Main Point(s):

1. **Welcome the class back from the break.**
2. **Regain their attention. Depending on the crowd, this make take some considerable effort and raising of your voice! Take Charge!**

Welcome back from your break. **…<click>**

Main Point(s):

1. **Give audience quick directions about what paperwork they will need to turn in before leave at the end of class.**
2. **By doing this here, your final words are not interrupted and the closing has a more dramatic effect. Just be sure that they do not get distracted and start filling out the paper work right now.**

Time: 30 seconds

Sample "script"/Facilitation:

Before we go into our last modules in this final hour we want to give you a reminder of what paperwork we need before you leave today.

For those who want CME (Continuing Medical Education - physicians and PAs), you must complete and turn-in the handout, the credit declaration, and the evaluation in the very back of the book, the front and back of that page – you must put your name on it.

For everyone who wants CNE (Continuing Nurses Education) certificate – you do not have to be a nurse to get the certificate, any one can apply – you must turn in the registration form in the front of the book, and the evaluation in the back of the book, front and back of that evaluation, with your name on it.

We can only give you continuing education credits if you complete and turn-in the required paperwork.

Even if you do not want any continuing education credits, we still encourage you to complete the evaluation form in the back of the book.

Please rip all of your completed forms out of your book and just leave the paperwork at your table. We will collect it at the end of the class.

You'll have time at the end of class to complete the paperwork but just wanted to give remind you before you rush out.

Sample Sample Transition: *We've discussed in detail what to Cross-Check, the Red Flags to See It and then how to Say It, now we'll look at the final step, how to Fix It…..*<**click**>

Main Point(s):

1. **Introduce last step of cross-check and assertion.**
2. **Last session will focus on Fixing It now through Team decision making and Fixing the future through a debrief.**

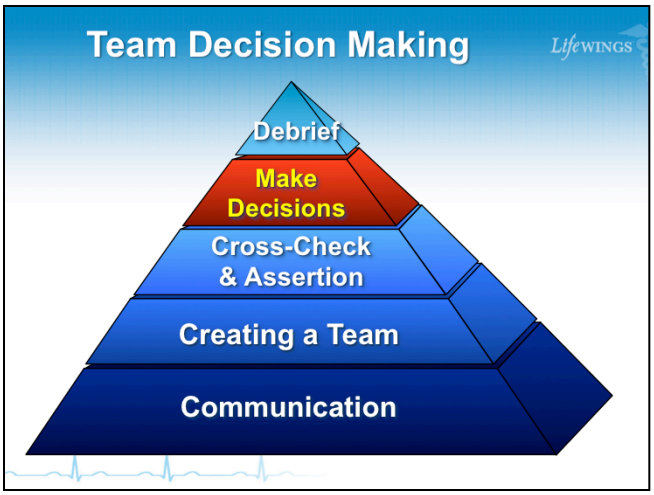
Time: 1 min

Sample "script"/Facilitation:

*…We've discussed in detail what to Cross-Check, the Red Flags to See It and then how to Say It, now we'll look at the final step, how to Fix It….***<click>…**

We've already discussed responding with a "thank you" and ensuring a decision is made to resolve the concern. Now we'll focus on Team Decision Making and Debriefing.

- *To arrive at the best decision to fix the now, the Team may have to problem solve together through a Team Decision Making process.*
- *To fix the future and improve our performance, the Team will need to Debrief to discuss what could have been done differently next time, as well as what done well and should be repeated.*
- **Sample Transition:** *Let's take a more in-depth look at Team Decision Making first….***<click>**



Main Point(s):

1. **Give brief introduction to Team Decision Making.**

Module Time: 10 - 15 minutes (depending on activities & videos)

When the student completes the module they will understand:

1. Pitfalls of Team Decision Making.

2. Leader's script for Team Decision Making process that ensures pitfalls are avoided: Say 2, Ask 2, Say 2.

3. Examples of Hardwired Safety Tools℠ for this skill.

Slide

Time: 30 seconds

Sample "script"/Facilitation:

…. Let's take a more in-depth look at team decision making.

Based on your experience in healthcare , who makes better decisions, an individual or a team? **Most will answer "a team."**

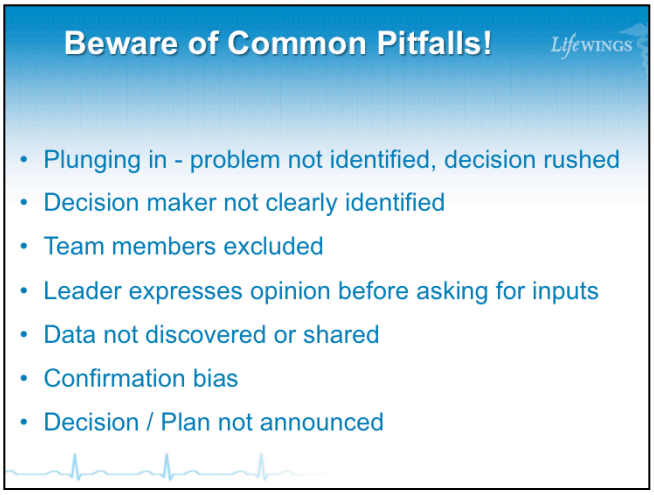
That's correct, On average, groups outperform individuals in making better critical decisions, as long as they have the time to do so, but those team decisions often are not as good as they could be because of common pitfalls.

Sample Transition: *Here is the list of those common pitfalls…***<click>**

Christensen C, Larson JR, Abbott A, Ardolino A, Franz T, Pfeiffer C. Decision making of clinical teams: Communication patterns and diagnostic error. *Medical Decision Making*. 2000 Jan 1;20(1):45-50.

Abstract

This study examined the discussion of information among mixed-status clinical teams while constructing differential diagnoses. Twenty-four ad hoc teams, each consisting of a resident, an intern, and a third-year medical student, were given two hypothetical patient cases to discuss and diagnose. Prior to discussion, team members individually viewed different versions of a videotaped interview with a "patient" (trained actor) Each videotape contained some information that was present in all three versions (shared information) and some that was present in only that version (unique information). In addition, half of the time, the cases were constructed so that the unique information that appeared in only one tape was crucial for a correct diagnosis (a "hidden profile" condition) After viewing the videotapes, team members met to discuss the case and develop a differential diagnosis. Discussions were videotaped and analyzed. Overall, shared information was mentioned more often than unique information ($p < 0.0001$). Furthermore, teams offered incorrect diagnoses significantly more often for hidden-profile cases than for control cases ($p < 0.01$). The teams' overreliance on previously shared information (inability to appropriately utilize unique information) was detrimental when a correct diagnosis demanded the inclusion of such information. Clinical discussions that require the consideration of uniquely held information may be susceptible to error. *Key words:* clinical teams; decision making; communication patterns; diagnostic error; information sharing. **(Med Decis Making 2000;20:45-50)**



Main Point(s): Time 1-2 minutes

1. **Show all pitfalls at once and have participants read through list and identify which they've experienced.**
2. **Ask them to identify which ones experience in their unit. Facilitate participant's inputs.**
3. **If they don't identify specifics or just say they experience all of them, highlight a couple relevant to audience (from site assessment) and discuss - do not go over every line.**

Time: 1-2 minutes

Facilitators: All pitfalls will come up at once.

Sample "script"/Facilitation:

…*here is the list of common pitfalls. Take a minute and read through these, and tell me if any of these look familiar to you. Which of these are frequently occurring in your unit?* **Give them some time to read through the list. You'll see their heads nodding. When it looks like they've read through, ask them which they identify with – which have they experienced before?**

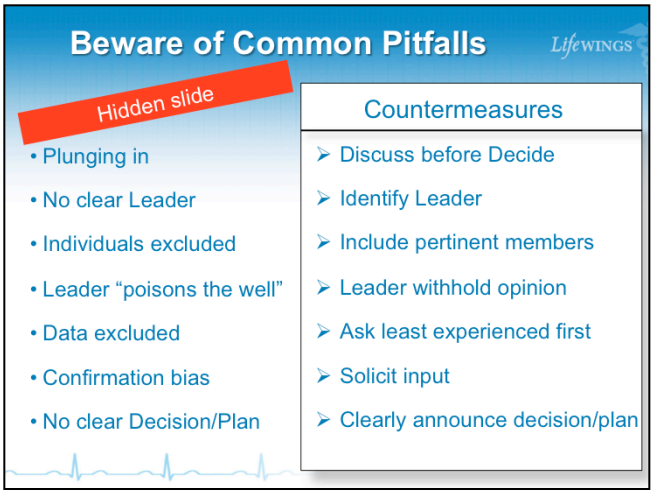
Facilitate their inputs - bring out specific examples.

Highlight or point out relevant pitfalls for your audience, or a pitfall you think needs further explanation. Do not go into great detail for every single pitfall. Highlight a pitfall that aligns with issues identified in the site assessment. For example, No clear decision or plan. It is common to these in an L&D unit – questionable strip, charge and bedside discuss but delay contacting the OB, or group gathers at central desk to discuss strip – often other staff and providers available will join in, a lot of discussion about what they think, often reasons why shouldn't worry, discussion is not organized and goes on for some time, finally individuals start to wander off, eventually everyone has departed and no decision has been made and/or announced to everyone. As LifeWings observer, ask what's the decision/plan – get answer from team members "Not sure." Even if the decision is to "wait 5 minutes, watch for specific tracings start prepping for C-section – meet back here in 5."

Sample Transition: *In order to avoid these pitfalls, follow a team decision making process designed around necessary countermeasures…***<click>**

More Information on the Pitfalls:

- **Plunging In - Problem is not clarified, decision is rushed. Leaders and/or Teams don't slow down enough to clarify what the situation is and take the time to use their team to gather data & brain-storm solutions. They make assumptions and can misidentify the problem and solutions. They jump to conclusions based upon some biases like what they have experienced most recently or which data they see first.**
- **Decision maker not clearly identified - Do you always know who is really the decision maker? There can't be any confusion about who is making the decision or confusion ensues - no one makes a decision, multiple decisions / directives are made that are likely to be conflicting and individuals don't know who to bring important data to. There are cases where there is confusion as to who is making the decision - I.e. Child died at Children's Hospital in Boston May 9, 2003 when providers and staff confused about who was really managing the case, for more information, see the article below: http://www.Boston.com/news/local/articles/2003/09/19/doctors_were_unsure_of_roles_as_boy_died_at_childrens/**
- **Team members excluded – lots of reasons why exclude individuals: not in immediate area, new, inexperienced, not personally liked, aren't even aware they have a role or pertinent information, etc.**
- **Leader "poisons the well"- leader expresses opinion first, then asks for input. as we saw in the number exercise earlier in class, what happened when the leader shouted out their opinion, like "6000" first? Exactly, the rest of team agrees - leader already has made up their mind, no sense in more discussion, information flow shuts down. Technique for explaining the bullet: Leader "poisons the well" –** *…The steering committee asked me to get your input on how to pronounce the capital of Kentucky. Now I think it's pronounced Louiville, some people think it might be Louisville. By a show of hands how many think you pronounce it Louisville. How many think you pronounce it Louiville? So our decision is Louiville. What was the problem with that?* **Wait for reply**. *The capital of Kentucky is Frankfurt…. What did I do? I "poisoned the well" giving you my opinion first, steered you towards my idea using my position, and solved the wrong problem!**
- **Data not discovered or shared - Which do you think teams are more likely to discuss when they come together, information that is common or known by all team members or "unique" information, information that is known by only one or a few individuals? Groups are twice as likely to discuss common information as they are to discuss unique information. That unique information could be that one missing piece of the puzzle that changes the whole problem / decision - may remain hidden to entire group unless individuals are willing and encouraged to bring all of their information forward. Important for leaders to play a facilitating role to encourage individuals to share all information. It is important that the process followed ensures all involved have a designated opportunity to bring their information forward. (Larson, et al, 1994) More Information on this study, explanation of remaining pitfalls and transition to next slide, are all on the next notes page.**
- **Confirmation Bias – Human nature is to search for data that confirms our initial intuition/solution and come up with very convincing reasons why the disconfirming data does not apply to our particular situation.**
- **Decision/Plan not made or announced - whether it is never made, or made, but team is not informed. Difficult, if not impossible, to carry out new decision if unaware of it in the first place or unaware of who does what to carry out the decision. Clear to see how this is detrimental to the team and patient. In these days of EMR integration, often an order is put in the EMR but never communicated to the nurse who will be executing the new orders. Orders sometimes put in different place than where used to seeing it, or nurse is overloaded, doesn't get to EMR for long time after. Even when doing multidisciplinary team rounds, not clear what the final decision for plan of care is – team confused – some assume one decision, others another, or have to wait till orders entered, delay in care. That's why many ICUs are including a standardized rounds "Recap" at the end of discussion for each patient.**

