

Utilizing TeamSTEPPS resources combined with a
simulated grand rounds workshop: Signature pedagogy
for interprofessional practice and education

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Medical Error: Since to Err is Human

Estimated Ranges of Preventable Hospital Medical Errors (Makary & Daniels, 2016).

- AHRQ (2004) 200,000/year
- James (2013) 210,000 – 400,000/year
- Classen et al. (2011) 400,000/year

Thus, why we are all here today.



Medical Error: What is Happening!

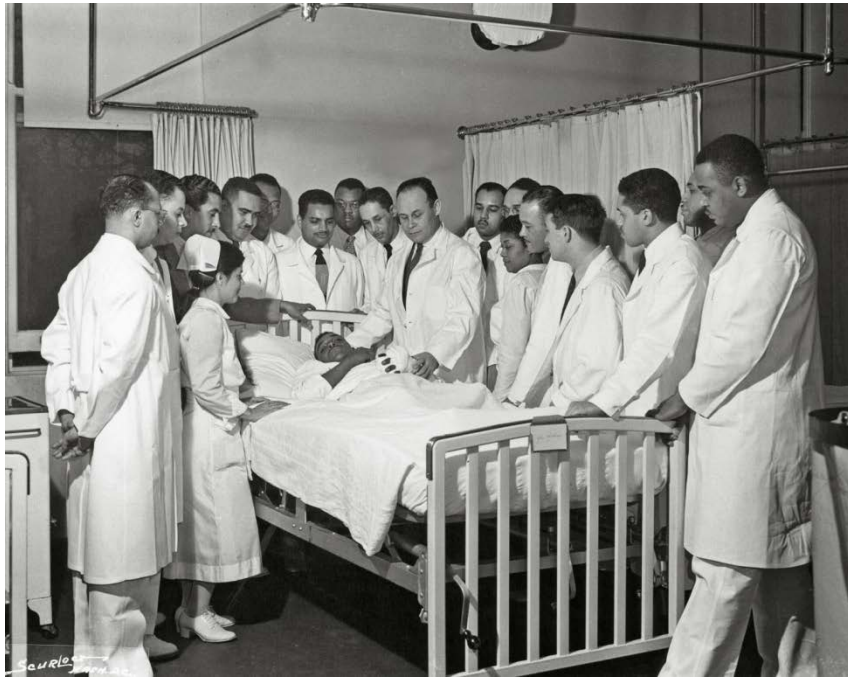
Makary and Daniels (2016) calculated a mean rate of 251,454 deaths per year, attributed to preventable medical error, using studies since the to err report of 44,000 – 98,000 deaths per year (Kohn, 2000).

Representing the third leading cause of death in the U.S. (Makary & Daniels, 2016).

Time to positively impact these numbers.



*Utilizing TeamSTEPPS resources combined with a simulated grand rounds workshop:
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Freedmen's Hospital, CA., 1947 by Addison Scurlock
(<http://i.imgur.com/7qDe7JW.jpg> accessed August 6, 2016)



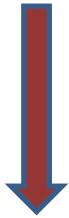
<http://childrensnational.org/education-training/continuing-medical-education/childrens-grand-rounds>



*Utilizing TeamSTEPPS resources combined
with a simulated grand rounds workshop:
[Signature pedagogy = clinical case
conferencing]
for interprofessional practice and
education*



Clinical Case Conferencing



Patient Rounds



Tumor Board



**Morbidity Mortality
Conference**

- **Regularly Scheduled Series (RSS) (Eiser, 2013)**
- **Pedagogies of Uncertainty (Shulman, 2005)**



