
Q	Questions: Solicit and answer questions. • What questions do you have for me?

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"Easy to do the right thing,
difficult to do the wrong thing"

Optional Slide – PL decide which examples of SBAR tools applicable to unit/organization. Only show 1 -2 examples.

Main Point(s):

1. This unit found often forgot to introduce themselves when calling and forgot to prompt for questions / acknowledgement.
2. This unit created printed pads of paper for individuals to compose their call before actually making it.
3. Only a worksheet, shredded when done, not a part of patient's record.

Time: 30 seconds

Sample “script”/facilitation:

Example of customized SBAR. This unit found they often forgot to identify themselves so they added I for Introduction at the start. They also tended to forget to prompt for questions to clarify /acknowledgement, so they added Q for Questions at the end. ISBARQ.

They made up printed pads, place around the unit, near the phones, so individuals could use it as a worksheet as they were preparing for a call to the physician or other individual. Helped them organize their thoughts before actually making the call. Worksheet was then shredded – not kept as part of patient's record.

Facilitators: You do not need to show all of these Tool examples. Choose one or two, or insert another Tool that may fit your class / unit type better. Participants like to see what other like-units have developed. This is your chance to customize the course for your audience. To get an idea of what Tools to show, look at the Risk Assessment report, see if can find examples of Tools recommended. Check with project lead to see if they there is a standard for what Tools must be shown for upcoming classes.

If the hospital already has some Tools in place (developed from previous project's HST), consider inserting those Tools in some of the course.

Sample Transition: *Let's switch gears slightly and look at patient handoff communication...<click>*



Main Point(s):

- 1. Facilitate these 2 questions. Most will overwhelming say they give good handoffs but don't receive good ones – why? Primarily because not standardized.**

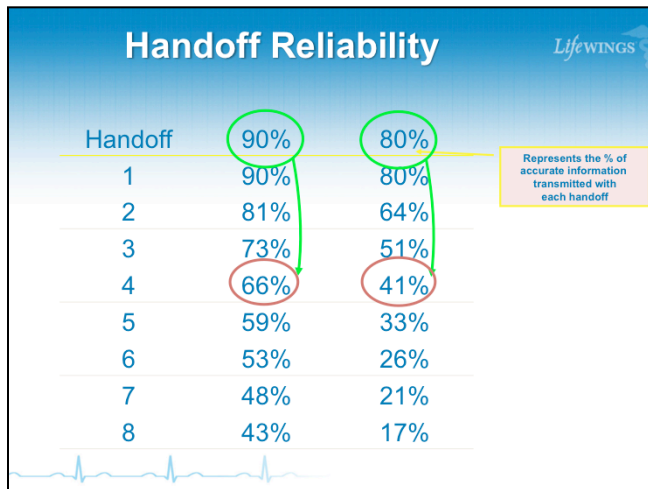
Time: 30 seconds

Sample “script”/facilitation:

Who gives good handoffs? Who gets good handoffs? How can that be – most say they give good handoffs, but don't receive good ones? Why the difference? That's correct – you have your way, and they have theirs – doesn't match. Very difficult to listen well if don't know order items presented. May be inconsistencies in what individuals think is important. Some are just disorganized, or less organized as you are, etc.

What are other reasons we have issues with handoffs, whether shift reports or signouts (physicians), relief when taking a break , or transferring a patient? Yes, we forget things (how many of you remember something important about the patient as you're driving home or after you returned home? There are numerous reasons including forgetting, omit by mistake or assume not important, distractions, fatigue, workload, hurrying, etc.

Sample Transition: *What about the accuracy and reliability of information passed during pt handoffs... <click>*



Optional Slides – PL decide how much time to spend /which in these series of slides to show for topic of handoffs - depends if and how much handoffs are an issue with your particular organization.

Main Point(s):

- 1. Simple math shows that when not maintaining 100% accuracy during handoffs, the accuracy significantly decreases after each handoff occurs.**

Time: 30 seconds

Sample “script”/facilitation:

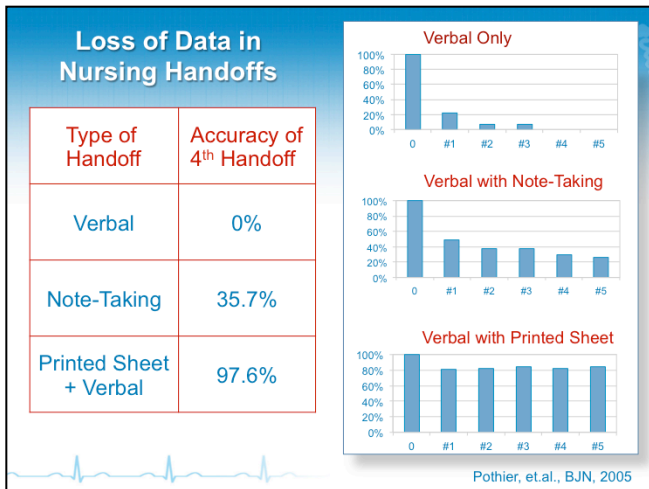
Has anyone ever played the telephone game? What happens in that game? That's correct, as the message is passed from one person to another, the information is lost or tainted. Same thing happens with handoff reports.

