Submission for the Maryland Patient Safety Conference

Organization: The Johns Hopkins Hospital

Solution Title: Developing a culture of teamwork takes time, creativity and resources.

Project Description:

The Institute of Medicine recommended in its 1999 Report To Err is Human that hospitals establish interdisciplinary team training programs (Institute of Medicine, 1999). The Joint Commission reinforced this recommendation in 2004 when recommending that perinatal leadership teach staff to work together and communicate more effectively to decrease patient harm (Joint Commission, 2004). In 2002, The Johns Hopkins Hospital Department of Gynecology and Obstetrics made a commitment to promote patient safety by focusing on processes to optimize the culture of teamwork in the Labor and Delivery (L&D) - Perinatal clinical care. This required a long-term allocation of time and resources to achieve a transition from a medical hierarchical model of care to one of inter-professional teamwork and collegiality.

The ongoing goals of this initiative are as follows:

1. Design processes to support and reinforce the expectation for inter-professional teamwork and collegial communication in the clinical arena
2. Measure the staff’s perception of teamwork at regular intervals
3. Develop processes to continue to improve teamwork and inter-professional communication.

Process and Solution:

Silo work patterns were evaluated and modified to promote a culture of teamwork and collaboration. Interprofessional shift hand-offs were implemented in 2002, providing all team members with a shared mental model of patients’ acuity and plans of care at the beginning of each clinical shift. Since 2005 all new staff members are required to attend an inter-professional team training session addressing; team structure and climate, planning and problem solving, team
communication, workload management and performance improvement (MedTeams, 2002). These sessions are all co-taught by a nurse and a physician to model the collaborative approach to communication and teamwork. Participants are provided time to discuss and practice teamwork behaviors and skills. Real case scenarios are presented with discussion of teamwork performance improvement opportunities. Over the past 10 years approximately 600 obstetric staff have participated in these educational sessions that introduce one to the importance of crew resource management skills (CRM) in promoting a non- hierarchical team oriented environment of care (Pratt. et al, 2007).

To further support the practice of teamwork, inter-professional interdepartmental team simulations were initiated in 2008. These sessions provide an opportunity for staff practice and shared learning during high-acuity, low-occurrence clinical situations. Emphasis is on learning together as a team in a low-stress environment without the risk of being harmed or harming a patient. These simulations provide a forum to reinforce and practice the expected CRM teamwork behaviors. An inter-professional team debriefing is part of each simulation and reinforces the strength of this collaborative learning practice in real clinical situations. The practice of non- hierarchical, inter-professional discussion and problem solving is reinforced on the clinical unit during team huddles, care coordination discussions and event debriefings. During these interactions the team focuses on risk identification, workload management and performance improvement opportunities.

**Measurable Outcomes:**

Staff’s perception of teamwork was measured over time by administration of a safety culture questionnaire. The registered nurse, OB attending and OB resident perceptions of teamwork on the perinatal unit from 2004 through 2015 are provided in the table below. There have been many staff transitions, unit and organizational changes over the past decade and research supports that these will influence scores on the safety culture survey. In addition there has been fluctuation in the number of respondents in the three job categories and this may affect the scores. Still the overall trend line for the RN, OB Attending and OB resident perception of teamwork from 2004 to 2015 is in a positive direction and staff relate that they perceive a stronger sense of teamwork on the perinatal unit.
CRM behaviors such as cross-monitoring, assertive closed loop communication, advocacy and assertion and the development of reflective communication for problem solving have become part of the unit’s culture. The incidence of team coordinating meetings and team huddles has increased with staff more empowered to request a team huddle to discuss a specific patient situation or the need for workload prioritization. Empowering all staff members to speak up and be equal members of the care team has a positive influence on patient safety. Changing culture takes time and requires administrative support and a long term commitment to inter-professional team development.

A more recent addition to supporting a culture of teamwork is the electronic “My Team” board that has been installed on the L&D unit. One of the key components of teams is knowing the names, roles and responsibilities of all the members. Leadership and staff collaborated with the hospital IT Department to develop an electronic team board. When staff tap-in with their hospital ID badge their picture, name and role appears on the large computer screen. All staff pictures are color coded based on role. Staff can easily review the board to clarify the names or positions of the other team members. It also reinforces the value of all team members as they see their picture on the board with everyone else.
**Sustainability:**

Department leadership is committed to ongoing development and support of a culture of collegiality and teamwork in the L&D - perinatal unit. All new staff are required to attend the team training session. Nurses attend a simulation once every 2 years and the residents attend a simulation every year. Staff continue to participate in the safety culture survey every 18 – 24 months to measure their perception of teamwork. The safety culture results are always shared with staff. Debriefing discussions are held and staff are asked to envision opportunities to continue to improve teamwork and communication and identify approaches to make the visions a reality. The OB patient safety nurse is available as a resource and often attends inter-professional shift hand-offs, coordinating team meetings and huddles. This provides an opportunity to coach newer team members regarding CRM behaviors and reinforce expected team communication and behaviors for all team members. The charge nurse in L&D records the occurrence of each coordinating team meeting and the number of participants. Periodically the patient safety nurse provides feedback to team on the frequency of the meetings.

**Role of Collaboration and Leadership:**

Department leadership was instrumental in establishing the initial vision for the inter-professional team training program and has had an ongoing role in the continued development and sustainability of the outlined teamwork initiatives. During staff meetings, administrative safety rounds, cases review conferences and team huddles the importance of speaking up clearly and respectfully for patient safety and the expectation that all staff will utilize CRM behaviors is reinforced. Fiscally, leadership supports staff participation in the required team training sessions and the inter-professional interdepartmental team simulations. Staff participation in event debriefings and Department Morbidity and Mortality conferences is encouraged to reinforce the concepts of inter-professional learning and improving team performance.

A nurse and a physician always co-teach the team training sessions and facilitate the team simulations, modeling the expectation of collaborative relationships and learning. Department and unit leadership is also required to attend a team training sessions and their active participation reinforces the importance of the team model for staff at all levels. Leadership works collaboratively with the OB patient safety nurse to identify opportunities to increase teamwork and improve team communication.
The teamwork safety initiatives and CRM behaviors have become part of the culture of the unit.

**Innovation:**

Many clinical units provide some degree of team training or education for their staff. Sometimes this is an isolated one-time event. The teamwork program described in this abstract is unique in that it starts with the teamwork basics and continues to introduce and reinforce the concepts of team work and inter-professional communication from many and varied approaches. In addition this program has been sustained for 10 years. While an initial training provides a brief introduction to the concepts of CRM, the continued exposure to the critical concepts must be reinforced in simulations activities, the daily work of the clinical unit and inter-professional event reviews to be successful in changing staff behavior. This is critical as it takes time and reinforcement of expected behaviors to change culture in an organization.

**References:**


**Related Resources**


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