The Problem Behind the Problem

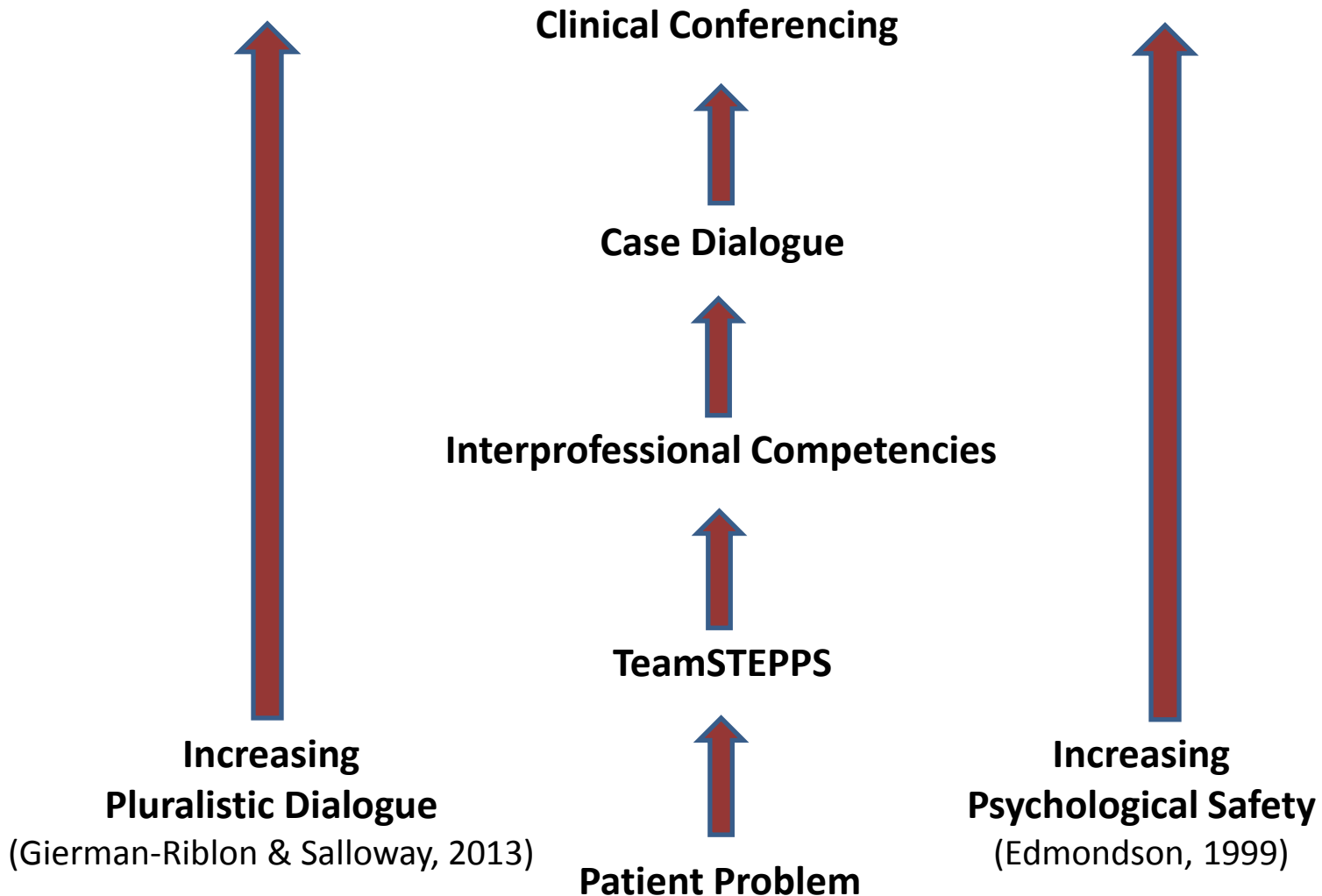


Table. 1 Comparison between levels of healthcare teamwork

	AHRQ, 2015	IPEC Expert Panel, 2011	Shulman, 2005
Characteristics	TeamSTEPPS Key Principles	Interprofessional Collaborative Practice	Clinical Case Conferencing
Intent	safety	defragment healthcare	problem resolution
Cooperation	communicative	collaborative	pluralistic
Communication	on an as-needed basis	continual and descriptive	routine and searching
Interdependency	sharing information	pooling knowledge	challenging knowledge
Teamwork	patient-focused	patient-centered	patient in attendance
Education	minimum competency	interpersonal skills	accountable talk
Scheme	continuity	complexity	uncertainty
Engagement	voice concern	deal with conflict	constructive conflict



Clinical Case Conferencing: Cooperation

Defined – pluralistic dialogue refers to the presentation of multiple realities for evaluation and presents information in a way that can change the providers' way of thinking (Gierman-Riblon & Salloway, 2013, McCallin, 2007).

