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Transforming Care at the Bedside

How-to Guide:

Optimizing Communication and Teamwork

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The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, MA, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action. Thousands of health care providers, including many of the finest hospitals in the world, participate in IHI's groundbreaking work.

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Introduction

Launched in 2003, Transforming Care at the Bedside (TCAB) is a national program of the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI) that engages leaders at all levels of the health care organization to:

- Improve the quality and safety of patient care on medical and surgical units;
- Increase the vitality and retention of nurses;
- Engage and improve the patient's and family members' experience of care; and
- Improve the effectiveness of the entire care team.

The ten hospitals in phase III of TCAB received technical assistance from IHI faculty which consisted of individuals selected for their expertise in quality improvement, innovation, change management, transformational learning, and change strategies. With the support of these faculty members, the TCAB hospitals were charged with dramatically improving performance through a focus on five themes:

- Transformational Leadership
- Safe and Reliable Care
- Vitality and Teamwork
- Patient-Centered Care
- Value-Added Care Processes

The hospitals participated in phase III of TCAB by creating and testing new concepts, developing exemplary care models on medical-surgical units, demonstrating institutional commitment to the program, and pledging resources to support and sustain these innovations. A number of hospital teams across the United States have joined these ten initial participants in applying TCAB principles and processes to dramatically improve the quality of patient care on medical-surgical units (these units, as well as those at the original sites, are referred to as "TCAB units" throughout the guide). Newer participants include more than 60 hospitals in IHI's Learning and Innovation Community, also called "Transforming Care at the Bedside," as well as 67 hospitals in the American

Organization of Nurse Executives (AONE) TCAB program. For more information on the TCAB programs and participating sites, please see the following:

- IHI website

  http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm

- RWJF TCAB brochure

  http://www.rwjf.org/files/publications/other/TCABBrochure041007.pdf?gsa=1

- RWJF TCAB Toolkit

  http://www.rwjf.org/qualityequality/product.jsp?id=30051

- AONE website

  http://www.aone.org/aone_app/aonetcab/index.jsp
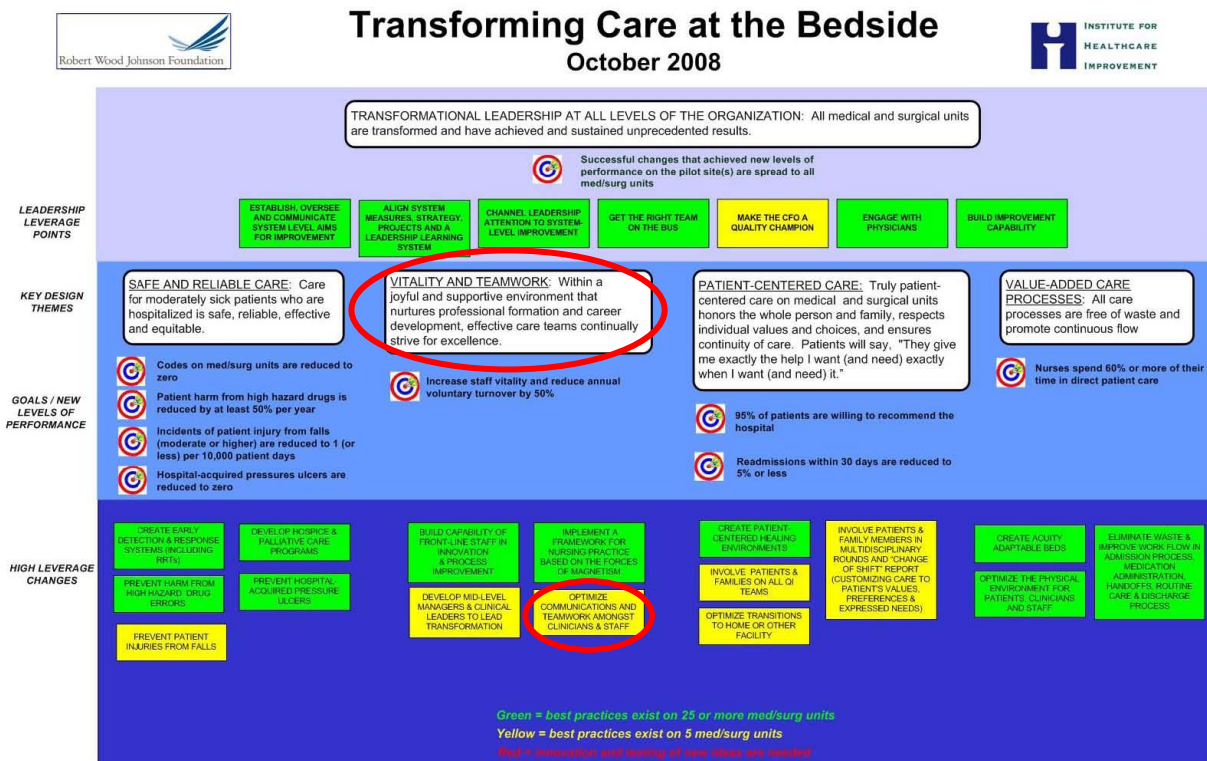
This TCAB How-to Guide is one in a series of guides describing improvements in the Vitality and Teamwork theme of Transforming Care at the Bedside. In TCAB "vitality" symbolizes far more than just staff satisfaction. Vitality includes a transformative shift to a more positive and proactive attitude toward work, and increased engagement of nurses and other staff on the TCAB units. The TCAB vision aims to recapture true "joy in work" as well as enhanced teamwork, empowerment, and commitment amongst the multidisciplinary team. In addition to promoting staff retention, a truly vital unit actually draws other staff to its ranks, sometimes resulting in a waiting list of applicants and the near elimination of voluntary turnover.

This guide describes the innovative changes that hospitals tested and implemented to improve the work environment for their medical-surgical unit staff. These changes focus on strategic applications of improved communication techniques across multiple disciplines, including nurses, physicians, and other clinical and support staff.

This How-to Guide is divided into four sections:

- **Section One** describes the rationale for why it is important to improve teamwork and communication in medical-surgical units.
- **Section Two** describes how to get started on designing strategies to improve communication and teamwork.
- **Section Three** describes strategies to improve communication and teamwork.
- **Section Four** includes two case studies that illustrate how Transforming Care at the Bedside teams at Cedars-Sinai Medical Center and Seton Northwest Hospital implemented changes to improve staff teamwork and communication.

