

Simulating Teamwork and Observation for Procedural Safety (STOPS)

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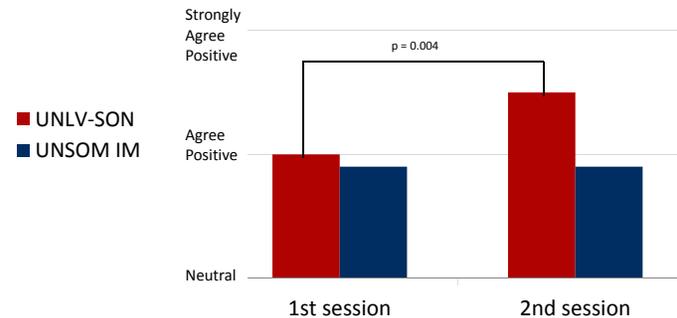
Introduction

- Hallmarks of safe systems within a hospital include development of teamwork competency
- The insertion of a central venous catheter (CVC) is a clinical practice where systematic implementation of safety strategies have been demonstrated to have a measureable effect on patient outcomes¹
- Current systems of practice do not provide an optimal amount of time to comprehensively educate nurses and residents of the value of a team approach to technically challenging operations like CVC insertion

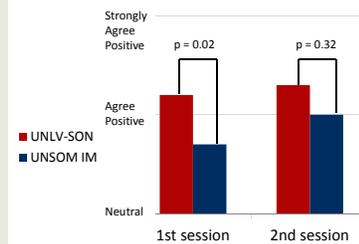
Methods

- STOPS is a prospective, 2 year observational pilot study
- Participants represent a multispecialty training background
 - UNLV school of nursing students
 - UNSOM internal medicine residents
 - Training pilot made part of standard curriculum
- Pairs of nursing students and residents were assigned & underwent:
- A multicomponent didactic session including:
 - An evidence based approach to central line insertion including a reference for training modalities, indications for stopping a procedure / minimizing complications, strategies for reducing central line associated blood stream infections (CLABSI)¹⁻⁴
 - An instructional video demonstrating the procedure itself from an available online training site⁵
 - The basics of team based communication adapted from TeamSTEPS training materials⁶
- Simulation (directly observed via one way glass and camera)
 - Complete autonomy by the procedural team.
- Debriefing
 - Focused feedback on the procedure, patient safety & team-based communication issues
- Research Survey (consent obtained)
 - IRB approved portion of STOPS
 - Questions adapted from AHRQ culture of safety survey⁷ and the initial STOPS didactic session
- Descriptive & comparative statistics derived from survey results

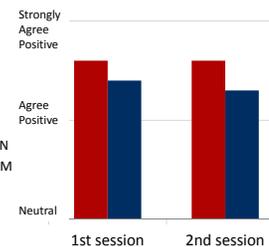
Survey Response to Constructive Communication & Feedback



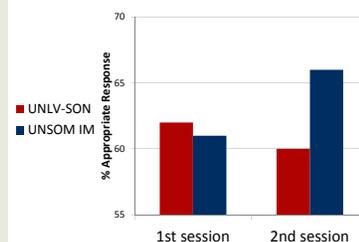
Survey Response to System Based Patient Safety



Survey Response to Teamwork



Survey Response to CVC Insertion / Technique



Survey Tool

Results

- 83 participant experiences were observed
- Nursing students had significantly more positive views of systems based patient safety at baseline
 - This difference was negated in 2nd session resident responses
- Statistically significant improvements were seen in survey questions designed around constructive communication and feedback among nursing students
- Non-significant positive trends were observed in teamwork, and systems based safety responses among nursing students
- Non-significant positive trends were observed in CVC procedural knowledge among internal medicine residents

Conclusions

- Currently there is little published experience on multispecialty procedural training for central venous catheter insertion
- Nursing empowerment and a team-based approach to central venous catheter insertion has been shown to improve patient outcomes (i.e. CLABSI rates, hospital costs)¹
- Training such a team based, communication focused, approach to central line insertion is both institutionally feasible and individually beneficial
- Simulation based training of the teamwork aspects of central line insertion and patient safety may create significant improvements in important aspects of the multispecialty team
- Nursing care providers may experience the greatest benefit to multispecialty training in a simulation environment
- The introduction of similar simulation education programs should be considered in other institutions

References

- Berenholtz SM. *Crit Care Med.* Oct 2004; 32(10):2014-20
- Hales BM. *Journal of critical care.* Sep 2006;21(3):231-235.
- Barsuk JH. *Acad Med.* Dec 2011;86(12):1513-1517.
- Velmahos GC. *Am J Surg.* Jan 2004;187(1):114-119.
- <http://www.nejm.org/doi/full/10.1056/NEJMc074357>
- <http://teamsteps.ahrq.gov/>
- <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html>