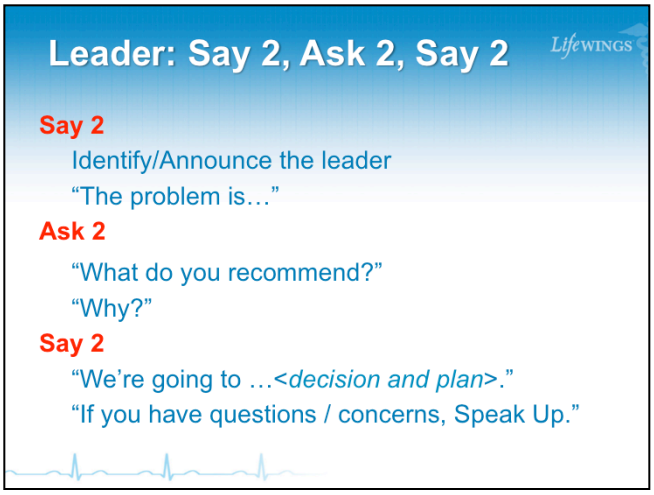


This slide is only here to provide background information to facilitators. Shows countermeasures to avoid each pitfall. Countermeasures are embedded in team decision making process led by leader in Say 2, Ask 2, Say 2.

Facilitators – this slide is for your background information only.

These are the countermeasures for each pitfall. The Team Decision Making process led by the leader as "Say 2, Ask 2, Say 2" was purposely designed according to these countermeasures.

Each of these pitfalls has a countermeasure…**<click> Right side list of countermeasures builds all at once. Highlight the most pertinent countermeasures for your audience – some of these are obvious, don't need to beat the dead horse. One that is key and may not be self-evident is "Ask least experienced first" Point this one out and ask,** *"Why is it beneficial to ask the least experienced first?"* **Take inputs.** *That's right, least experienced may have new, better idea than our usual way of doing things. Also, develop engaged team member - set expectation for them to be active part of team, we expect them to have critical thinking skills. If we always go to the most experienced, the inexperienced will always stay in that role – just the*



Main Point(s):

1. **Leader "Script" for Team Decision Making Process, to avoid pitfalls.**

Time: 1 minute

Sample "script"/Facilitation:
How do we avoid the pitfalls? By ensuring the leader follows a process that deliberately employs countermeasures for each of the known pitfalls. Leader should Say 2, Ask 2, Say 2. Team members also need to be aware of these steps and participate.

*First, **Say 2***
1. Identify leader - announce so all aware/no ambiguity, no doubt who to bring information & concerns to, and who will be making the decision. Then leader follows the rest of the script.
2. The problem is …." Be clear what problem team is solving together.

*Next, **Ask 2** – get input from all pertinent team members no matter their experience – key to the process. This is the group's opportunity for brain-storming the best solution. Leader – do not poison the well, save your ideas/thoughts until last. Ask least experienced first – Why? To promote input & critical thinking by inexperienced – grooming your future team members, and they may have new, better idea - "outside-the-box" innovation – different from what used to doing. May be more expeditious to ask most experienced first, but by the time get to least experienced – what will they say? Exactly what the others before them said.*
1. *"What do you receommend?*
2. *"Why?" – need logic / data behind recommendation to weigh it's value / make best decision.*

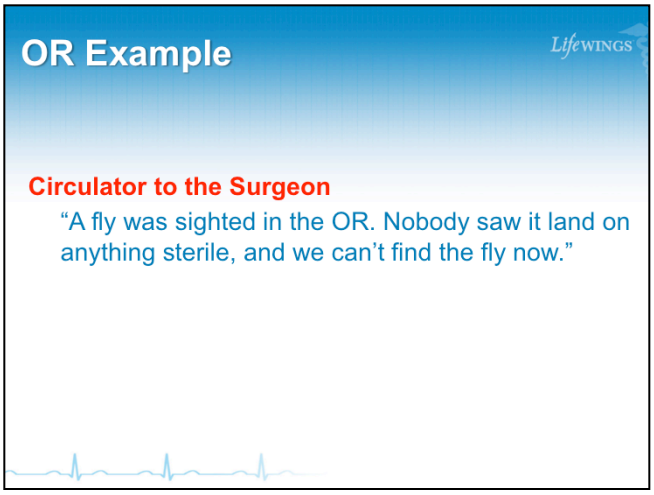
*Lastly, **Say 2***
1. *"We're going to…" Announce decision and plan with who's doing what – be specific, no ambiguity. Remember you are building new Shared Mental Model so consider this a briefing.*
2. *"If you have any questions / concerns, Speak Up" Just like with a team briefing, always invite participation through opportunity for questions and bringing concerns to leader immediately (Safety Statement).*

The Say 2, Ask 2, Say 2 process is on your toolkit card for quick reference.

If showing the series of slides with clinical example or the math problem for them to solve:
Sample Transition: *Let's apply the Say 2, Ask 2, Say 2 to a situation* **…<click>**

If showing video next:
Sample Transition: *Let's watch a video of a team making a decision***…<click>**

If short on time and going straight to Team Decision Making tool examples:
Sample Transition: *Let's apply the Say 2, Ask 2, Say 2 to this situation* **…<click>**



Optional series of slides – use this OR example or develop your own.

Main Point(s):

1. **These 4 slides are example of team problem solving process / leader script utilized in specific OR example – use as a demo.**
2. **Set up scenario – patient in the room, just prior to incision, Circulator tells surgeon about fly problem.**

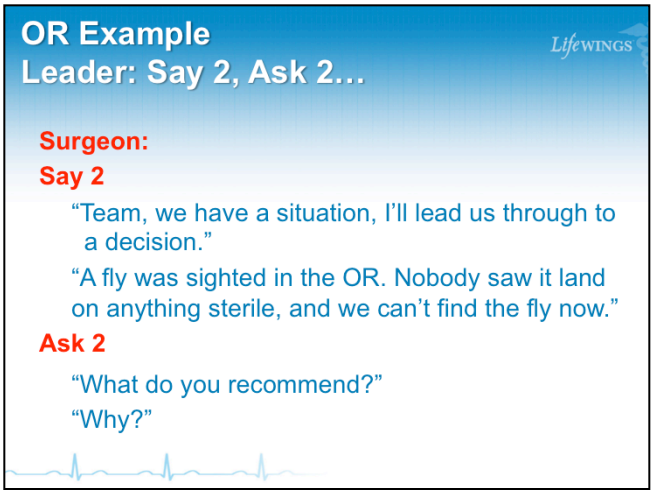
Time: 15 seconds

Sample "script"/Facilitation:

Set up scenario: *Patient in the room, just prior to incision, circulator says this to the surgeon.* **Read quote on slide.**

Another technique - set up that this is the Jane case, after solved latex problem, just prior to incision – now this comes up…

Sample Transition: *Let's apply the Say 2, Ask 2, Say 2 to this situation* **…<click>**



Main Point(s):

1. **Surgeon Says 2: "I'm leading the discussion, here's the problem…"**
2. **Surgeon Asks 2: "What do you recommend and Why?" - asks least experienced first.**

Time: 15 seconds

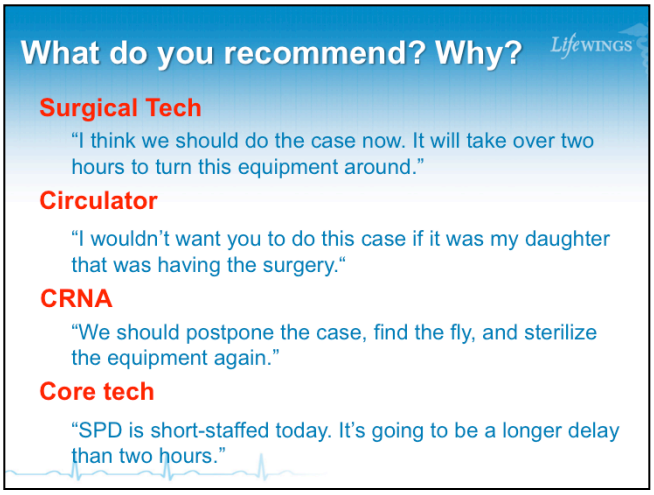
Sample "script"/Facilitation:

Surgeon Says 2 – **read the script on slide.**

Surgeon then Ask 2 – asking the least experienced first. – What do you recommend & why?

(if have time, can ask class what they would recommend, take inputs from class)

Sample Transition: *Here is how the team members respond…*<**click**>



Main Point(s):

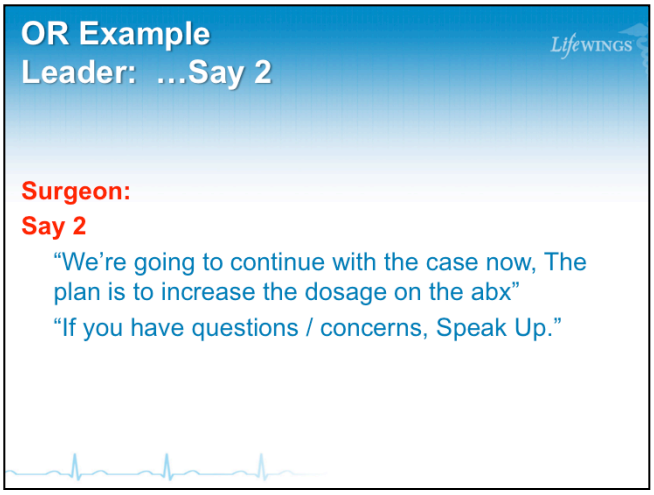
1. **Team members recommendations with the why.**

Time: 30 seconds

Sample "script"/Facilitation:

Here's the responses from the team members – given in order of least to most experienced. They offer a recommendation with their Why. **Read the recommendations or have them read.**

Sample Transition: *Now the surgeon makes a decision and Says 2 to the team…***<click>**



Main Point(s):

1. **Surgeon Says 2: Decision with plan and if any concerns, speak up.**

Time: 30 seconds

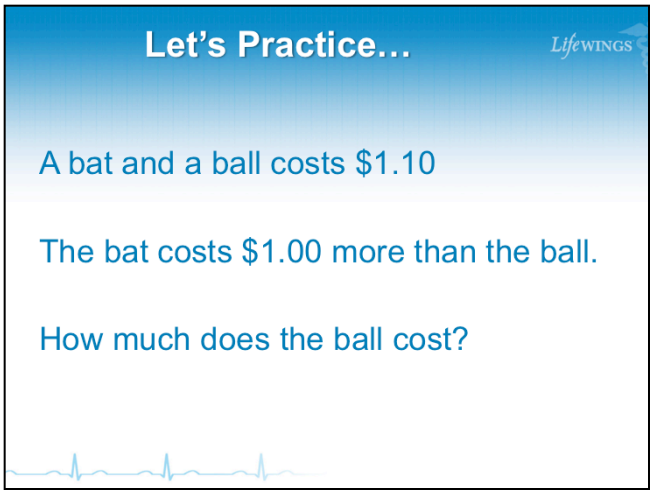
Sample "script"/Facilitation:

Read from the slide what the surgeon says.