Pluralistic cooperation permits the expression of multiple thought on the team both individually and collectively (van den Brink et al., 2015) allowing pluralistic cooperation to accommodate emergent issues (Weigert, 2016).



Clinical Case Conferencing: Communication

Communication is considered routine and searching with case conferencing (Shulman, 2005) rather than just on an as-needed basis with TeamSTEPPS (AHRQ, 2016) or continual and descriptive as with interprofessional practice (Seneviratne, 2009).

Routine relates to the regularly scheduled nature of the event while searching elevates the texture of the meeting with more pointed and probing examination by the team.



Clinical Case Conferencing: Interdependency

Interdependency extends beyond sharing of information as with TeamSTEPPS (AHRQ, 2016) and pooling of knowledge as in interprofessional care (IPEC, 2011) with the requisite routine challenging of providers' knowledge or agreement to disagree (Shulman, 2005; Davis & Thurecht, 2001).



Clinical Case Conferencing: Teamwork

Teamwork with TeamSTEPPS is patient-focused (AHRQ, 2016) while it is considered patient-centered in interprofessional care (IPEC, 2011).

Clinical case conferencing mandates the patients presence as a functional part of the team.



Clinical Case Conferencing: Educational Goals

Educational goals related to TeamSTEPPS is to provide minimum competency in regard to safety (AHRQ, 2016) while interprofessional collaboration embeds interpersonal behavioral learning (IPEC, 2011).

Accountable talk in conferencing require that providers build on what was said, in response offer a counterargument with new data and provide a plan (Shulman, 2005).



Clinical Case Conferencing: Scheme

Conferencing structure promotes continuity of care as with the TeamSTEPPS program (AHRQ, 2016) and managing complexity as with interprofessional collaboration (IPEC, 2011).

Case conferencing focuses on complexity and resolving substantive uncertainty by the team in regard to the patient's care (Shulman, 2005).



Desired Degree of Engagement

Finally, discourse with the TeamSTEPPS program requires participants to voice concern (AHRQ, 2016) while interprofessional collaborative practice suggests dealing with conflict (IPEC, 2011).

Clinical case conferencing may promote constructive conflict referring to a Sophist tradition of pluralistic dialogue whereby intellectual conflict will not necessarily be resolved (MacSuibhne, 2010).



Clinical Case Conferencing

Case Conference Dissected (Davis & Thurecht, 2001;
Kindsvatter & Wilen, 1981)

- 1) Precepts
- 2) Structure
- 3) Skills
- 4) Strategy
- 5) Closure



Precepts

Characteristics of the Clinical Case Conference (Davis & Thurecht, 2001)

- 1) Formal collaborative meetings
- 2) Implies ongoing regularly scheduled series
- 3) Face to face or communicate simultaneously
- 4) Full complement of providers plus patient
- 5) Discourse on matters related to patient concern



Structure

Structure of the Clinical Case Conference (Davis & Thurecht, 2001; Halcomb, 2009)

Brief - roles and responsibilities to be understood by all; with situational awareness; and division of effort

Conference – team meeting again establish situational awareness ; monitoring and modifying the plan; confirm plans already in place, and assess the need to adjust the plan as a team with the patient

Debrief - improve each provider's knowledge, skills, retention and patient safety, feedback with closure



Skills

Skills Required for Effective Case Conferencing (Kindsvatter & Wilen, 1981)

- **Climate Building:** relationships and rapport
- **Commentary:** inference; guiding; paraphrase
- **Questioning:** extend thinking; development of dialogue
- **Openness:** language and new terminology; ideas
- **Communication:** free flow of concise information
- **Teamwork:** behaviors & shared (power) decision making
- **Sensitivity:** express empathy and provide praise
- **Modeling:** encourage ideas and opinions of other



Strategies

Strategies Toward Effective Case Conferencing

(Kindsvatter & Wilen, 1981)

- **Target Setting:** dual focus on patient and system
- **Balanced:** engaged two way discussions
- **Deliberate practice:** new learning;
- **Reflect nonjudgmentally:** team psychological safety
- **Feedback:** praise and appreciation
- **Closure:** summarize
- **TeamSTEPPS Scripts:** SBAR; DESC ; CUS (AHRQ, 2013)



Intervention: Grand Rounds

In a scoping review of interprofessional interventions patient rounds were recognized as an effective practice intervention (Reeves et al., 2011).