Section One: The Rationale for Improving Teamwork and Communication on Medical-Surgical Units

Vitality (the vibrancy and satisfaction of the workforce), teamwork, and effective communication are all essential to improving care in medical-surgical units because they beneficially affect both staff retention and patient care. Enhanced teamwork and communication can improve the working relationships among members of the health care team thus supporting the retention of health care professionals. A recent survey found that health professionals who are confident in their ability to communicate with co-workers about concerns experience better patient outcomes, are more satisfied and engaged in their work, and are more committed to staying in their jobs.

> Maxfield D, Grenny J, McMillan R, et al. *Silence Kills: The Seven Crucial Conversations for Healthcare.* Provo, Utah: VitalSmarts; 2005. Available at: http://www.silencekills.com.

Improved workforce satisfaction is especially critical to effective health care delivery today because of looming shortages and high turnover in many health care professions, including registered nurses, imaging technicians, pharmacists, and lab technicians. Institutions that enact strategies to enhance staff effectiveness and vitality have demonstrated increased nurse, patient, and physician satisfaction, and reduced turnover.

> Page A, ed., Committee on the Work Environment for Nurses and Patient Safety. Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academies Press; 2004.
>
> Bureau of Labor Statistics, US Department of Labor. *Occupational Outlook Handbook, 2008-09 Edition: Registered Nurses.* Available at: http://www.bls.gov/oco/ocos083.htm.

Effective communication is crucial for both patient safety and quality of care. According to The Joint Commission, communication breakdown is the most frequently cited root cause for sentinel events. A key element of the Commission's 2009 National Patient Safety Goals for Hospitals is improving the effectiveness of communication among health care providers. It says, "Effective communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved [patient] safety."

Joint Commission Patient Safety Goals for Hospitals 2009. Available at:
http://www.jointcommission.org/NR/rdonlyres/31666E86-E7F4-423E-9BE8-
F05BD1CB0AA8/0/09_NPSG_HAP.pdf.

Improved physician and nurse teamwork has been shown to enhance the job
satisfaction of nursing staff, which has been linked to improved patient outcomes. In
addition, researchers have shown that access to information, support, and resources
improves job satisfaction and that teamwork and communication are essential to
optimizing such access.

Baggs JG, Schmitt, MH, Mushlin AI, et al. Association between nurse-physician collaboration and patient
outcomes in three intensive care units. *Critical Care Medicine.* 1999;27(9):1991-1998.

Aiken LH, Clarke SP, Sloane DM, Lake ET, Cheney T. Effects of hospital care environment on patient
mortality and nurse outcomes. *Journal of Nursing Administration.* 2008;38(5):223-229.

Laschinger HKS. Effect of empowerment on professional practice environments, work satisfaction, and
patient care quality: Further testing the nursing worklife model. *Journal of Nursing Care Quality.* 2008;23(4):
322-330.

What are staff in the TCAB hospitals saying about these strategies to improve communication and teamwork?

Robert Vos, MS, RN, CNAA, BC, Service Line Manager, Cedars-Sinai Medical Center

"This has been a great journey for us. We take pride in the empowerment of the staff. TCAB is a leadership philosophy for us and most certainly allowed us to involve all the front-line teams to make decisions that drive the changes."

Charles Levenback, University of Texas MD Anderson Cancer Center

"The communication situation has improved by initiating a direct dialogue between nurses and physicians. Timely communication of subtle changes in patient status, free exchange of ideas, and maintenance of firm boundaries regarding policy and procedures are all important aspects of safety that have been enhanced during this project."

Susan Cepeda, RN, Team Leader and Staff Nurse, Seton Northwest Hospital

"Ever since TCAB you can go in on Thursday and say 'Hey, I think something should be done differently, let's do it this way,' and by Friday, we're doing it with a small test of change—and you get instant gratification . . .This place, more than any other place, has a sense of teamwork. I know I have a strong base of support if I need help."

Jo Keisman, RN, MBA, Senior Director of Nursing, Seton Northwest Hospital

"I have found it to be very freeing, that the pressure is off me. I don't have to make all the decisions; I don't have to decide how to do everything. It's so nice to have the nurses come up to me and say I want to change this. They feel free to tell me, and my role [as a nurse manager] is to help them find ways to be successful."

Mary Viney, RN, MSN, NEA-BC, Vice President Nursing Systems, Network Accreditation, Seton Family of Hospitals

"In the past, staff would complain about their work . . . Managers would try to remedy. … Several months went by, and then return with the solution. Now…the team discusses, ensures the right problem is identified, and assigns a buddy to help develop testing."

Section Two: Getting Started

Establish an Aim

Set an aim to begin improving teamwork and communication. The aim statement should include: 1) a clear statement of purpose; 2) a measurable goal; 3) a description of how this will be done; and 4) a specific timeframe. For example, "On 5 East, we will increase by 50 percent the number of 5's on the vitality survey question 'I can discuss challenging issues with care team members on this unit' by September 2009." The team engaged in the work sets an aim that reflects what *they* want to accomplish, so the team feels ownership and support for the outcome.

Form a Team

Form a core team of five to seven people who want to test and implement changes to improve staff satisfaction. Members should be front-line staff registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants. Include physicians and experts from pharmacy, respiratory therapy, and other areas, as appropriate. Finally, include a patient and/or family member on the team.

> Institute for Healthcare Improvement. *How to Improve: Forming the Team*. Available at:
> http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/formingtheteam.htm.

> Institute for Family-Centered Care
> http://www.familycenteredcare.org/

Use the Vitality Survey

Utilize a standardized measurement tool to assess the vitality of unit staff. The Healthcare Team Vitality Instrument (HTVI) was created to evaluate the functioning of health care teams. The tool, which has been tested and validated for use with health care providers, assesses four dimensions: work environment; engagement and empowerment; handoffs and care transitions; and team communication.

> Lee B, Upenieks V. *Healthcare Team Vitality Instrument*. Available at:
> http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/HealthcareTeamVitalityInstrument.htm.