What do you think? Which information from the team members helped the surgeon make this decision? Did the surgeon avoid the pitfalls by following this process?

(take inputs from class)

Sample Transition: …<click>



Main Point(s):

1. **Short group exercise to practice team decision making process.**
2. **Simple problem with a catch – proves how faulty intuition / rushing to self decision can be less effective.**
3. **More heads are better than one – if go through organized process designed to avoid pitfalls to make informed & better informed team decision.**

Time: 5 minutes or less

Sample "script"/Facilitation:

Break up into your table groups and solve this problem using the Say 2, Ask 2, Say 2. Don't skip any steps. Give them 2 minutes to solve the problem as a team.

*What was your individual intuitive reaction to the answer? $***1**

*What is the correct answer? $***1.05 The key is $1 *MORE*.**

When we act alone, we many times make bad decisions because we are overconfident in our intuition. Having a group discussion can help avoid the pitfalls.

Don't be too hard on yourself if you got this wrong initially. Over 50% of Harvard students get this wrong. 80% of all university students get it wrong.

(http://www.businessinsider.com/question-that-harvard-students-get-wrong-2012-12)

Even if they don't exactly follow the Say 2, Ask 2, Say 2 format, getting everyone in the group to give his/her opinion is how we effectively come to the correct answer / decision.

The key to solving this puzzle is "the bat is a $1.00 more," not "the bat is $1.00" – easy to jump to conclusion, follow intuition, unless listen to that one (or more) team member who might see things differently. Group discussion before jumping to a conclusion will bring out "Thinking outside the box, or thinking logically through problem with more input, rather than just relying on self intuition.

BTW, if you want the actual mathematical equation that solves the riddle (as opposed to trial-and-error), here it is:

X + Y = 1.10

X + (X+1) = 1.10

2X + 1 = 1.10

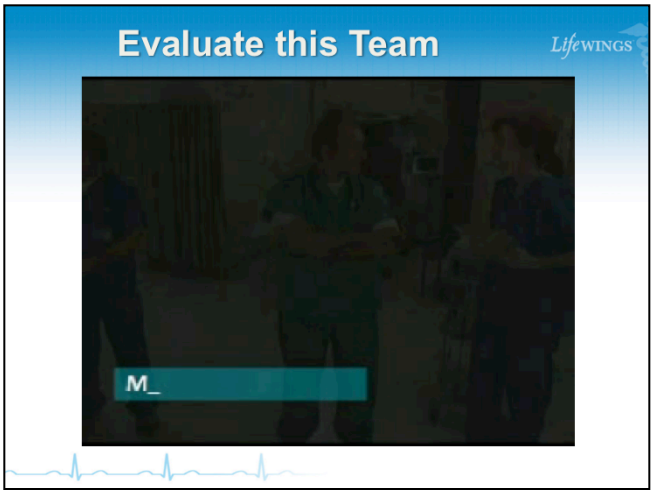
2X = 1.10 - 1 = .10

X = .05

Y = 1.05

If showing video next:
Sample Sample Transition: *Let's watch a video of a team applying team decision making in healthcare…***<click>**

If going straight to Team Decision Making tool examples:
Sample Transition: *Here are a few examples of tools customizing Team decision making* **…<click>**



Optional Slide: Video of ED team decision making.

Main Point(s):

1. **Always introduce a video with: What they will see (short setup of situation) and what to look for (What went well? & What can be improved?).**
2. **Debrief the video: What did they do well? What can be improved?**

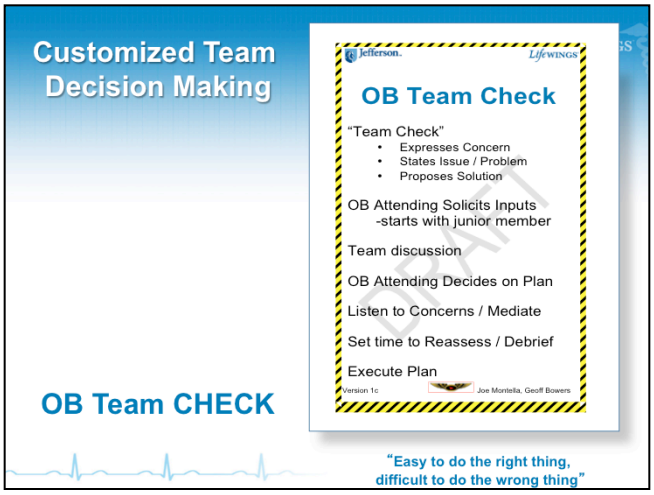
Time: 1 minute

Sample "script"/Facilitation:
Let's watch a team meeting for Team decision making in an ED. They are discussing a patient suspected of having a heart attack.
Look for what they do well and what they can improve, and what information might they have missed if they did not discuss this patient as a team? **…<click> to play video.**

When video stops – *What did they do well? What can they improve?* **(they did not use the script!).**
What information might they have missed if they did not discuss the situation as a team? Hypotensive.

(take inputs from class)

Sample Transition: *Here are a few examples of tools customizing Team decision making* **…<click>**



Optional Slide: OB Team Check
Main Point(s):

1. **Show examples of customized team decision making.**
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 an OB Team Check – when OB patient problem arises, OB Team Check called. They follow this process.

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>**

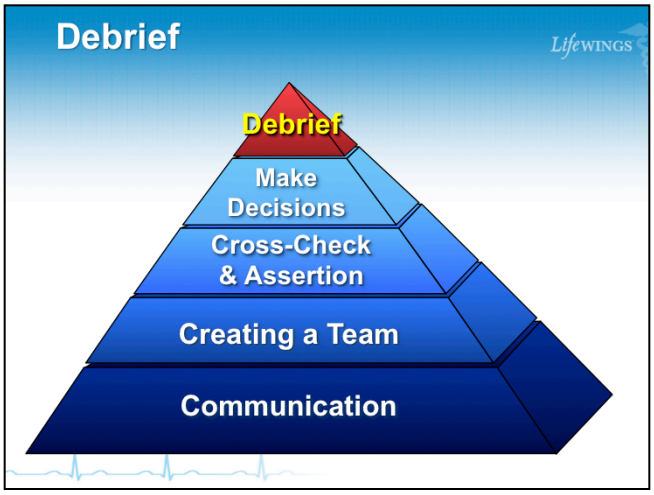
Main Point(s):

1. **Ask specifically "What questions do you have…."**
2. **Take questions.**

Time: 30 seconds or longer depending on questions asked.

Sample "script"/Facilitation:

What questions do you have about team decision making? **…<click>**



Main Point(s):

1. **Give Brief introduction of "Debrief."**

Module Time: 15 minutes

When student completes the module they will understand:

- **Why it is important to Debrief.**
- **The "FAST" guidelines to properly and effectively conduct a Debrief (Focus on Performance, All Team Members Included, Solicit Specifics, and Timely).**
- **Examples of Hardwired Safety Tools℠ for this skill.**

Slide

Time: 30 seconds

Sample "script"/Facilitation:

The last skill we will discuss today iis the team debrief. A debrief is simply a short discussion at the completion of an event, procedure or shift to discuss and review the team's performance.

How many times have we debriefed during this class today? That's right, several times we practiced What went well? And What can be improved?

Sample Transition: *Why debrief back in your unit?…***<click>**

Technique: Ask if anyone commonly conducts a debrief (getting more and more classes where at least one or two are familiar with this and can share their experience - good way to gain buy-in). Ask them when it occurs?, what is discussed?, do they like it? - why or why not?, etc.). Some may mention M&M's but keep in mind that those are generally lengthy and rarely include team members other than physicians.

Main Point(s):

1. **Gain Buy-in to conducting debriefs - explain what they will gain & what the future patient or situation will gain, if they take the few minutes to debrief.**

Time: 1 minute

Sample "script"/Facilitation:

…why debrief? **(Facilitate answers from class - take responses.)**

A debrief is necessary because it **…<click>**

..Defuses conflicts arising from differences in expectation. Done effectively, a debrief will analyze the different expectations that caused the conflict and determine alternate courses of action that can prevent the conflict in the future.

It also provides closure on an event (I.e. patient death) so the team members can focus their attention at their new task at hand (taking care of other patients).

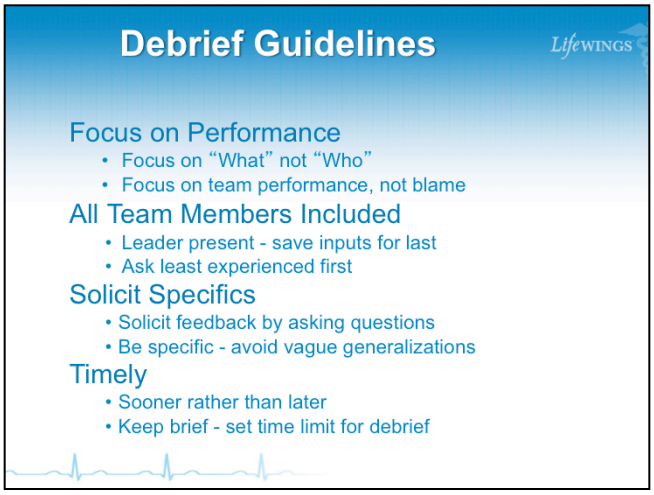
The debrief is opportunity for system the to learn and evolve - beyond your team, lessons learned can be shared with many others to fix the system itself.

When done right, a debrief will help prevent the same problem or error from happening next time.

Lastly, and most importantly, a debrief will improve the team's performance next time, directly impacting patient safety and quality of care.

The pre-brief is about the actions necessary for the current patient or event, the debrief is the desired actions for the next patient or next event.

Sample Transition: *In order to debrief effectively.* **…<click>**



Main Point(s):

1. **Follow "FAST" Guidelines when debriefing to be brief but effective.**
   - **Focus on team performance. Not a blaming session – it's about What not Who.**
   - **All included – Leader holds opinion till last, ask least experienced first.**
   - **Solicit Specifics – not just "We'll do better," but how specifically.**
   - **Timely – sooner rather than later & keep it brief.**

Time: 1 - 2 minutes

Sample "script"/Facilitation: (do not go into great detail on all points – choose which particularly relevant to unit.)