Let's say the first handoff is 90% accurate (start out with 10% loss of accuracy). After just 4 cycles or iterations, with the same 90% accuracy (10% loss of accuracy each handoff cycle), the accuracy is down to 66%. After 8, accuracy is less than 50%.

What if initial handoff is less accurate – 80% accurate (start out with 20% loss of accuracy). After 4 handoffs with the same 80% accuracy continuing (20% loss of accuracy each handoff) cycle, the accuracy is down to 41%! After 8, only 17%.

Think back to your unit. What percentage of accuracy do you think the very first handoff is? How many handoffs occur for just one patient in a day? Given this, how reliable is the information being passed for each patient?

Sample Transition: *One Study looked at how to best retain handoff information and accuracy...<click>*



Optional Slides – PL decide how much time to spend /which in these series of slides to show for topic of handoffs - depends if and how much handoffs are an issue with your particular organization.

Main Point(s):

1. Most accurate / reliable method for handoffs is verbal supplemented with printed sheet (computer generated).

Time: 30 seconds

Sample “script”/facilitation:

...looked at data loss in nursing handoffs, after 5 consecutive cycles, They compared the results of information lost depending on the method used to pass the handoff information – verbal only, note-taking or a printed sheet with verbal handoff.

They found using only verbal exchange resulted in loss of nearly all the information.

Note taking style resulted in only about one third of the information retained.

The most effective method was the combined method of a verbal handoff supplemented with a printed sheet. Why do you think this was the most effective?

Which method do you currently use in your unit?

Pothier, David, et.al.,

Method

- 12 simulated patients
- 5 consecutive handoff cycles
- 3 different styles

Results

- Verbal handover = loss of 98% of data
- Note taking style = loss of 31% of data
- Printed sheet + verbal = minimal loss

Types of Handoff	Definition
Verbal	Sender and receiver “give and take” handoff verbally
Note-taking	Sender verbally gives handoff; receiver takes notes
Printed Sheet	Handoff sheet is printed (computer generated); sender and receiver verbally discuss

Pothier Study Abstract Pothier D, Monteiro P, et al. *Br J Nurs.* 2005;14(20):1090-3.

A good nursing handover process is a crucial part of providing quality nursing care in a modern healthcare environment. The conservation of patient data during the handover process is vital to ensure good continuity of care and safe practice. Any errors or omissions made during the handover process may have dangerous consequences. The authors observed the handover of 12 simulated patients over five consecutive handover cycles between nurses. Three handover styles were used and the amount of data loss was recorded for each style. A purely verbal handover style resulted in the loss of all data after three cycles. A note-taking style (the traditional style used in most hospital wards) resulted in only 31% of data being transferred correctly after five cycles. When a typed sheet was included with the verbal handover, data loss was minimal. Current handover methods may result in significant loss of important data that may impact on patient care. The authors recommend that prior to handover, a formal handover sheet be constructed that can be transferred as part of the handover process.

Medical Error & Handoffs LifeWINGS

Intervention

- 10,740 patient admissions (pre/post=5516/5224)
- 870 Residents
- Implemented I-PASS Handoff Bundle

Results

- 23% reduction in the overall medical-error rate
- 30% reduction in the rate of preventable adverse events
- 21% reduction in the rate of near misses and non-harmful medical errors

N Engl J Med 2014;371:1803-12.
DOI: 10.1056/NEJMsa1405556

Optional Slides – PL decide how much time to spend /which in these series of slides to show for topic of handoffs - depends if and how much handoffs are an issue with your particular organization.

Main Point(s):

- 1. Implementing a standardized verbal and Written handoff protocol for residents significantly reduced rates for overall medical-error, preventable adverse events and near-misses.**

Time: 30 seconds

Sample “script”/facilitation:

This study published in the New England Journal of Medicine looked at improving handoffs between residents. They implemented an I-PASS Handoff Bundle.

I Illness Severity

P Patient - Summary of Pt

A Action List

S Situational Awareness / Contingency Planning

S Synthesis by receiver

The I-PASS bundle included both verbal and written handoff following the standardized format of I-PASS. The results were significant.

23% reduction in overall medical-error rate.

30% reduction in rate of preventable adverse events.

21% reduction in rate of near misses and non-harmful medical errors.