Evaluate Voluntary Turnover

Evaluate and track the monthly voluntary turnover rate of nurses in the participating units. The rate at which nurses choose to leave their positions is reflective of both staff satisfaction and the overall stability of a clinical unit. The voluntary turnover rate is the ratio of the number of voluntary separations during the month for unit RNs and advanced practice nurses (APNs), to the number of RNs and APNs employed on the last day of the month. Turnover due to uncontrollable circumstances such as death, illness, pregnancy, relocation, retirement, performance or discipline, and cutbacks, are not included in the calculation. Ideally, voluntary turnover for unit nurses should average no more than five percent annually (this represents no more than 0.4 percent on a monthly basis). For a detailed definition and suggestions for data collection, see the measure description on IHI's website.

> Institute for Healthcare Improvement. *Measure: Percent of Voluntary Nurse Turnover*. Available at: http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Measures/VoluntaryNurseTurnover.htm.

Measure Progress Over Time

Track your team's progress over time using a run chart. Figure 1 displays a sample run chart showing nurse voluntary turnover rate.

Figure 1: Example Run Chart Measuring Nurse Voluntary Turnover
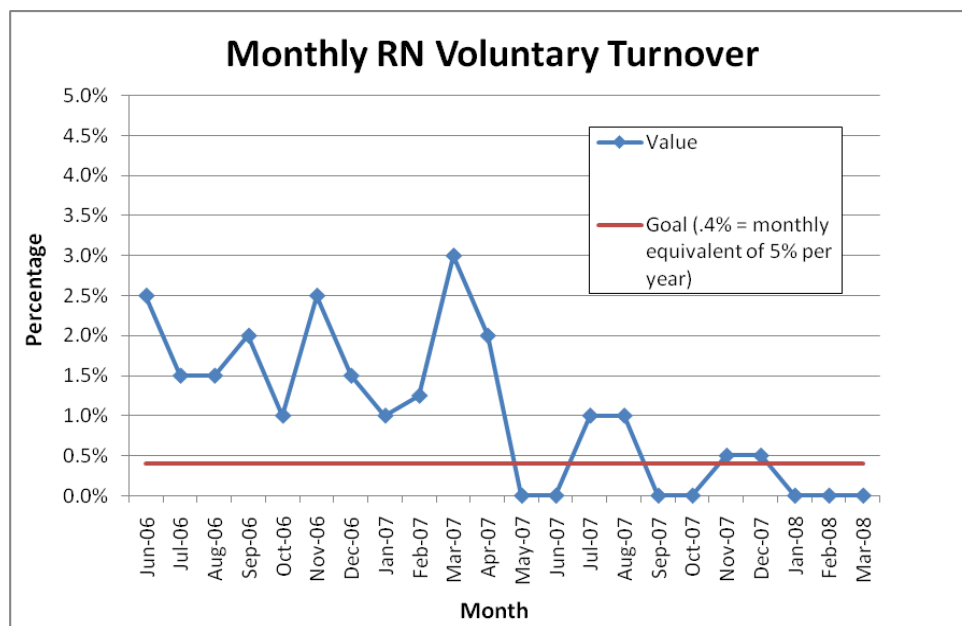
Use the Model for Improvement

IHI recommends using the Model for Improvement, a simple yet powerful tool for accelerating improvement developed by Associates in Process Improvement. The model has two parts: Part one has three fundamental questions that guide improvement teams to: 1) set clear aims; 2) establish measures that will tell if changes are leading to improvement; and 3) identify changes that are likely to lead to improvement. The second part uses the Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change (e.g., decrease non-value added work) by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method applied for action learning.

After testing changes (see Section 3) to improve teamwork and communication, and ascertaining a high degree of belief that the change is an improvement and will work in a variety of conditions (e.g., on all shifts, including weekends, when the unit is busy or has many admits and discharges, etc.), the next step is to implement the changes and make them permanent. This requires training existing staff, orienting new staff, and writing policy and procedure to sustain the gains. Any significant decline in teamwork and communication as evidenced by the responses on the Healthcare Team Vitality Survey instrument and/or qualitative observations requires immediate intervention to understand the causes, and re-testing to solve the problem. In some of the TCAB hospitals, team members have used a quick screening mechanism to determine whether to adopt, adapt, or abandon the change. This tool is a valuable way for teams to rapidly assess whether ideas should be adopted in their current form, modified and adapted to better fit the unit's needs, or abandoned as not useful for achieving the desired results.

> Model for Improvement (including PDSA worksheet). Available at:
> http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove.
>
> Institute for Healthcare Improvement. *OnDemand Presentation: An Introduction to the Model for Improvement*. Available at:
> http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationMFI.htm.

Section Three: Strategies for Improving Communication and Teamwork

The TCAB conceptual framework depicts four essential building blocks for improving staff vitality. These include: building capability of front-line staff in innovation and process improvement; developing mid-level managers and clinical leaders to lead transformation; implementing a framework for nursing practice based upon the "forces of magnetism;" and optimizing communication and teamwork among clinicians and staff. This How-to Guide will address key change concepts and tips for improving teamwork and communication. Tips for improving the other elements of staff vitality are available through other resources:

1. Key change concepts for engaging and empowering front-line staff are included in the *TCAB How-to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement.*

2. Suggestions about how to develop unit-level managers to support transformational change can be found in the *TCAB How-to Guide: Developing Front-Line Nursing Managers to Lead Innovation and Improvement.*

3. The requirements for Magnet certification describe key elements of organizational and nursing leadership to support positive work environments. One way Magnet principles tangibly improve staff vitality is through the adoption of shared governance models, which increase structured empowerment for front-line staff nurses.

Rutherford P, Phillips J, Coughlan P, Lee B, Moen R, Peck C, Taylor J. *Transforming Care at the Bedside How-to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement*. Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at: http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/TCABHowToGuideEngagingStaff.htm.

Lee B, Peck C, Rutherford P, Shannon D. *Transforming Care at the Bedside How-to Guide: Developing Front-Line Nursing Managers to Lead Innovation and Improvement*. Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at: http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/TCABHowToGuideDevelopingFrontLineNursingManagers.htm.

American Nurses Credentialing Center. Magnet Recognition Program. Available at: http://www.nursecredentialing.org/Magnet.aspx.