…there are key guidleines to follow. In aviation, we also don't have a lot of extra time but we have found if we followed.. **<click>***… the "FAST" Debriefing Guidelines to make effective in*

First, the debrief must remain focused on improving performance and fixing problems, rather than a finger pointing session determining who is to blame. Remember to focus on what the team can do to improve, not who is to blame.

All team members must be included if at all possible. What message is sent if the leader is not present? .. Or team members not included? Debrief is not important.

For the same reasons discussed in decision making, it is critical that the leader withhold feedback until inputs gathered from team, and the least experienced should be solicited first.

Solicit Specifics - Ask questions of team members to solicit specific performance improvements. Inputs need to be specific enough to be repeatable behaviors - just as we required of you in the team skills exercise this morning. There is a tendency for individuals to give vague answers - why? Fear of being put on the spot and giving the wrong answer - they hope the vague answer will cover it all!

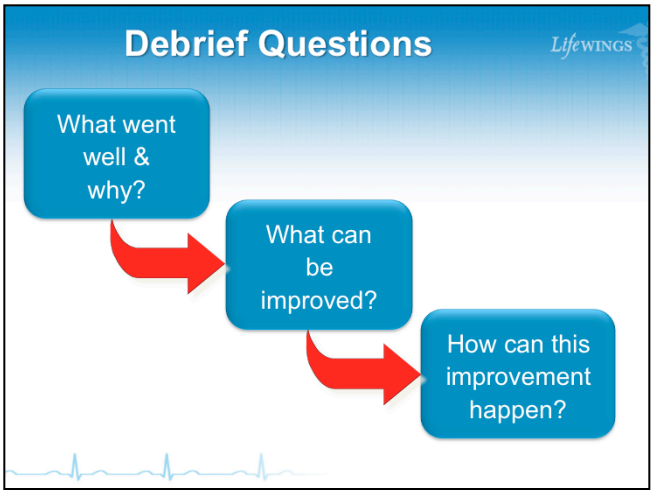
For example if you asked an individual "what could be done better next time to ensure the team was aware of the the latex allergy?" The individual may answer "We need to say something." or "We need to communicate." Can you be sure that next time a red flag appears the team members will speak up effectively; that they will say the right words? What could you ask instead to solicit a specific response? How about "Specifically, what could be said next time to ensure we are all aware of the latex allergy? Now the individual's feedback would be exactly the words that they would say. The team may have to tweak the words but now the feedback becomes a repeatable behavior that increases the likelihood that the correct words will be said next time.

It is up to the leader to ensure the inputs are specific. Eventually, as you refine their inputs to be specific your team members will realize it is expected of them and begin to immediately respond with specifics.

Timely - Debrief as soon as possible after the event. Why? So specifics are fresh in their minds and they can remember events clearly. Provides closure on events as soon as possible so individuals can now focus on the new tasks at hand. Also can be difficult to find time when all can be together again. But if have to meet at a later time, write notes on what you want to discuss or you are likely to forget. What if have to postpone it? Team members need to write down their thoughts they want to debrief so can remember later. By timely, we also are referring to the need to set a time limit on the debrief and stick to it as much as possible – Keep it BRIEF!. What if some issues aren't resolved? Schedule time to reconvene or a method to discuss it further, perhaps by email.

Follow the FAST guidelines to keep your debriefings on track!

Sample Transition: *How does a leader ensure all these principles are followed?…***<click>**



Main Point(s):

1. **Offer three questions commonly used by our healthcare clients to conduct an effective debrief.**
2. **Departments can adopt / change as they see appropriate. Questions give them a place to start and practice with today.**

Time: 30 seconds

Sample "script"/Facilitation:

… by using standardized, predetermined questions to conduct the debrief.

Three questions commonly used in healthcare debriefs are:

First, <u>What went well and why?</u> Why would you want to discuss the positives? (take responses) Yes, positive reinforcement to ensure they understand something was a good thing and they need to repeat it.

The "why" is asked to determine exactly why something went well so it can be broken down into repeatable actions, and perhaps passed on to other teams as a good technique for a given situation.

It is also good to not just focus on problems - individuals are then more willing to participate in the debrief!

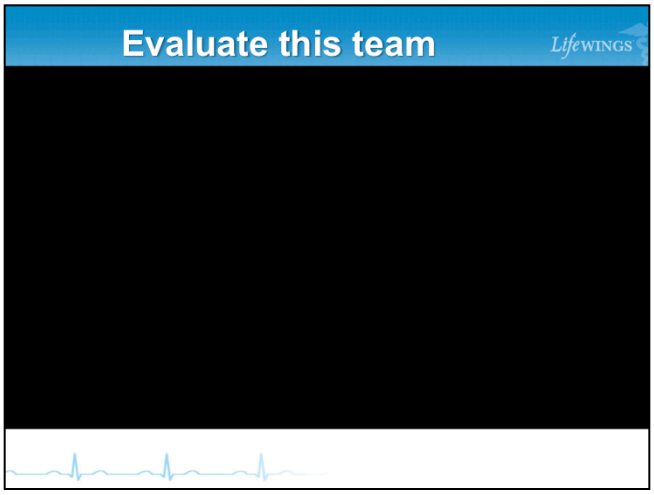
Next ask, <click> <u>What can be improved?</u> Identify specifically <u>what</u> the problems were (not who!)

And finally, <click> <u>How can this improvement happen?</u> What can be done differently next time to improve performance and therefore, improve patient care. This may include assigning an individual to follow-up or contact someone else who has the authority to fix a particular problem - I.e. sterile processing issue or supply issue, etc.

What specific questions will you use in your unit's debriefs? It depends on what works best for your situations. Departments can adopt / change as they see appropriate. These questions give you a place to start and practice with today.

What questions do you have about the FAST guidelines or these three questions?

Sample Transition: *Now, let's watch a team put these concepts into practice….<click>*



Optional Slide: Surgical Team Debriefing

Main Point(s):

1. **Always introduce a video with: What they will see (short setup of situation) and what to look for. (What went well? & What can be improved?)**
2. **Debrief the video: What did they do well? What can be improved?**

Time: 1 minute

Sample "script"/Facilitation:

…let's watch this team debrief…**<click> to play movie.**

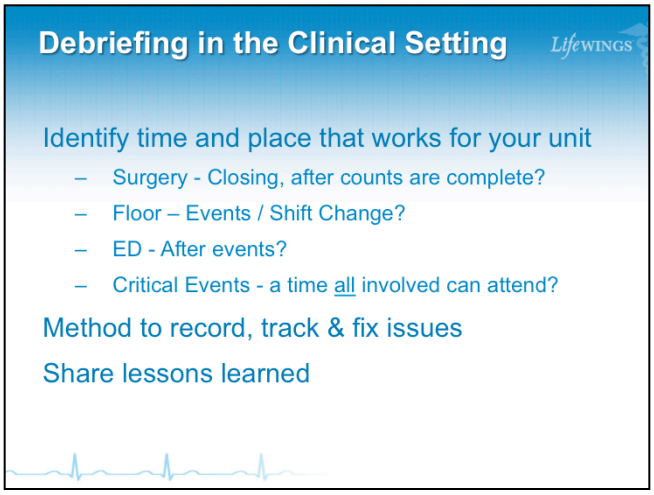
When movie is complete:

Let's debrief this team's performance in their debrief:

What went well?

What can be improved? How or What can they do/say specifically to improve?

Sample Transition: *How do you hardwire a debriefing into your daily processes in your clinical setting?…* ***<click>***



Main Point(s):

Key points to remember when debriefing in the clinical setting:

1. **Identify a time that works for your unit.**
2. **Method to record trends - so management can record & address.**
3. **Method to share lessons learned with others in the unit.**

Time: Time: 30 seconds

Sample "script"/Facilitation:

…in your clinical setting.

First, Identify a standard time and place that works for your unit

Times to consider:

Surgery - Closing - after counts are complete?

Floor - Prior to Shift change? Weekly?

ED - After events?

Critical Events - a time all involved can attend?

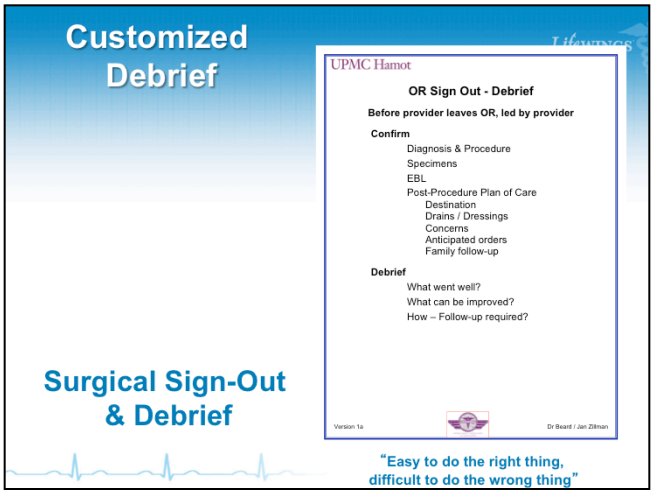
Be prepared to get some pushback for those who have awake patients. Facilitator can respond by acknowledging that is a common issue, ask for ideas of what can be done – how to still benefit from a debrief? Can also offer what others have done – some include the patient by asking them what went well, what can be improved. For topics that you do not want to discuss in front of patient can use a brevity code word/phrase that signals need to meet at a particular location after patient handed off. Example is Missouri University Medical Center uses phrase "I have a tiger note." Tiger is their mascot. That phrase is not something that alerts the patient.

Some may also be concerned about protection of discussion from litigation – that is a question for their risk management office. Most states do have protection for information / processes falling under the identification of Quality Improvement. Leadership will be looking into that.

Next, ensure there is a Method & Process to record, track & fix trends, and share lessons learned with others so

In the past we often pass or report our problems verbally as we see our manager or leader on the floor. But when we're done talking to them, they walk a couple more steps and someone else tells them their issues. By the time they get back to their office, what happens with that information? Easy to lose track of it. This is the one time we see the need for additional paperwork, or a simple method to record debrief finding on the computer. A process to ensure the issue is recorded, goes to the responsible individual for tracking, addressing and providing feedback to the person/group who reported it.

Sample Transition: *Let's look at customized Debriefing Tools…***<click>**



Optional Slide: OR Sign-Out with Debriefing embedded.

Main Point(s):

1. **Show other examples of Tools that use the team skills with a standard checklist format.**
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:

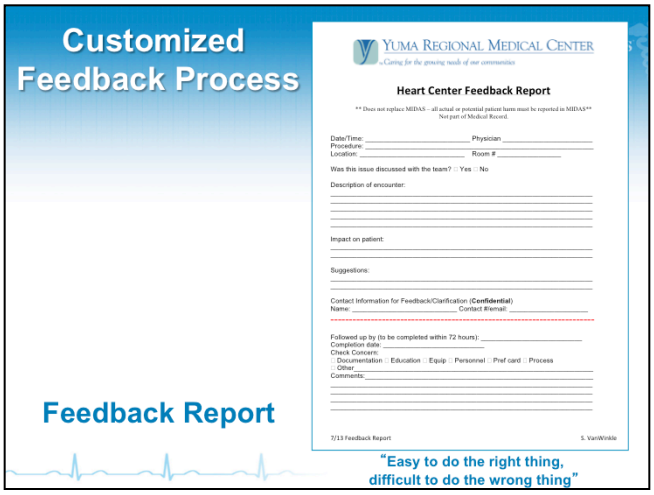
This OR group developed embedded their Debriefing right into their Sign-Out. Their Sign-Out is their discussion at the end of a procedure where they discuss and verify critical information about the patient's care. Then they follow right into the Debrief. They conduct their discussion before the surgeon departs the room. Many time they start their discussion right after final counts are completed, as the surgeon is finishing up the closing. Surgeon leads the discussion.