Sample Transition: *Here's a summary of key traits of highly reliable handoffs...<click>*

Effective Handoffs

LifeWINGS

- Standardized / Streamlined
- Unit / User Customized
- Sterile Environment
- Face-to-Face / Bedside / Interactive
- Acknowledgements / Readbacks
- Verbal with Written / Printed Info
- Opportunity for Questions / Clarification

How do your Handoffs measure up?

Main Point(s):

1. **Best Practices or key traits of highly reliable handoffs.**
2. **Ask class to compare their current handoff protocol and practices (as actually occurring) with these best practices, how can their current practices be improved?**

Time: 30 seconds

Technique – pepper in a few facilitation questions for a couple bullets, depending on handoff issues already identified in site assessment, brought up in class or LDI – Why is this important?, or What does this achieve? or, How does that happen?, etc.

Sample “script”/facilitation:

Highly reliable handoffs are:

Standardized and Streamlined – standardized ensures critical/ only necessary information is included, maintains both effectiveness and efficiency. Easier to listen / receive if know what's coming next, the order. Can cross-check and identify what's been missed if following standardized format.

Customized for specific unit and customized by the users.

Conducted in a sterile communications environment – distractions are kept to a minimum for accuracy and efficiency.

Conducted face-to-face and bedside with patient/patient family engagement, interactive so information can be actively cross-checked and verified or clarified/questions asked & answered.

Receiver acknowledges to sender they've received and understand the information – or clarify if not. Verbal readbacks verify that critical information is accurately received and understood.

Conducted verbally with supplemental written / printed form.

And finally, always have opportunity for Questions / Clarification at the end of the handoff. One technique is to simply ask at the end of the handoff, “What questions do you have?”

Friesen MA, White SV, Byers JF. Handoffs: Implications for Nurses. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 34. Hughes RG, editor. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK2649/>

As you look at this list, how do your current Handoffs measure up? What could be improved?

Sample Transition: What ...<click>



Optional Slide – PL decide which examples of handoff/communication tools applicable to unit/organization. Can insert your own examples. Only show 1 -2 examples.

Main Point(s):

- 1. Show other examples of communication Tools.**
- 2. Show Tool(s) that will resonate with your audience / type of unit. Limit how many you show - 1 or 2 is sufficient.**

Time: 30 seconds

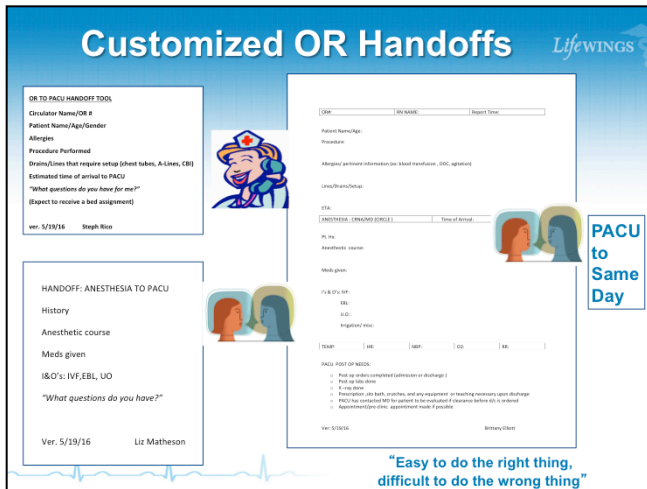
Sample “script”/facilitation:

Here is one example of a handoff checklist. This unit conducts their handoffs following this order/format referring to the patient's EMR / charts, then refer to the checklist to ensure all items covered, and end with Questions/Clarification.

Facilitators: You do not need to show all of these Tool examples. Choose one or two, or insert another Tool that may fit your class / unit type better. Participants like to see what other like-units have developed. This is your chance to customize the course for your audience. To get an idea of what Tools to show, look at the Risk Assessment report, see if can find examples of Tools recommended. Check with project lead to see if they there is a standard for what Tools must be shown for upcoming classes.

If the hospital already has some Tools in place (developed from previous project's HST), consider inserting those Tools in some of the course.

Sample Transition: *What questions do you have about these Tools? ...<click>*



Optional Slide – PL decide which examples of handoff/communication tools applicable to unit/organization. Can insert your own examples. Only show 1 -2 examples.

Main Point(s):

1. Show other examples of communication Tools.
2. Show Tool(s) that will resonate with your audience / type of unit. Limit how many you show - 1 or 2 is sufficient.

Time: 30 seconds

Sample “script”/facilitation:

This example shows 2 handoff checklists used to handoff pt to PACU (one for OR nurse, one for Anesthesia – both refer to EMR for information, checklist provides format/order and then list to cross-check to ensure not missed anything). PACU records information on this data sheet, then uses to handoff to Same Day Surgery or Inpatient if patient is admitted.

