

# Growing High Performing Teams to Improve Patient Safety in Australian Health Care

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**Government  
of South Australia**

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SA Health

# Introduction: SA Health TeamSTEPPS Program Team

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Karen Stead, Management Facilitator (aka the  
TeamSTEPPS lady)



TeamSTEPPS Faculty and Master Trainers  
Site Coordinators



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# Situation

SA Health “piloted” TeamSTEPPS for feasibility in the Australian context with generous support from and partnership with:

- The US Dept of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ)
- The Australian Commission on Safety and Quality in Health Care are supporters of the program (grant funding for the pilot)
- The program is now re-badged and adapted for use in Australia
- The model for S&Q improvement in SA Health



AUSTRALIAN COMMISSION ON  
SAFETY AND QUALITY IN HEALTHCARE



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## Situation - TeamSTEPPS

- > TeamSTEPPS uses a “Train the Trainer” model
- > Master Trainers facilitate teamwork training, implementation, and evaluation
- > Universities, clinical educators, DH Workforce participate in the program
- > Piloted in Queensland and Victoria
- > Commenced integration into health professional curricula in SA Universities
- > 50 sites, 5 major hospitals in process of hospital wide implementation

# Background



High performing teams have been shown to have less medical error, reduced patient mortality, a stronger culture of safety, and better patient and staff satisfaction.

Little or no formal team training... but  
“figure out what works”

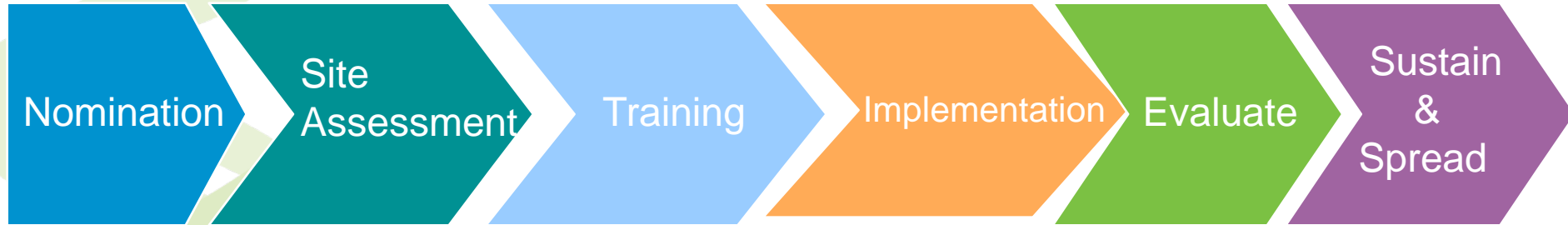




## Background

- > SA Health S&Q data  
...Gaps in communication within and between teams
- > Patient Experience data shows we need to improve involvement of consumers in their care

# TeamSTEPPS Process



- Call from SA Health for state-wide nominations (4 per year)
- Selection process considers readiness
- Master Trainer Assigned

- Site assessment meetings
- **Leadership Governance**
- **Team Structure**
- Baseline data:
- Observation
- Culture survey
- Teamwork surveys
- S&Q data
- **Pt Experience**
- **Workforce**
- **Process mapping**

- Train the trainer
- Site training
- **Education, Training & Supervision**

- **Standard Protocols & Procedures**
  - **Kotter's Change Management**
  - **Coaching**
  - **Model for Improvement**
- 
- Model for Improvement
- What are we trying to accomplish?  
 How will we know if a change is an improvement?  
 What changes can we make that will result in improvement?
- ACT PLAN  
 STUDY DO

- **Blend of Kirkpatrick & Donabedian**
- **Foundation:** Knowledge skills & attitudes/ structure
- **Operational:** Behaviour & Process
- **Outcome:** Pt experience & staff outcomes
- ROI

- NHS Sustainability Model
- Reaching critical mass
- Engagement of: SA Govt Workforce University/TAFE
- Simulation
- Web support programs
- Master Trainer Network
- Faculty

# Assessment

They like the training and it changes attitudes

- Patient Safety Culture (4%)
- Knowledge, skills and attitudes (2%)
- Team Assessment scores (9%)

90% - will make use of tools, feel they are applicable, confidence in using them



# Team Structure

## Change Team Meetings



## Leaders clearly identified



## Signage and Armbands



# Morning Brief at Women's and Children's Hospital





TQED ED Huddles include the patients  
and family

SA Health

## Debrief in Theatres



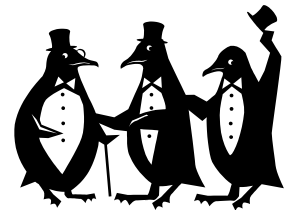
## ISBAR Journey Board



## ISBAR telephone handover

## *Huddles* in Mental Health resulted in an 83% reduction in seclusion rates

- > Ad hoc, touch-base meetings to regain situation awareness
- > Discuss critical issues and emerging events
- > Anticipate outcomes and likely contingencies
- > Assign resources
- > Express concerns





# Improvements at Women's and Children's Hospital

- > Decrease in patient complaints in the surgical service by 26% and an increase in patient compliments by 37% from Jan 2007-Dec 2009.
- > In Paediatric surgical unit:  
Jan- Dec 09- reported medication omissions decreased by 66% compared to previous year. Achieved by using bedside handovers, a structured handover technique and safety checks



## Feedback from Staff

- > “New staff and patients don’t understand how far we have come. They think it has always been like this!”
- > “We can’t believe we haven’t done this [briefs] before. It is common sense.”
- > “We are now problem solving with staff who we thought were the problem.”



## Recommendation

- > Use teams to drive S&Q improvement
- > Adopt this within the mission and values of the health service
- > Actively include consumers in the team model
- > Partner with others (education providers and Workforce planning)
- > Design for sustainability
- > Evaluate
- > Experience the rewards