This is posted on the wall in all ORs large enough for all in the room to read and follow along with.

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 Debriefing? ...***<click>**



Optional Slide: Heart Center Feedback Report
Main Point(s):

1. **Show other examples of Tools that show method to get debrief issues / any problem noted to the management / leadership.**
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 an example of a feedback form. Can be used no matter how issue identified, by team in the debrief or an individual. The completed form goes to an identified manager who records, tracks, identifies trends, either addresses the issue or takes to someone in leadership who can, and then finally provides feedback to the individual or group that reported the issue.

Spend a little time explaining why need for recording feedback, what management does with this, portion at bottom where you can request follow-up on what is being done to address issue, etc.

Sample Transition: *What questions do you have about Debriefing?* **…<click>**

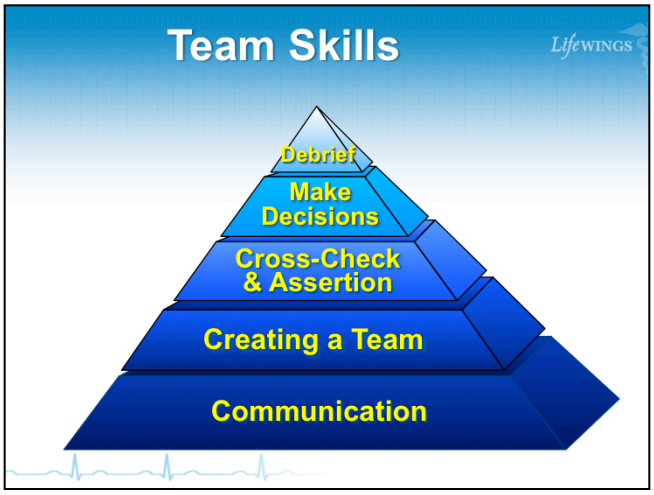
Main Point(s):

1. **Ask specifically "What questions do you have…."**
2. **Take questions.**

Time: 30 seconds or longer depending on questions asked.

Sample "script"/Facilitation:

What questions do you have about Debriefing? **…<click>**



Main Point(s):

1. **We have covered all of these skills today and provided "How to's" for each.**

Module

Time: 15-20 Minutes (including wrap-up slides)

When students complete the module they will understand:

- **Use of skills and HST (checklist) will improve performance – 2nd number exercise.**
- **What must occur for Checklists to really work.**
- **What's next in their unit's TeamSTEPPS project – Hardwired Safety Tools℠ workshop.**
- **Their role in the development and implementation of the skills / Tools.**
- **Their unit patient safety and team challenges and possible Hardwired Safety Tools℠ to consider developing / implementing - list from team exercise will be collected.**

Time: 15 seconds

Sample "script"/Facilitation:

We have covered **…<click>** *all of these skills today and provide "How To's" for each.*

Sample Transition: *Now we're going to have you put all of them into practice as a team…***<click>**

Main Point(s):

1. **Set up teams for 2nd attempt at number exercise - this time they will choose a leader and then brief using checklist on next page.**

Time: 2 minutes

Sample "script"/Facilitation:

…Remember the number exercise this morning? We finally get a chance to do it a gain. This time, we are going to put the team skills into practice in order to remedy the issues you experienced the first time.

Teams, you will again be shown a series of numbers and your task is to add up the numbers as a team and determine the total sum. Your patient's life depends on the accuracy of your answer. Same rules as before, no pens, pencils, pda's, cell phones, calculators, etc.

IF they did not identify a leader yet: *First, we want you to identify a leader. Take 1 minute to do that - your leader will be the individual at your table who has the most number of years of experience in healthcare.* **Give them one minute and then ask leaders to identify themselves.**

If they have already identified a leader: *Your leader will be the same from the last exercise.*

Sample Transition: *Leaders, I want you to brief your team following this briefing checklist. ….**<click>***

Main Point(s):

1. **You are setting them up to SUCCEED!**
2. **Have them Brief by following this checklist to experience the difference it makes in creating an effective team and how it changes their outcomes.**

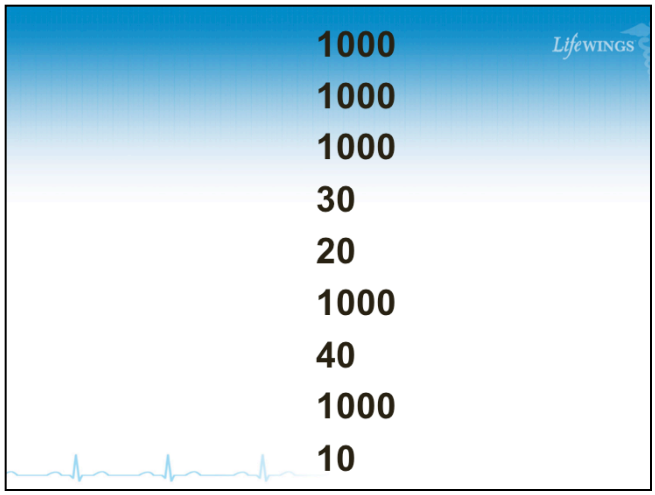
Time: 1 minute

Sample "script"/Facilitation:

Leaders, brief your team following this briefing checklist. This checklist has best practices – follow them. Don't skip any steps. Leaders take 1 minute to brief your team.

After one minute: *Leaders give me a thumbs up if you have completed the briefing checklist. Are there any special instructions for me?* **Expect they will tell you to stand still off to the side and be quiet.**

Sample Transition: *Okay, here comes your patient / the numbers again…***<click>**



Facilitators remember:

- **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.**
- **DO NOT cause distraction – stay still, off to side and be quiet.**
- **Before class, you must check timing of auto build of numbers on your computer and adjust if necessary since may change with different versions of PowerPoint.**

PROCEDURE: Before class 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 number exercise.

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

DO NOT distract your audience – stand off to the side, stay put and keep quiet.

When last number builds, next slide will automatically build.

Main Point(s):

1. **Give the leaders time to talk with their team – Remember, you want them to get it correct this time so do not rush them.**
2. **Get teams' answers for the second # team challenge.**

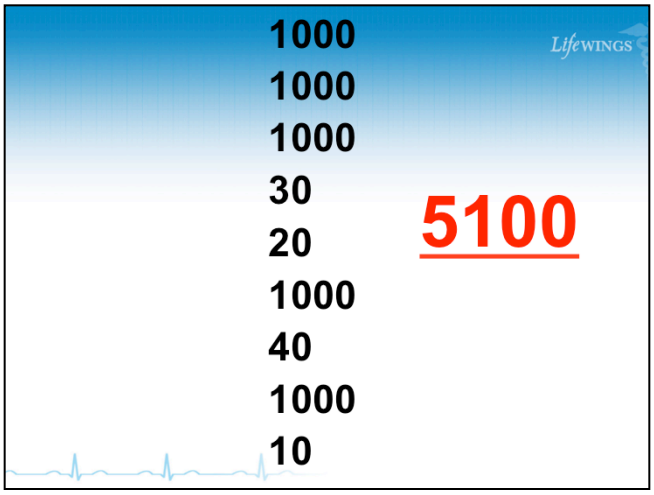
Time: 1 minute

Sample "script"/Facilitation:

Give the leaders time to discuss with their team so they get the right answer. Then get the results from each team leaders…most will get the right answer this time. Ask them how sure they are with their results. Most will be quite sure this time.

If you still get one or a few wrong answers– don't dwell on it. Just take their answer and move on to the next group. Then after the debrief on the next slide you can com back to them and ask them if they discovered what went wrong – most often it's because they did not use the checklist / best practice division of numbers. Instead they decided to do it their own way, e.g.. They tell first team member to take the first number, 2nd team member takes the next number, 3rd team member takes the next number and so on – gets very confusing and definitely not best practice.

Sample Transition: *As most of you said, the answer is…* **…<click>**



Main Point(s):

1. **Show audience the correct answer.**
2. **Settle any remaining covert disagreements from participants who may still insist it's 6000.**

Time: 1 minute

Sample "script"/Facilitation:

Do the math verbally - I.e. *"1000, 2000, 3000, 3030, 3050, 4050, 4090, 5,090 plus 10 is?"* **or do the math the way the checklist called for (count all the 1000s, then the 10s:** *"5 1000s is 5000. 30 + 20 is 50, plus 40 is 90 plus 10 is 100, for a total of what?"* **And they will all answer "5,100"as you click, show and say,** *"5100"*.

The common mistake the first time is to add the last ten and jump up a thousand to 6000.

Facilitators: Often, if you don't add up the numbers and explain the common mistake,, some individuals will still be stuck on trying to figure out what they did wrong and sidebar discussions are likely to occur or you may lose some individual's attention.

Technique her or after the debrief of this exercise on next slide: If anyone got the wrong answer, ask them how they arrived at their answer (look for a weakness in their teamwork, or team building, or communication - skipping a checklist item, not thoroughly covering an item, getting too complex with their plan, or not listening to concerns) See if anyone on that team did have the correct answer, and ask why the team leader didn't use that number - did they speak up, etc..

Bottom line; More, if not all, got the right answer this time.

Sample Transition: *What led us to these significantly Improved outcomes for your team and your patient?…* **<click>**

Main Point(s):

1. **Debrief each bullet/skill - focus questions to emphasize that their success on this attempt was primarily due to their use of the Briefing checklist with the team skills built in.**

Time: 1-2 minutes

Sample "script"/Facilitation:

Let's conduct another debrief to find out specifically what we learned about working together as a team.