Optimizing Teamwork and Communication

An integrated approach to improving staff communication within and across departments, and between various types of caregivers, is a solid platform on which to build increased staff vitality and enhanced patient safety. In the 2007 Joint Commission's Annual Report on Quality and Safety, *Improving America's Hospitals*, inadequate communication between care providers, or between care providers and patients/families, is cited as the root cause of most sentinel events. In early 2005, the American Association of Critical Care Nurses (AACN) and VitalSmarts[TM] held a web-cast discussing the links between patient safety and improving "crucial conversations" skills.

> *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2007.* Chicago: The Joint Commission; November 2007. Available at: http://www.jointcommissionreport.org.
>
> American Association of Critical Care Nurses (AACN)
> http://www.aacn.org/aacn/pubpolcy.nsf/vwdoc/webcast
>
> Thornby D. Beginning the journey to skilled communication. *AACN Advanced Critical Care.* 2006;17(3):266-271.
>
> Patterson K, Grenny J, McMillan R, Switzler A. *Crucial Conversations: Tools for Talking When Stakes are High.* New York: McGraw Hill; 2002.

Assertive communication between team members and the use of specific, critical language techniques in crisis situations are hallmarks of high-reliability organizations. High-risk industries with a history of improving reliability to prevent errors, such as airlines and nuclear power, rely on open and honest communication with standardized communication strategies for high-pressure situations.

> Weick KE, Sutcliffe KM. *Managing the Unexpected: Resilient Performance in an Age of Uncertainty (2nd edition).* San Francisco: Jossey Bass Publishers; 2007.

In order to create a culture of safety, all staff members must feel that they work in an environment built on mutual trust and respect. This culture is reflected in the way individual team members communicate with one another both on a daily basis, and when the stakes are high. The Institute of Medicine's 2004 report, *Keeping Patients Safe: Transforming the Work Environment for Nurses*, cites communication as one of seven essential elements of an effective safety culture. The authors note that in

effective safety cultures, communication is not hierarchical, but "free and open up and down the chain of command and across organizational divisions. Regardless of rank or level of authority, staff members are encouraged to speak up if they identify a risk or uncover an error." Leaders at Cedars-Sinai Medical Center in Los Angeles have promoted communication across the boundaries of hierarchy by implementing regular physician-nurse rounding and monthly unit-based meetings of physicians and nurses to address issues affecting staff or clinical care. (For more information, see the case study section.)

> Page A, ed., Committee on the Work Environment for Nurses and Patient Safety. Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academies Press; 2004.

High-Leverage Changes for Optimizing Team Communication

Creating positive, assertive, and effective communication strategies between and among clinicians and other staff requires work at many levels of interaction. The following four changes have proven to be effective elements of a strategy to optimize team communication.

1. Promote assertive, effective communication among multidisciplinary team members;
2. Encourage staff to communicate effectively during "difficult" or "crucial" conversations;
3. Enhance multidisciplinary and unit-based teamwork; and
4. Improve handoffs and transitions.

1. Promote Assertive, Effective Communication among Multidisciplinary Team Members

True transformation in a medical-surgical setting begins and ends with the front-line staff, working in close collaboration with a multidisciplinary team. Nurses, physicians, pharmacists, dietitians, respiratory therapists, and other providers all make contributions to ideas for improvement and transformation of work processes. Without a multidisciplinary team, efforts to improve patient care and staff vitality often fail. To improve communication, organizations can institute changes such as multidisciplinary
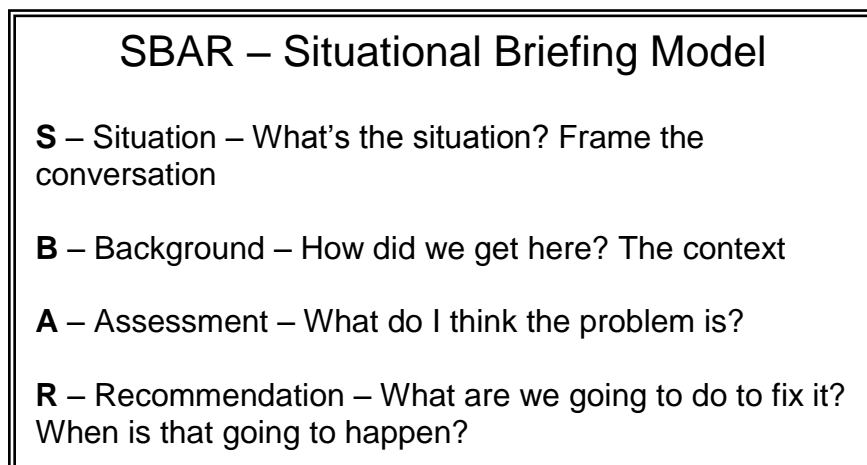
rounds, communication training to promote assertiveness by front-line workers, and behavioral-based competency development to reinforce an organizational value of, and emphasis on, open communication.

A valuable resource called TeamSTEPPS^{TM} is available from the Agency for Healthcare Research and Quality (AHRQ) and the United States Department of Defense. This team training methodology describes two "assertion tools" that can be helpful in medical-surgical and other care settings. The first is called the "Two Challenge Rule" whereby one should voice concerns up to two times. The other strategy involves using a technique called CUS. This strategy encourages staff to use terms like, "I am **C**oncerned," "I am **U**ncomfortable," or "This is a **S**afety issue" when trying to convey concern in an effective manner to colleagues or physicians.

> Agency for Healthcare Research and Quality/Department of Defense. TeamSTEPPS^{TM} materials. Available at: http://teamstepps.ahrq.gov/abouttoolsmaterials.htm.

Situational briefing techniques, such as SBAR (Situation-Background-Assessment-Recommendation), are effective system-wide strategies to standardize communication during critical events. The SBAR tool, initially developed by Michael Leonard, Doug Bonacum, and Suzanne Graham at Kaiser Permanente of Colorado, is an effective mechanism to level the traditional hierarchy between physicians and other caregivers, notably nurses (see Figure 2). This situational briefing model builds a common language platform for communicating critical events, such as patient deterioration.

Figure 2: Situation-Background-Assessment-Recommendation (SBAR) Technique

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SBAR – Situational Briefing Model

S – Situation – What's the situation? Frame the conversation

B – Background – How did we get here? The context

A – Assessment – What do I think the problem is?

R – Recommendation – What are we going to do to fix it? When is that going to happen?