Facilitators: You do not need to show all of these Tool examples. Choose one or two, or insert another Tool that may fit your class / unit type better. Participants like to see what other like-units have developed. This is your chance to customize the course for your audience. To get an idea of what Tools to show, look at the Risk Assessment report, see if can find examples of Tools recommended. Check with project lead to see if they there is a standard for what Tools must be shown for upcoming classes.

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Sample Transition: *What questions do you have about these Tools? ...<click>*

Optional Slide – PL decide which examples of handoff/communication tools applicable to unit/organization. Can insert your own examples. Only show 1 -2 examples.

Main Point(s):

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- 2. Show Tool(s) that will resonate with your audience / type of unit. Limit how many you show - 1 or 2 is sufficient.**

Time: 30 seconds

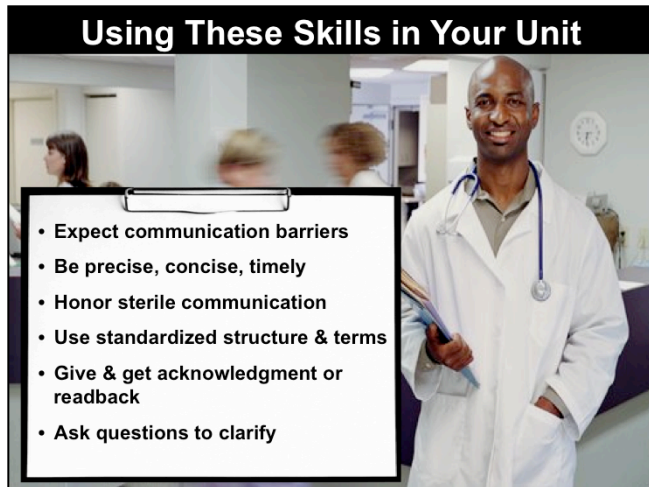
Sample “script”/facilitation:

This is example of a Customized Handoff for OR – uses mnemonic SWITCH.

Facilitators: You do not need to show all of these Tool examples. Choose one or two, or insert another Tool that may fit your class / unit type better. Participants like to see what other like-units have developed. This is your chance to customize the course for your audience. To get an idea of what Tools to show, look at the Risk Assessment report, see if can find examples of Tools recommended. Check with project lead to see if they there is a standard for what Tools must be shown for upcoming classes.

If the hospital already has some Tools in place (developed from previous project's HST), consider inserting those Tools in some of the course.

Sample Transition: *What questions do you have about these Tools? ...<click>*

**Main Point(s):**

1. Summarize the module by reminding the audience what is expected of them in their clinical setting with respect to communication barriers and skills to overcome them.
2. Encourage participants to immediately start using these skills today – refer them to their Toolkit.

Time: 30 seconds**Sample “script”/facilitation:**

First, here are the top items to remember about effective communication to take back to your unit / clinical setting. Your leadership expects you to:

- *Anticipate communication barriers*
- *Be precise, concise & timely*
- *Honor “sterile” communication*
- *Acknowledge communication*
- *Get acknowledgment of your communication*
- *Ask questions to clarify if unclear*
- *Follow standardized formats when established, even if experienced or comfortable with the receiver.*

Sample Transition: *What questions do you have about effective communication and what you can do to overcome barriers? ...<click>*



Main Point(s):

1. Ask specifically “What questions do you have....”
2. Take questions.

Time: 15 seconds, or more, depending on questions.

Sample “script”/Facilitation:

What questions do you have about effective communication?

Answer any questions the class might have....<click>

Sample Transition: *Before we take our first break.... <click>*

Administrivia LifeWINGS

Sign-in Sheet: check appropriate box if want CNE/CME

CME – Physicians & PAs

- Credit Declaration Form - Handout
- Course Evaluation (last page in book) with your name at the top

CNE – Nurses and anyone who wants a certificate

- Registration Form (first page in book)
- Course Evaluation (last page in book) with your name at the top

Breaks → 5 minutes

Main Point(s):

- 1. Cover admin items before the break.**

Time: 30 seconds

Sample “script”/facilitation:

...before our first break, we need to cover a few admin items.

Has everyone signed in? If not, please make sure you sign the attendance roster located_____.

If you want CNE or CME, here are the requirements. If you do not complete this paperwork as outlined here, you will not be awarded any continuing education credits.

Sample Transition: *Now, let's take a short...<click>*



Main Point(s):

- 1. Release attendees for a five minute break and be sure to tell them what time they need to be back.**
- 2. Confirm all have signed in on sign-in sheet.**

... break for 5 minutes. Please be back by ____.