*…***<click>***Communication. What was different this time about your communication? Why?*

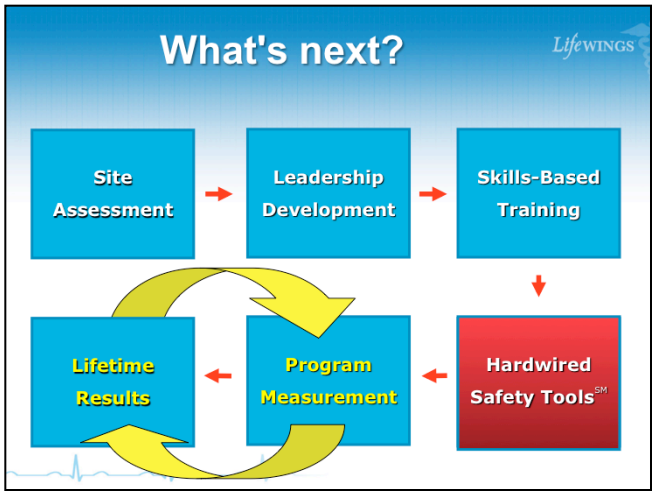
*…***<click>***Team management: How did you use your team more effectively this time? Did you use the team skills we just covered? What ensured you used those team skills?*

*…***<click>***Recognizing Warning Signs / Adverse Situations: Teams, did you discuss any possible problems or concerns during your briefing - what were they? Did it help your accomplish the task with less errors?*

*…***<click>***Decision making: Leaders, how did you go about making your decision this time - as an individual or using your team' inputs? With the way the roles were divided, you had to take inputs from your team to even come up with the answer.*

*…***<click>***Debriefing. Did our debrief from the first number exercise improve your performance? What ensured you carried through on those lessons learned? If we did this exercise again, we would get event better and more efficient.*

Sample Transition: *Congratulations! You just demonstrated and experienced first-hand how a Hardwired Safety Tool ensure the skills are used and improves performance and outcomes …***<click>**



Main Point(s):

1. **Discuss what's next after all attend the four hour skills training class – The Hardwired Safety Tools Workshop.**

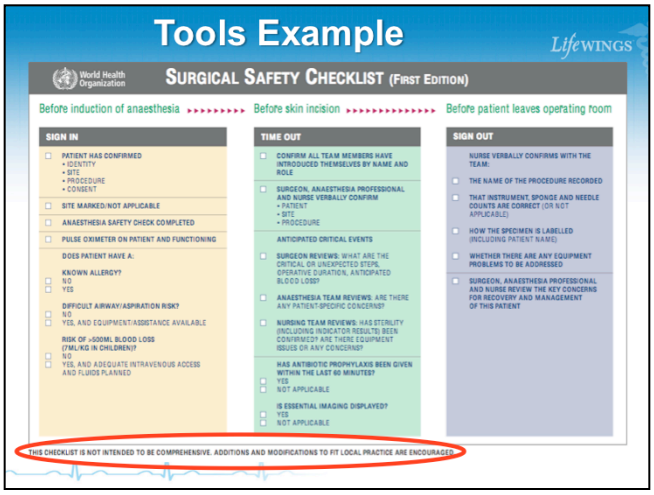
Slide

Time: 30 seconds

Sample "script"/Facilitation:

Hardwired Safety Tools is the next phase of your unit's TeamSTEPPS program. It is literally the cornerstone of the program. **….<click> To highlight the Hardwired Safety Tools℠ block in red.**

Sample Transition: *In this phase, frontline staff will develop and implement Hardwired Safety Tools* ***….<click>***



Main Point(s):

1. **This is the World Health Organization's Surgical Safety Checklist, includes Sign-in, Time-out, and Sign-out.**
2. **Checklist designed to be a verbal interactive team verification of the checklist items.**
3. **Never intended to be adopted exactly as they designed it – idea was to customize it to your unit.**

Time: 30 seconds

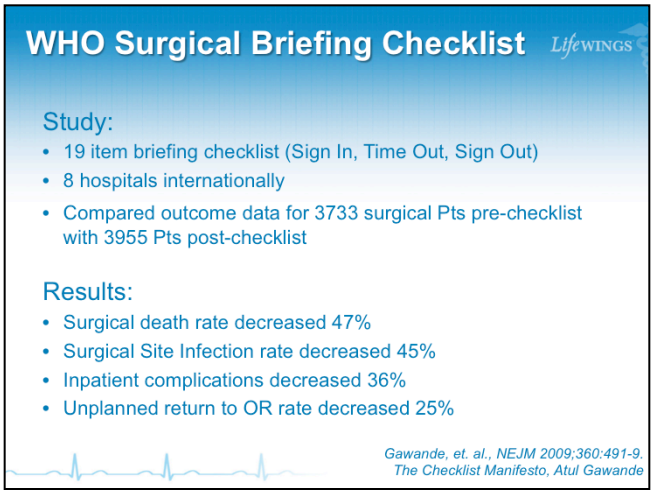
Sample "script"/Facilitation:

In this phase, frontline staff will develop and implement Hardwired Safety Tools like this one.

This is the World Health Organization's Surgical Team Checklist that includes a Sign-in just before anesthesia, a Time-Out just prior to the incision, and a Sign-Out just prior to the patient leaving the room.

Those that built this checklist never intended the checklist be adopted exactly as originally designed. **<click>** *They included this footnote –" This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged."*

Sample Transition: *When this checklist was implemented in 8 hospitals worldwide...* **<click>**



Main Point(s):

1. **Details of WHO Checklist origins and related study - give them a brief overview of study and results:** *This 19-point briefing checklist was implemented at 8 hospitals (mix of diverse cultures and economies) worldwide to reduce surgical errors. After only 3 months of use, the data showed reduction in surgical deaths by 47%, complications 36%, infection 45%, and unplanned return to OR by 25%.*

Time: 30 seconds

Sample "script"/Facilitation:

When this checklist was implemented in 8 economically and culturally diverse hospitals worldwide, they found by simply by stopping as a team at key points and verifying critical items and discussing the case, before proceeding, they were able to significantly improve patient surgical outcomes.

<click>

After only 3 months of use, the data showed Surgical deaths decreased by 47%, complications decreased by 36%, infection decreased by 45% and unplanned return to OR decreased by 25%.

Sample Transition: *Beyond the data, what did those who used the checklist have to say about it? …* **<click>**

"A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population"
N Engl J Med 2009;360:491-9.

Dr. Gawande and others were recruited by WHO to brainstorm a solution worldwide to decrease surgical complications/ deaths. Needed solution to be cheap / simple and apply to poor and rich countries / environments Thought about how simple act of providing soap to those in Indian Slums significantly reduced infections/deaths. Came up with checklist. Even Dr. Gawande himself was skeptical – couldn't imagine this would make a difference. Dr. Gawande concluded that more than anything difference came from just getting team members to talk to each other. Highly suggest you read his experience with this checklist in his book, "Checklist Manifesto." An easy, quick, and enjoyable read.

WHO Safe Surgery Saves Lives Study Group

Methods

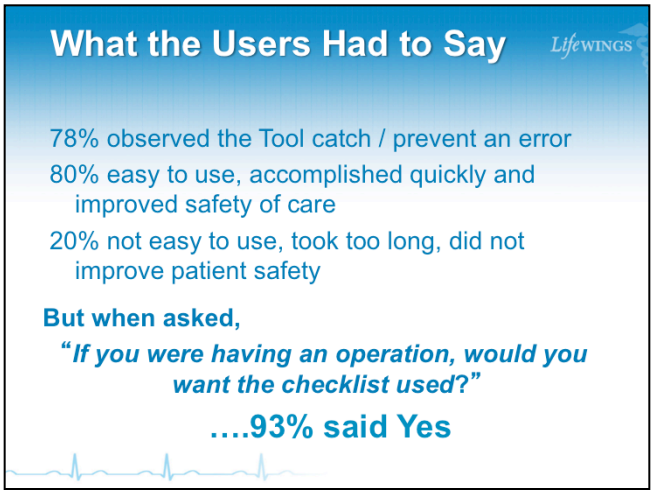
Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ifakara, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization's Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3733 consecutively enrolled patients 16 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 3955 consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including death, during hospitalization within the first 30 days after the operation.

Results

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P = 0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).

Conclusions

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.



Main Point(s):

1. **Overall, positive reaction from users.**
2. **Even the majority of 20% who initially said checklist not easy, took too long, and did not improve patient safety, wanted the checklist used if it was their own surgery.**

Time: 30 seconds

Sample "script"/Facilitation:

What did the front line users (physicians, nurses, and techs) have to say about the checklist? **… <click>**

78% observed the Tool catching and preventing an error,

80% thought easy to use, did not take too long and improved patient safety,

but 20% disagreed, they though it was not easy to use, took too long and did not improve patient, however, **… <click>**

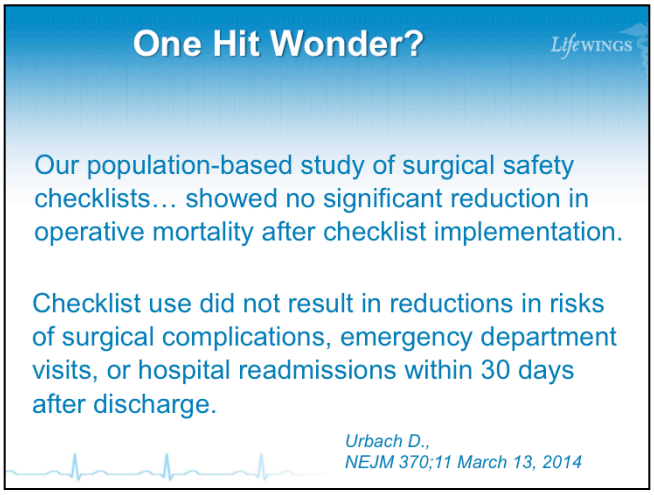
*When asked if they were having an operation, would they want the checklist used? What would be your answer?…***<click>**

93% of the users said Yes! *What does this really mean? Some believe they don't make mistakes themselves so checklist is unnecessary, but they believe others make mistakes so need the checklist, especially if operating on them. A bit of hypocrisy shines through here!*

Sample Transition: *Since this checklist was introduced in 2009, many ORs have adopted this checklist….* **<click>**

Note: What about the claim that results can be attributed to Hawthorne Effect - if observer is present, team will provide better care and improve outcomes? The researchers considered this. First, observers were in only about 20% of the cases, cases that were both before and after the checklist. They also compared the results of the cases without an observer with those with an observer and found no difference between the two. The difference in outcomes only became apparent when the checklist was introduced and used.

It is also important to note that the rollout of this Tool included the leadership stepping forward first and physically meeting with physicians and staff to layout the policy that they were required to use the checklist. Then they conducted training to ensure everyone clearly understood and demonstrated ability to perform the team checklist as designed/ intended.



Main Point(s):

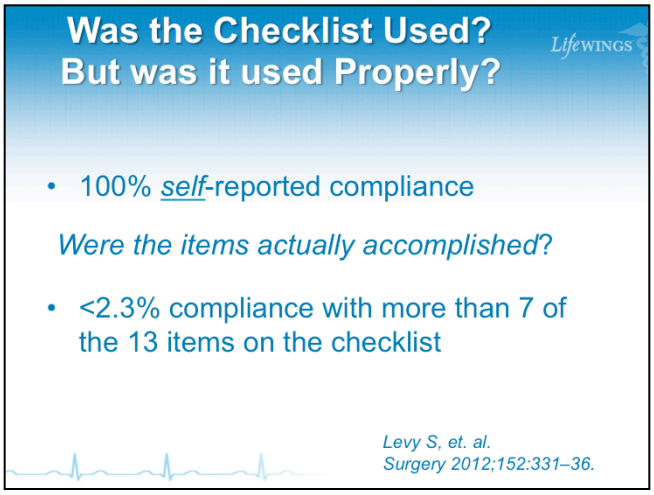
1. **The success of checklists In healthcare is extremely variable, some organizations have had great results but in some places there was no impact.**

Time: 30 seconds

Sample "script"/Facilitation:

….many ORs have adopted this checklist, but a study in 2014 did not find similar results to the initial study. They did not find a significant reduction operative mortality or reductions in complications.

Sample Transition: *Another study then looked at those same hospitals using the checklist and asked….*
<click>



Main Point(s):

1. **Checklists have been adopted and self-reported to be used, but in most cases are not used properly / in compliance.**

Time: 30 seconds

Sample "script"/Facilitation:

Another study then looked at 142 cases in organizations that had implemented the checklist and first asked was the checklist used?