Assessing the competency of front-line staff to use the SBAR tool is an important step in ensuring standardized communication in critical situations. As a means of assessing SBAR competency, leaders at Bronson Healthcare Group in Kalamazoo, Michigan, developed a series of scenarios that reflected a range of clinical conditions and patient circumstances. Front-line staff are provided with one or more of the scenarios and asked to record a voicemail message responding to the scenario with SBAR-based communication. Subsequently, leaders at Iowa Health System borrowed and expanded Bronson's assessment tool, developing additional scenarios and creating answer keys.

> Bronson Healthcare Group. *SBAR Training Scenarios and Competency Assessment*. Available at: http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/SBARTrainingScenariosandCompetencyAssessment.htm.

Both organizations have found the assessment tool useful in evaluating SBAR competency at new staff orientation and during competency reviews of existing staff.

Another important technique to enhance the strength of SBAR is using critical language, or key words, that signal all parties to stop and listen. An example might be, "I need a little clarity," or "I'm concerned." Using critical language provides everyone the permission and opportunity to speak up even when feeling hesitant or worried.

> Leonard M, Graham S, Bonacum D. The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care.* 2004;13(Suppl 1):i85–i90.
>
> Delivering Safe and Optimal Care Through Effective Teamwork and Communication (IHI Seminar) http://www.ihi.org/IHI/Programs/ConferencesAndSeminars/ImplementingTeamCommunicationJune2008.htm
>
> Institute for Healthcare Improvement. *OnDemand Presentation: Effective Teamwork as a Care Team Strategy – SBAR and Other Tools for Improving Communication Between Caregivers*. Available at: http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/Effective+Teamwork+as+a+Care+Strategy+SBAR+and+Other+Tools+for+Improving+Communication+Between+Careg.htm.
>
> Kaiser Permanente of Colorado. *SBAR Technique for Communication: A Situational Briefing Model*. Available at: http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm.

In addition to the SBAR technique, TCAB hospitals used other staff competency assessments and clinical scenario exercises to improve communication during critical moments.

2. Encourage Staff to Communicate Effectively During "Difficult" or "Crucial" Conversations

Improving communication by teaching staff to engage in difficult conversations with co-workers, supervisors, and other staff is the second tier of optimizing staff communication. Publications such as *Crucial Conversations: Tools for Talking When Stakes are High* and *Difficult Conversations: How to Discuss What Matters Most* offer relevant advice and skills for staff training. Leaders at Seton Northwest Hospital have instituted mandatory staff training on how to handle difficult or crucial conversations—defined as discussions between two or more people in which the "stakes are high, opinions vary, and feelings run strong." The training at Seton Northwest provides participants with step-by-step instructions for approaching these conversations.

> Patterson K, Grenny J, McMillan R, Switzler A. *Crucial Conversations: Tools for Talking When Stakes are High.* New York: McGraw Hill; 2002.
>
> Stone D, Patton B, Heen S. *Difficult Conversations: How to Discuss What Matters Most.* New York, NY: Penguin Books; 2000.

TCAB faculty created a checklist and worksheet, based on information from *Difficult Conversations,* that teams can use to guide them through challenging conversations. The checklist describes the three key components of a difficult conversation—what actually happened from both parties' perspectives, what emotions were involved, and what is at stake for each individual in the conversation. The worksheet provides step-by-step guidance for exploring both sides of the situation—both the related emotions, and the underlying goals of each individual. It also describes ways to share viewpoints and begin problem solving. The worksheet includes a list of questions to help individuals identify their contributions to the situation, their intentions, and the impact of the situation on them. (To create similar tools, see pages 3 to 20 and 217 to 234 in *Difficult Conversations.*)

The TeamSTEPPS™ training program describes another approach to addressing difficult conversations called "DESC." Using this strategy, one would take the following steps to discuss a sensitive issue with a colleague or care partner:

- **D**escribe the situation(s)

- **E**xpress concerns about what is happening

- **S**uggest alternative approaches

- **C**onsequences should be stated if change doesn't occur

> Agency for Healthcare Research and Quality/Department of Defense. TeamSTEPPS^{TM} materials. Available at: http://teamstepps.ahrq.gov/abouttoolsmaterials.htm.

3. Enhance Multidisciplinary and Unit-Based Teamwork

TCAB hospitals used several approaches to enhance multidisciplinary teamwork, including:

- Inviting representatives from all disciplines involved in the care of patients on the unit(s) to participate in idea-generation meetings;

- Enlisting front-line staff in planning and testing ideas for improvement in areas of concern; and

- Setting aside time for employees to work on improvement.

> Description of IHI Improvement Methods. Available at:
> http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.
>
> Rutherford P, Phillips J, Coughlan P, Lee B, Moen R, Peck C, Taylor J. *Transforming Care at the Bedside How-to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement*. Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at:
> http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/TCABHowToGuideEngagingStaff.htm.
>
> Upenieks VV, Needleman J, Soban L, Pearson ML, Parkerton P, Yee T. The relationship between the volume and type of transforming care at the bedside innovations and changes in nurse vitality. *Journal of Nursing Administration.* 2008;38:386-394.

An observational study by the University of California at Los Angeles/RAND TCAB evaluation team demonstrated that as front-line nurses become more engaged in testing and implementing changes for improvement, their self-reported vitality increased. TCAB hospitals also found multidisciplinary rounds on their medical-surgical units to be effective means for enhancing teamwork. Often referred to as "care team rounds," the multidisciplinary approach requires close communication between the members of the care team.

ThedaCare in Appleton, Wisconsin, implemented a collaborative model of care on their Collaborative Care Unit—a unit modeled on efficiency and teamwork that encourages

clinicians to work together at the bedsides of patients with greater input from those they treat. Every patient admitted to the unit is seen first by the "trio"—a nurse, provider, and pharmacist. Working together with the patient, the three complete an evaluation that includes a risk screening and the development of a collaborative plan of care. The collaborative plan of care includes "tollgates," which are agreed-upon checkpoints at which progress will be assessed and changes made if needed. The nurse, provider, pharmacist, and care manager hold a bedside care conference each day for every patient.

At 6:00 AM daily, the resource nurse from the night shift reviews every patient in the unit with other nurses, then attends the morning change-over meeting of the providers. He or she makes suggestions for care that commonly result in new orders. Often these orders can be enacted before providers arrive for morning rounds on the unit. Overall, these changes have resulted in increased trust among care team members and a heightened sense of nurse satisfaction. The unit has achieved measurable improvements in adjusted length of stay, cost of care, and patient satisfaction scores, when compared to other care units.