Zwarenstein et al. (2009) categorized interprofessional teaching rounds as one of the few interprofessional collaborative practice-based interventions that can improve teamwork and patient outcomes when compared with a control or alternative treatment groups.



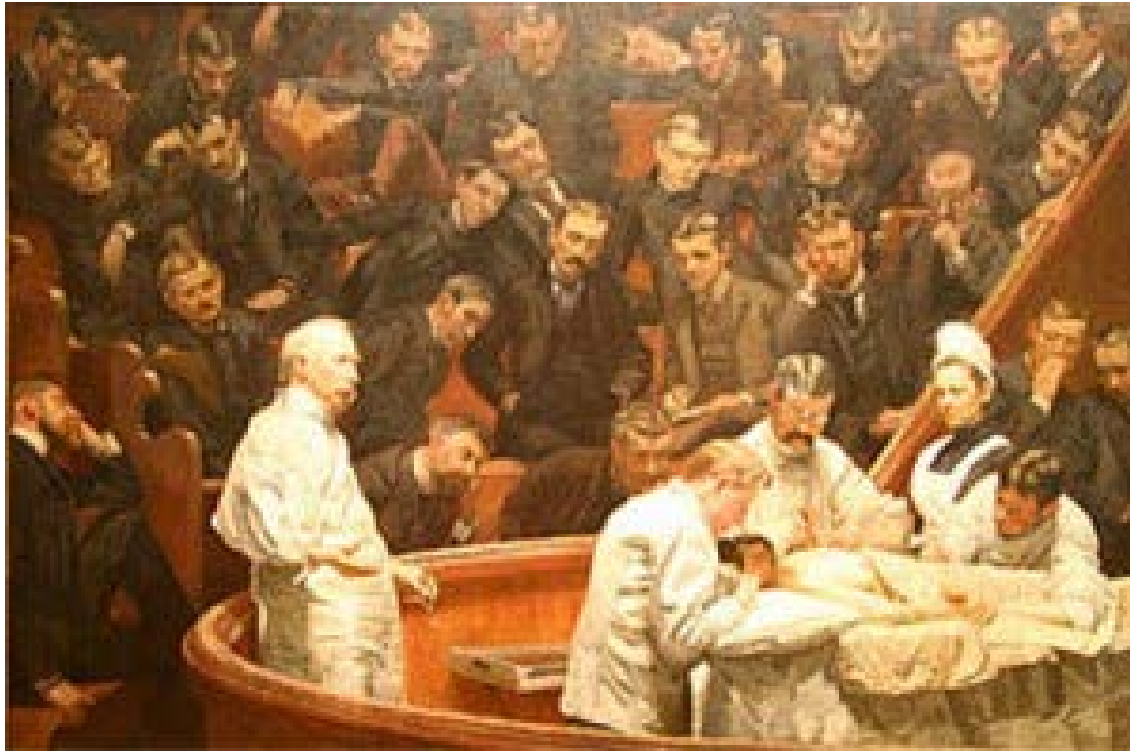
Workshop Summary

In summary

- TeamSTEPPS resources provide the communication tools and dialogue scripts
- Interprofessional teamwork provides the elements of effective interpersonal collaboration
- Grand rounds simulation provides the setting for clinical case conferencing with deeper pluralistic dialoguing



Original Patient Grand Rounds



Harvard Medical School and Brigham and Women's Hospital. Integrative Medicine Grand Rounds.

http://www.brighamandwomens.org/Departments_and_Services/medicine/services/osh/ercenter/IM%20Grand%20Rounds.aspx accessed Aug 6, 2016



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