They found 100% self reported compliance. Self-reported? Not very accurate way to record compliance. So there is a question of whether the checklist is really used.

Then the study asked in the cases where the checklist really was used, was it used properly?

Less than 2.3% complied with more than 7 of the 13 items on the checklist. That's one out of 30 cases where they even complete a little over half of the 13 required checklist items.

How can a checklist work when it is used incorrectly or with less than half the items completed?

What if a pilot said to you and your family, before your next flight, "I only completed half of the checklist, I'm sure we've done everything right, no need to check"…?

Sample Transition: *Let's take a look at a checklist that was poorly designed & used incorrectly. ….* ***<click>***

Info from this study:

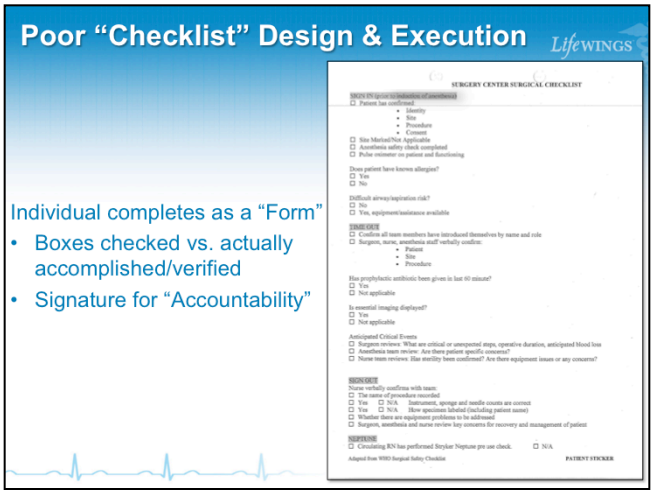
Results. A total of 142 pediatric surgical cases were observed. Hospital reported data demonstrated 100% compliance with the pre-incision phase of the checklist for these cases. None of the cases completely executed all items on the checklist, and the average number of checklist items performed in the observed cases was 4 of 13. The most commonly performed checkpoint were the confirmation of patient name and procedure (99%) and the ''timeout'' at the start of the checklist (97%). The rest of the checkpoints were performed in less than 60% of cases. Adherence did not increase during the observation period.

Conclusion. These data show that despite the 100% documented completion of the pre-incision phase of the checklist; most of the individual checkpoints are either not executed as designed or not executed at all. These findings demonstrate lack of checklist implementation fidelity, which may be a reflection a poor implementation and dissemination strategy. (Surgery 2012;152:331-6.)

And then from the Discussion section of the article:

DISCUSSION

Our study showed that although compliance with the perioperative checklist was documented in 100% of observed cases in the electronic medical record, adherence to individual components of the checklist was significantly less. The BSI checklist was carried out in 97% of cases, but only 4 observed cases demonstrated completion of more than 7 of 13 checkpoints (Table I).



Main Point(s):

1. **This checklist utilizes most of the items from the WHO checklist.**
2. **Without training the circulators would go into Pre-op and complete or "check off the boxes" on the checklist out through Post-op with the items done.**

Time: 30 seconds

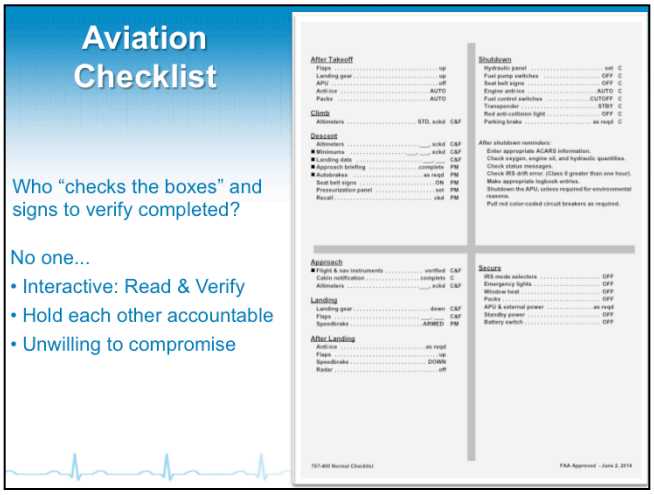
Sample "script"/Facilitation:

This checklist was used at a busy ASC. It is derived from the WHO checklist and covers mandatory items as well as issues found to contribute to patient safety and improved outcomes. The problem was that the circulators had been given the checklist and told when it was mandatory but they had not been trained as to how to use it. They usually got the checklist from the Pre-Op nurse and filled it out before the patient ever entered the OR. This organization had 2 sentinel events and 7 close calls. The physicians were under the impression that safety checks were being completed 100% of the time.

This is an example of a poorly designed checklist – it is interpreted to be a form to be completed, checkboxes to be checked off, rather than the team together verbally verifying the items.

Many times there is also a signature block at the bottom of these checklists. Why? For accountability. Let's be honest…how many of us have checked the boxes without going through each item – we're short on time, too much to do, we're sure we've done the right things....and then we just sign it, and move on to the more important tasks.

Sample Transition: *Let's compare this to an aviation checklist*…**<click>**



Main Point(s):

1. **Aviation Checklist example – simple, interactive , mindful verbal verification between team members, minimum critical items.**
2. **Not paperwork to be checked off and signed.**
3. **Accountability? Team members hold each other accountable: "Unwillingness to compromise" not matter who working with.**

Time: 30 seconds

Sample "script"/Facilitation:

Here is an example of an airliner checklist. The text on this front and back piece of paper has all necessary checklists for a complete flight, from gate to gate.

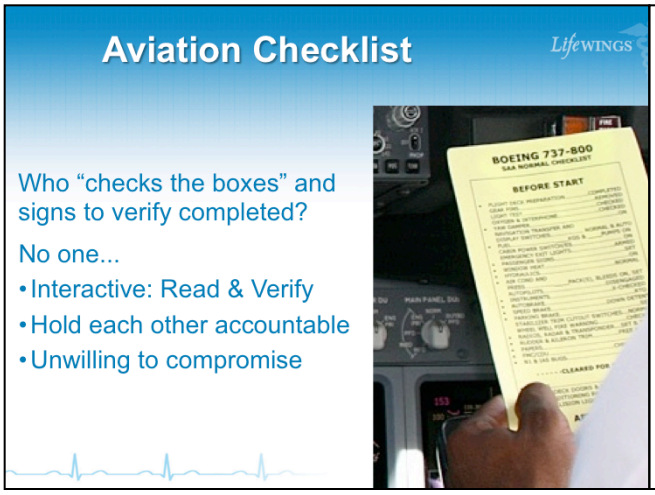
Does it have every item that a pilot has to know to fly an airplane? No, of course not. What it contains are the critical items that cannot be missed, so must be verified between the Captain and the Co-pilot, at different stages of their flight.

Who fills this out and signs this form to verify it has been completed? (most say the Captain or Copilot)

Trick question – this is not a form, no boxes to check, nothing to sign. It is simply their standard operating procedure all are trained to, when at critical points, team together verbally verifies items on the checklist. They are mindfully engaged.

So how are they held accountable if no paperwork / signature? Team members hold each other accountable, no matter who they are working with. Instilled in our culture is the "unwillingness to compromise."

Sample Transition: *Checklists only work when…***<click>**



Optional Slide (show slide before or this one):

Main Point(s):

1. **Aviation Checklist example – simple, interactive , mindful verbal verification between team members, minimum critical items.**
2. **Not paperwork to be checked off and signed.**
3. **Accountability? Team members hold each other accountable: "Unwillingness to compromise" not matter who working with.**

Time: 30 seconds

Sample "script"/Facilitation:

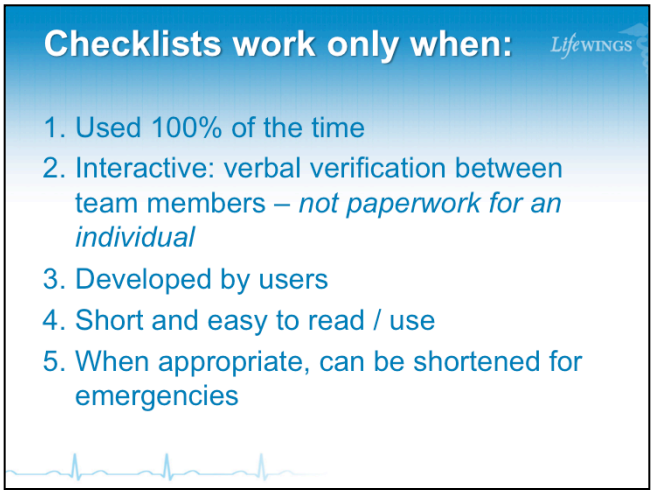
Here is an example of an airliner checklist. This is a 737 before start checklist. Does it list everything the pilot has to know to get prepared for and actually starting the engines? No, of course not. This list only the critical items that cannot be skipped or wrong.

Who fills this out and signs this form to verify it has been completed? (most say the Captain or Copilot)

Trick question – this is not a form, no boxes to check, nothing to sign. It is simply their standard operating procedure all are trained to, when at critical points, team together verbally verifies items on the checklist. They are mindfully engaged.

So how are they held accountable if no paperwork / signature? Team members hold each other accountable, no matter who they are working with. Instilled in our culture is the "unwillingness to compromise."

Sample Transition: *Checklists work only when…***<click>**



Main Point(s):

1. **Checklists work only when…**

Time: 30 seconds

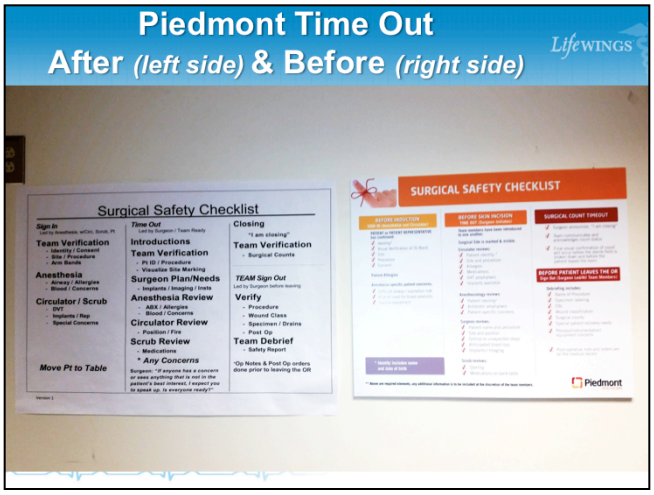
Sample "script"/Facilitation:

Checklists only work when….

1. *Used 100% of the time.*
2. *Interactive…*
3. *Developed by users.*
4. *Short and easy to read/use.*
5. *When appropriate, can be shortened for emergencies.*

Go through the list quickly.

Sample Transition: *Let's look at a well designed healthcare checklist*…**<click>**



Choose this slide or previous slide.

Main Point(s):

1. **Compare with poorly designed healthcare checklist on the left.**
2. **Show traits of well designed healthcare checklist on the right.**

Time: 30 seconds

Sample "script"/Facilitation:

Let's go back to a healthcare checklist and compare this hospital's before and after surgical checklist. The one on the right is the one the leadership at the hospital put into place. The one on the left is the checklist the frontline staff and physicians designed. Which one do you prefer? Why?