Multidisciplinary rounds have been shown to improve communication and collaboration, as well as the satisfaction of physicians, nurses, and patients.

> Empowering Better Nursing Care: The Seton Northwest Hospital Video
> http://www.rwjf.org/pr/product.jsp?id=21069
>
> Vazirani S, Hays RD, Shapiro MF, et al. Effect of a multidisciplinary intervention on communication and collaboration among physicians and nurses. *American Journal of Critical Care.* 2005;14(1):71-77.
>
> Institute for Healthcare Improvement. *Implement Multidisciplinary Rounds.* Available at: http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Changes/ImplementMultidisciplinaryRounds.htm.
>
> Viney M, Batcheller J, Houston S, Belcik K. Transforming Care at the Bedside: Designing new care systems in an age of complexity. *Journal of Nursing Care Quality.* 2006; 21(2):143-150.

4. Improve Handoffs and Transitions

In health care, a handoff is the transfer of responsibility for the care of a patient from one care provider to another, such as a nursing change of shift. Transitions of care are the shift in responsibility for care of a patient from one hospital team or unit to another.

Handoffs and transitions are especially vulnerable to miscommunication, and miscommunication at these crucial junctures can often lead errors and harm. Staff at TCAB hospitals found that improved communication among care providers also helped standardize teamwork behaviors and fostered an improved sense of connection among team members. To improve handoffs and transitions of care, participating TCAB hospitals focused on three approaches for standardizing communication during these vulnerable times: a) convening briefings and debriefings; b) enacting structured handoffs; and c) holding change of shift reports at the bedside.

a. **Convene briefings, huddles, and debriefings.** Staff at TCAB hospitals found it helpful to convene concise meetings before and after handoffs and transitions. The concept of conducting briefings, huddles, and debriefings originated in health care settings through the adaptation of crew resource management techniques used in military and commercial aviation. These techniques were first applied to health care in high-risk settings such as operating suites, emergency departments, and labor and delivery units. Some of the core tenets of these approaches have been adapted for use in medical-surgical settings. (See the Seton Northwest Hospital case study below.) These structured, brief meetings increase situational awareness and enable team members to align priorities and to reach a common understanding of the patient's situation.

As described in the TeamSTEPPS[TM] training modules, briefings provide an arena for the team to engage in short- and long-term planning; huddles serve as a means for teams to discuss and address critical issues and emerging events; and debriefings, held after a shift or a specific event, afford the team a chance to exchange information, provide feedback, analyze key events, and plan alternate responses for similar events in the future.

Agency for Healthcare Research and Quality/Department of Defense. TeamSTEPPS[TM] materials. Available at: http://teamstepps.ahrq.gov/abouttoolsmaterials.htm.

b. **Enact structured handoffs.** Some TCAB teams enacted structured handoffs and relied on checklists to improve communication. Staff at Kaiser Permanente

Roseville uses a processed called the Nurse Knowledge Exchange (NKE) to facilitate handoffs at change of shift. The NKE is an electronic record-keeping system designed specifically for handoffs. The departing charge nurse creates the report, which is tailored to the patient and the incoming nurse. It includes concise and pertinent patient information (e.g., allergies, language barriers, recent lab results, changes in medication). The pair of incoming and outgoing nurses then reviews the record while rounding on their shared patients. The process allows them to review plans and progress, clarify information, and share suggestions, but takes only a few minutes. TCAB team members feel the process has fostered improved communication and accountability.

At Trinity Regional Health System in Rock Island, Illinois, teams use a house-wide, standardized transportation form in SBAR format. The SBAR form must be filled out with the patient's critical information, including risk for falling and injury, before the patient leaves the unit. As a safety visual aid, the paper form is rolled into a section of yellow PVC pipe ("baton") that is kept with the patient and handed off formally to the next nurse or transporter. Batons are available at each nursing station. Also available are "I am a yellow baton" folders (for those who like their forms unrolled) and disinfecting wipes to clean batons between handoffs (see Figure 3).

Figure 3: Yellow SBAR "Baton" at Trinity Regional Health System

c. **Hold change of shift reports at the bedside.** Staff at several TCAB hospitals have moved the change of shift report from the nurses' station or conference room, to the bedside. At UPMC Shadyside, nurses use a "shift handoff," in which both the oncoming and off-going nurses go to their assigned patients, introduce themselves, update the whiteboard, and discuss the timing of the next dose of medication.

Staff at James A. Haley Veterans' Hospital in Tampa, Florida, have adopted bedside reports whenever and wherever feasible. The oncoming nurse is introduced to the patient by the off-going nurse, and the three go over what was done, what is yet to be done, and what the patient expects to be done. The oncoming nurse gets a chance to review the situation and ask questions of the off-going nurse. After all the oncoming nurse's patients have been visited, the off-going nurse provides updates (outside the patient's room) on any new information or developments that occurred since the shift change handoff tool was typed, as well as information that might be privileged (e.g., "daughter and wife are have different opinions"). The hospital staff has found that performing more work at the bedside requires re-learning how to connect with patients. Staff nurses were accustomed to connecting briefly with the patient and then leaving to complete their tasks outside the patient's view.

The four high-leverage changes outlined above—1. Promote assertive, effective communication among multidisciplinary team members; 2. Encourage staff to communicate effectively during "difficult" or "crucial" conversations; 3. Enhance multidisciplinary and unit-based teamwork; and 4. Improve handoffs and transitions—are all proven strategies that can enhance the essential vitality and joy of front-line staff. The two case studies that follow illustrate the successes of these changes.

Section Four: Case Studies

This section includes two case studies that examine how Cedars-Sinai Medical Center and Seton Northwest Hospital implemented high-leverage changes identified through the TCAB initiative for optimizing teamwork and communication.

- Case Study 1: Cedars-Sinai Medical Center, Los Angeles, California

- Case Study 2: Seton Northwest Hospital, Austin, Texas

Case Study 1: Cedars-Sinai Medical Center, Los Angeles, California

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Background

Part of Cedars-Sinai Health System, a fully integrated health care delivery system, Cedars-Sinai Medical Center is a nonprofit health care organization that serves about 10 million people in Los Angeles County. The academic medical center is one of the largest nonprofit hospitals in the western United States. Two 24-bed general surgical care units at Cedars-Sinai Medical Center served as pilot units for TCAB initiatives. The TCAB team at Cedars-Sinai implemented all four of the high-leverage changes for optimizing teamwork and communication.