The hospital leadership's checklist is colorful but small text, hard to read. Also, it has checkboxes and they're already checked!!

What is done well on the customized checklist to the left? There are fewer items compared to the one on the right. Notice how large the font is so all can see it from a distance. It is clear who is responsible for which portions. A safety statement is included so easy for the leader, in this case the surgeon, to say it. No checkboxes – all verbal verification between team members.

Sample Transition: *This customization and proper design will be the focus of the Hardwired Safety Tools Workshop….***<click>**

Main Point(s):

1. **Outline HST workshop so all aware of when, who (in general terms) and what workshop will be about.**
2. **Provide them with date and location if able.**

Time: 30 seconds

Sample "script"/Facilitation:

This customization and proper design will be the focus of the Hardwired Safety Tools Workshop conducted on _____. Location will be at _____.

A multi-disciplinary group from your very own front-line staff and physicians will spend 3 days identifying your unit's team, communication and patient safety challenges and then developing customized Hardwired Safety Tools to address those challenges. They will also spend a great amount of time putting together a detailed implementation plan that they will then need your help implementing successfully.

There will also be measurement and continuous tweaking to ensure the Tool works to make it easier to do the right thing, difficult to do the wrong thing.

Sample Transition: *What is your role in these upcoming events?* **…<click>**

Main Point(s):

1. **Cover what is expected and needed from them as the hospital moves ahead in the project.**
2. **Emphasize the impact they have in determining the success of the program.**

Time: 30 seconds

Sample "script"/Facilitation:

Discuss the role of all involved in developing and implementing their Tools.

…your role is vital to the success of the Tools. Your role includes…

Volunteer.

If you're experienced, hard-working, and committed to solving the challenges that prevent your hospital from delivering the best care possible, volunteer to be part of that 3-day workshop. Even if you cannot attend all 3 days you can be part of the workshop. Please stop in when you can to provide your input, even if you can only come by for 15 mins.

Being Flexible.

Know that the Tools are not likely to be absolutely perfect when they're first created. The only way to know what works and what doesn't is to….

Lead by example - use the Tools!

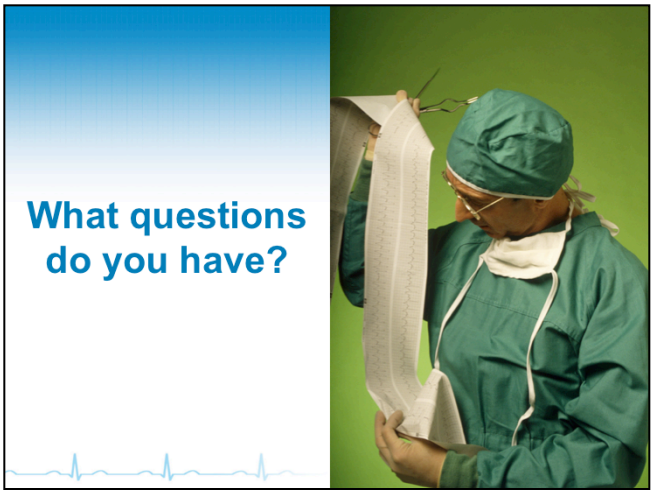
Provide Mutual support & mutual accountability - assist others in using the Tools and hold them accountable - in a respectful and professional manner, require that they use the Tools.

And don't complain about them In front of the "troops," instead…

Try them and then provide constructive feedback & suggestions *to those who can make changes.*

The Tools won't be perfect, your feedback is essential to make them so.

Sample Transition: *What questions do you have about* **…<click>**



Main Point(s):

Main Point(s):

1. **Ask specifically "What questions do you have…."**
2. **Take questions.**

Time: 30 seconds or more.

Sample "script"/Facilitation:

What questions do you have about Hardwired Safety Tools℠ and what to expect next in your TeamSTEPPS program?

Transition *. . . In these last minutes* **…<click>**

Main Point(s):

1. **Reminder that the focus of the TeamSTEPPS skills is simply the patient - providing safe and quality care.**

Time: 30 seconds

Sample "script"/Facilitation:

.. . In these last minutes, let's review what we have discussed today.

Keep in mind that all of the team skills are focused on patient safety and quality care…

Sample Transition: *Those skills began with* **. . .<click>**

Main Point(s):

1. **Very brief review of the TeamSTEPPS skills that they can use immediately to start improving their team and communication skills.**
2. **All skills discussed today focus on patient safety and quality of care.**

Time: 30 seconds

Sample "script"/Facilitation:

…Overcoming communication barriers,

using techniques to create an effective team where there is an open environment for communicating and all team members have a shared mental model,

Cross-Checking critical items, recognizing red flags to alert us to possible adverse situations

and then responding by precisely communicating those red flags assertively, and ensuring the concern is fixed before it is too late.

Ultimately Teams coming together to make better informed decisions for the patient

And finally, by debriefing, teams will strive to improve their performance.

Everyone, take a moment and pick up your toolkit **(Hold up the toolkit)**. *Each of the take-away skills & techniques we discussed today are right there for you to quickly refer to. Fits easily into your scrub pocket. These simple skills can make a difference immediately. Start practicing and using these skills as soon as you return to your unit.*

Sample Transition: *These simple skills can make a difference immediately.* **. . .<click>**

Main Point(s):

1. **Evolution starting with simply their thoughts to changing the culture.**

Time: 30 seconds

Sample "script"/Facilitation:

… with you, the individual.

They begin with focusing your thoughts on patient safety and then putting your thoughts and these skills into action.

If those actions are repeated, they become habits. (21 days for action to become a habit.)

Your habits will eventually change your practice

When those habits and your practice influence others and are adopted by team mates,

you have begun to change the culture where we can achieve a level of patient safety to which we would entrust our most cherished loved ones.

Sample Transition: *We recognize that you have given up a tremendous amount of valuable time to participate in this training…***<click>**

*al change, just as a pilot does during their training****….<click>***

Main Point(s):

1. **They will be awarded with a set of wings.**
2. **Set the stage for branding - a Tool for gaining buy-in. Tell them what the wings represent and to wear them proudly!**

Time: 30 seconds

Sample "script"/Facilitation:

<click>

When a pilot graduates from pilot training, they are given a coveted set of wings.

They are a symbol of doing the right thing and committing to purpose and safty.

<click>

As you depart today, we'll give you a set of your own wings. They are a reminder to do the right thing, even when it isn't necessarily easy; a commitment to patient safety and spreading the word - when asked by someone, "What are those wings?" you can share the information you learned today.

Sample Transition . . . *There is no written test today, but the real test will occur* **…<click>**

Main Point(s):

1. **Moments of truth for the attendees will occur when they take the skills to the floor and advocate / intervene for the patient.**
2. **May not always be easy, but it is the right thing to do.**

Time: 30 seconds

Sample "script"/Facilitation:

When you return to work, you will face "moments of truth"… moments when you will face the need to intervene.

Your willingness to exercise the skills we discussed in this training may very well make the difference between a successful or an unsuccessful patient outcome.

Sample Transition . . . *Remember Jane?*…**<click>** .

Choose appropriate conclusion slide to match your opening story.

Main Point(s):

1. **Return back to where the class started!**

Time: 5 seconds

Sample "script"/Facilitation:

Remember Jane? What happened?

Sample Transition: *What was the outcome?* **…<click>**

Choose appropriate conclusion slide to match your opening story.

Main Point(s):

1. **Complete the opening story - Rebecca spoke up with an assertive statement and the team appropriately responded. Jane was saved by teamwork and a culture of safety.**
2. **State an assertive statement Rebecca said.**

Time: 15 seconds

Sample "script"/Facilitation:

She was saved by skill, knowledge and the culture of safety - Rebecca saw and recognized the red flag, effectively said it through a standard assertive statement:

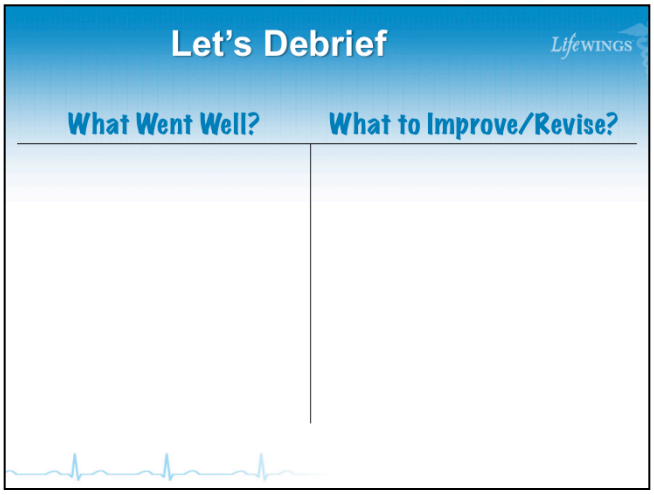
"Dr. Smith, I'm concerned. The patient has a severe latex allergy, We need to stop an re-glove."

What do you think the trauma's surgeon's response was?

Exactly, "Thank you for speaking up." The surgical team responded appropriately and fixed the situation!

Sample Transition if not conducting the debrief: *After all, that's what it really is all about*……**<click>**

Sample Transition if conducting a debrief of the 4 hour class on the next slide: *To model one of the skills we talked about today, let's debrief today's class…***<click>**



Optional slide: conduct only if have time.

Main Point(s):

1. Model the skills by conducting a debrief for the 4 hour training class.

Time: 1 - 2 minutes

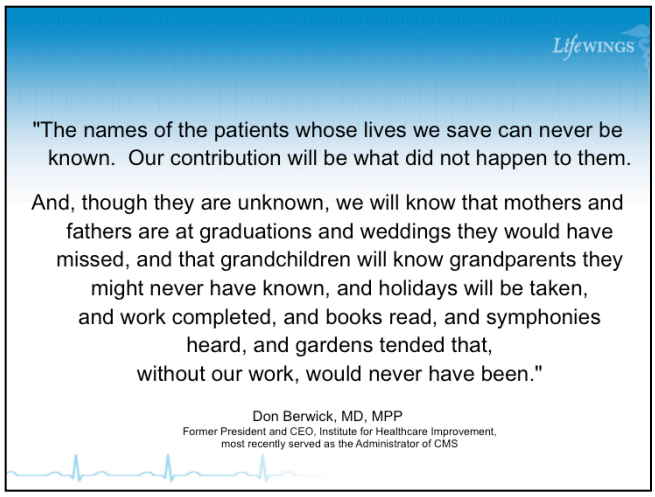
Sample "script"/Facilitation:

Depending on how much time you have available, conduct a debrief with your class of the 4 hour class.

What went well in today's class?

What can be improved?

Sample Transition: *Thank you for your comments. This is all about what you do everyday for the patient.* **……<click>**



Main Point(s):

1. **Final reminder of the ultimate goal.**

Time: 30 seconds

Sample "script"/Facilitation:

Let class read quote or you can read it to them.

Expect some emotional reactions to this.

Sample Transition: *Thank you…..* **<click>**

Main Point(s):

1. **Sincerely thank the class for their valuable time and attention.**
2. **Remind them to turn in their critiques and pages 8.3 in exchange for their wings.**

Sample "script"/Facilitation:

…Thank you for your time and attention.

Please turn in your completed critiques and page 8.3 to us, and in return we will give you your wings.

Have a great day!