Promoting Assertive, Effective Communication among Multidisciplinary Team Members

Leaders at Cedars-Sinai chose to use regularly scheduled multidisciplinary rounds to promote more effective communication among care providers. Each day on the pilot unit, the case manager, social worker, and charge nurse met to discuss the current status and future plans for each patient on the unit. When appropriate, they invited additional care providers, such as physicians, pharmacists, physical therapists, and nutritionists, to discuss and develop plans for patients with particular needs. Once a week, the entire care team met to talk about specific care issues, such as plans for those patients scheduled to be discharged over the weekend.

To promote effective communication among staff on the unit, the TCAB group included all staff in unit activities. For example, the housekeeping team is invited to staff meetings to foster problem solving, and social events to encourage strong relationships among all staff on the unit. These and other interventions helped create robust communication among care providers and other support staff on the pilot unit. In

addition, strong communication on the unit translated into both high regulatory compliance and high staff satisfaction ratings.

Encouraging Staff to Communicate Effectively During "Difficult" or "Crucial" Conversations

TCAB leaders at Cedars-Sinai recognized the need for additional staff training on communication during difficult conversations. They hired a consultant to create a training workshop on the topic. Attendance was open to all members of the hospital community but was not mandatory. The training described the steps to take in the midst of a heated discussion and suggested tactics for use after the urgent situation was addressed. For example, if a physician yelled at a nurse about a missing piece of documentation, the nurse should apologize for the oversight and ask, "What could I do right now to address the problem?" The next day, either the nurse or nurse manager should calmly approach the physician and ask to speak over coffee. During the conversation, the nurse should identify the inappropriate behavior, explain the way it made him or her feel, and emphasize that he or she really wants to work with the physician to resolve any and all communication issues.

Because the workshop has been highly rated by staff from the pilot unit, Cedars-Sinai leaders now intend to spread the training, and have planned an upcoming training for all staff, including employees of other units and departments.

Enhancing Unit-Based Teamwork and Communication across Hospital Departments

Prior to TCAB involvement, leaders at Cedars-Sinai Medical Center had created a task force to address physician job satisfaction. The group's focus was later expanded to include job satisfaction of nurses. The task force suggested implementation of physician-nurse patient rounds, but at the time staff failed to fully embrace the initiative. Later, as part of the TCAB project, the physician champion launched a unit-based collaborative that included regular meetings of physicians and nursing staff to address

issues currently troubling the unit. The intervention was initiated on the general surgical wards that served as the TCAB pilot unit.

Nursing staff, attending physicians, and residents attended the monthly meeting. Internists and other non-surgical physicians also participated. The group was provided with sample goals, tips, and instruction on how to make small tests of change. The group first addressed technical issues, by implementing the use of staff cell phones, for example. They also agreed to the policy that physicians stay on the unit until nursing staff has read their written orders and the physicians have explained any related issues to the staff nurse or charge nurse. Once they had achieved a measure of success in improving the technical issues, the group began to focus on personnel issues, such as the implementation of physician-nurse rounding. Although many physicians initially resisted the team-based approach to rounding, after one-on-one discussions to address their concerns, all medical staff eventually embraced the change. Staff found that the regular physician-nurse meetings improved communication on the pilot unit, thereby reducing the number of calls from nurse to physicians for clarification of orders, among other improvements.

Improving the Quality of Handoffs During Transitions in Care to Promote Patient Safety

The TCAB team at Cedars-Sinai chose to implement SBAR communication to improve handoffs during transitions in care. The group sponsored a three-part, web-based seminar in the hospital auditorium, to which both nurses and physicians were invited. Teams implemented the communication tool in both verbal communication, (e.g., when a nurse called a physician about a change in patient status), and written communication, (e.g., when a patient is transferred from the unit to the imaging department).

Demonstrating the organizational significance of this initiative, Cedars-Sinai leaders decided to implement SBAR not only in the TCAB pilot unit, but throughout the whole organization simultaneously. Tests after the training showed that staff had effectively implemented the new method of communicating. Teams found that the use of SBAR

communication improved what was previously fragmented communication between nurses and physicians, resulting in a decreased need for order clarification and improved timeliness in carrying out of orders.

The group's physician champion set the example for physician engagement in SBAR through his active involvement in communicating the new plan to physicians. He, along with two other executive leaders, stationed a table in the physician parking lot one morning to hand out free "smoothie" drinks and to spread the word about the use of SBAR. The communication tool is now used throughout the hospital for most verbal and written communication, including emails.

Case Study 2: Seton Northwest Hospital, Austin, Texas

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Background

The Seton Family of Hospitals is a not-for-profit health care system that serves a population of 1.7 million in an 11-county region in central Texas. A member of the Ascension Health network, the health care system comprises five urban acute care hospitals, two rural hospitals, and a mental health hospital. A 64-bed medical-surgical unit at Seton Northwest Hospital, an acute care hospital in Austin, Texas, served as the pilot unit for TCAB initiatives. The TCAB team at Seton Northwest focused on implementing three of the high-leverage changes for optimizing teamwork and communication.

Promoting Assertive, Effective Communication among Multidisciplinary Team Members

The TCAB team initially identified nurse-physician communication as a starting point for improvement. The team decided to test the implementation of physician-nurse rounding as a means for improving communication. Team members hypothesized that physicians would be resistant to rounding with nurses, due to concern about the additional time involved. To minimize the time required for physician-nurse rounds, the team created a list of questions to help guide and focus the rounds. These questions were:

- What problems did the patient have overnight?
- What are the results from previous tests?
- What is the plan for the current day?
- What is the patient's progress towards discharge?
- Are there any questions from the patient or family?

The team tested the change with one physician and one nurse before spreading to other physician-nurse combinations. During these initial tests of change, the team learned that the questions were both relevant and helpful, and they remain unaltered. The team also learned that their initial hypothesis was incorrect: physicians were enthusiastic about rounding with the nurses and appreciated the availability of lab results and other pertinent information from the nurses. However, the teams found that nurses needed additional training to prepare for the rounds, because the task was novel to the nurses. With time, the team found that effective physician-nurse rounding could be accomplished in just five minutes per patient.

The TCAB team conducted a series of tests of change to find the best way to ensure a timely start to physician-nurse rounds. Nurses now place a "Dear Doctor" letter on each patient's chart at the beginning of the day shift (see Figure 4). The letter includes contact information for the nurse caring for the patient that shift, including the nurse's portable phone extension number. The back of the letter lists the five questions used to guide physician-nurse rounds. In the pilot unit, patient records are stored at the bedside, which facilitated communication via the patient chart. Upon arriving at the unit, physicians phone the assigned nurse and the two begin rounding.

Figure 4: Dear Doctor Letter

ATTENTION DOCTOR:

Please call the nurse before you round on your patient.

NURSE: _____

PHONE: _____

DATE: _____

SHIFT: _____

DISCUSS:

1. RESULTS FROM PREVIOUS DAY

2. PREVIOUS PROBLEMS UPDATE

3. PATIENT ISSUES/ QUESTIONS

4. PLAN FOR TODAY

5. PROGRESS TOWARD DISCHARGE

The unit staff feels that physician-nurse rounding has improved communication between doctors and nurses about patient care issues. In addition, nurses in the pilot unit reported that the implementation of physician-nurse rounds has substantially reduced the need for calls to physicians to clarify orders.

Encouraging Staff to Communicate Effectively During "Difficult" or "Crucial" Conversations

A second intervention the TCAB team implemented to improve teamwork and communication was the provision of staff training on how to communicate during "difficult" or "crucial" conversations. One team member conducted a literature search on communication skills and researched the obstacles to effective communication during difficult or crucial conversations. The team then created training based on the literature

that included role-playing, lecture, and a question and answer period. The team posted the slides from the training to allow teams in other units to benefit from the training.

According to hospital leaders, the communication training helped staff to recognize crucial conversations and to understand why such conversations can be difficult. Unit staff reported that the communication skills they acquired from the training allowed them to speak more assertively to other health care providers.

Enhancing Unit-Based Teamwork and Communication across Hospital Departments

The TCAB team at Seton Northwest Hospital implemented two interventions to support improved teamwork: a nursing status board and a set of structured questions for team huddles. A TCAB team member had attended a conference at which she learned of a Wisconsin hospital that had implemented a unique admission-capping program. Nurses were entrusted with indicating whether their unit could safely take additional admissions. The TCAB team member wondered whether the program could be adapted for use in monitoring the workload of individual nurses.

The TCAB team began testing the use of a status board to monitor nurses' workload (see Figure 5). Nurses are asked to grade their subjective sense of their workload, which is recorded by the charge nurse on the status board. The board is color-coded: red indicates that the nurse feels overloaded—e.g., with an unstable patient, a time-intensive post-op patient or new admission, or a new set of orders—and needs some help with the workload; yellow indicates that he or she feels busy but is in the process of getting caught up with the workload and expects to be caught up within the hour; and green indicates that the nurse feels caught up with his or her workload and would be able to accept a new admission or help another nurse if needed. The charge nurse calls each unit nurse every two hours and updates the status board as needed.

Figure 5: Nursing Status Board at Seton Northwest Hospital

Mary Johnston, RN, standing at the Seton Northwest Admission Board.

The TCAB team member who presented the intervention to the staff emphasized that the philosophy underlying the tool was a spirit of teamwork. The team was careful to avoid judging the self-reported status of the nurses, and instead enlisted help and engaged in an honest conversation about the nurse's workload.

The status board serves as a visual indicator of the workload of the nursing staff throughout the unit, which was especially helpful in the physically expansive pilot unit. The team found that staff automatically checked the board and offered help to nurses reporting a red status. Although team members were concerned that staff might report a red status to avoid additional work, they found instead that staff worked to avoid reporting a red status.

The TCAB team tested the status board with staff on a single day shift before spreading the tool to a second day shift and finally to the evening and night shifts. Staff interviewed after the intervention reported that they felt better supported with their workload and that the fear of receiving additional work if they reported a green status

had proved false. Hospital leaders believe that use of the status board has engendered a greater sense of teamwork and trust among team members.

The Seton Northwest TCAB team also used structured questions during huddles to improve teamwork and communication. Prior to the hospital's involvement in TCAB, the nursing staff was encouraged to use huddles twice during each nursing shift to improve communication and facilitate work plans. However, staff found it very challenging to schedule and execute the huddles. After joining TCAB, the Seton Northwest team tested the use of a structured format to help focus team huddles (see Figure 6). Teams were asked to hold huddles two hours before and two hours after each shift change. The goals of the quick ad hoc meetings were to help staff communicate about their outstanding work and to allow the more experienced nurse to prioritize remaining tasks. The team found that the use of structured questions helped the teams consistently and reliably execute the huddles. In addition, the huddles increased the team's ability to focus on patient concerns and increased the effectiveness of communication among staff.

Figure 6: Structured Format for Team Huddles at Seton Northwest Hospital

Latest News/Updates re: Care, Treatment, Services
    • How's it going with . . . ?
    • How is that new admit . . . ?
    • Current status . . . ?

Anticipated Needs/Potential Changes   • Physical and/or emotional
Reinforce Expectations

Red Flags
    • Adverse Events
        o Fall precautions
        o Isolation necessary
        o Negative interpersonal experience with staff
    • Near misses
        o Aspiration risk
        o Confused; trying to get out of bed
    • Resolutions
        o Restraints applied
        o Teaching to family/patient
        o Family to stay with patient
    • Intuitive concern: "Things don't feel right"
    • Ambiguity/confusion of staff
    • Deviation from established procedures/norms
    • Task fixation
    • Task saturation
    • Behind schedule

Patient/Family Issues
    • Same name alert
    • Patient attitudes/expectations
    • Patient's primary expressed need**
    • Family issues/attitudes/expectations
    • Any negative experiences this visit? Prior visit?
 	
**Patients are to be asked each day/shift: "What is the most important thing we can do for you today/this shift?"

Unit/Assignment Issues
    • Equipment issues?
    • Personnel issues?
    • What assignments not yet completed?
    • Who is the best person to complete these tasks?
    • Potential admits / discharges / transports / procedures