TeamSTEPPS™
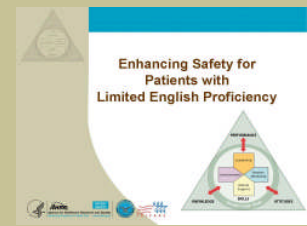Team Strategies & Tools to Enhance Performance & Patient Safety

Enhancing Safety for Patients with LEP

INTRODUCTION

Slide

SAY:

In recent years, the Agency for Healthcare Research and Quality and the Department of Defense have worked together to enhance patient safety. The TeamSTEPPS system is a powerful set of teachable and trainable skills, behaviors and tools that has been shown to reduce medical errors. In this module, we show how the TeamSTEPPS system can be used to enhance the safety of patients with Limited English Proficiency (LEP).

Before we start the module, I'd like you to complete a baseline survey. This survey is anonymous and will help us track our progress as a team. Everyone in this session should complete the learning outcomes survey. In addition, everyone in the group except for interpreters should complete the baseline behavior change survey. You will have 15 minutes to complete these surveys.

(Collect baseline surveys and thank participants).

⊙ INSTRUCTOR NOTE:

This module may be customized based on the group's knowledge and experience with LEP and culturally diverse patients and TeamSTEPPS™. For example, if the group is aware of medically significant miscommunication incidents that have occurred with LEP patients in their hospital, it may be useful to replace one of the presentation's case examples with the example that participants know. Similarly, depending on the amount of exposure to TeamSTEPPS, the group may need more or fewer slides with information on TeamSTEPPS.

MODULE TIME:

60 minutes + evaluation time (20 minutes)

EVALUATION:

15 minutes pre-training

15 minutes post-training

MATERIALS:

- Evaluation forms
- Exercise worksheets and pens
- LEP Video (Opportunity Lost and Won examples)

Slide

Overview/Objectives
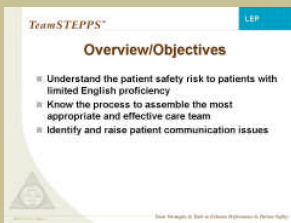
SAY:

This module will help you to:

❏ Understand the patient safety risk to patients with limited English proficiency

❏ Know the process to assemble the most appropriate and effective care team for LEP and culturally diverse patients

❏ Identify and raise patient communication issues

The Story of Willie Ramirez

SAY:

To illustrate why LEP patients are at risk of patient safety events, I would like to share the story of Willie Ramirez. This case is one of the most well-known examples in which limited English proficiency and cultural misunderstandings resulted in a tragic medical error.

In 1980, 18-year-old athlete Willie Ramirez was taken to the ER by ambulance in a coma, accompanied by his Mom, his sister, his girlfriend, and his girlfriend's Mom. The ER physician, who did not speak Spanish, assumed Willie had a drug overdose because he had pinpoint pupils and because the girlfriend's Mom said, in broken English, "he is intoxicado". In Cuban Spanish "intoxicado" means "poisoned". The family thought he had eaten a bad hamburger at a new Wendy's that day.
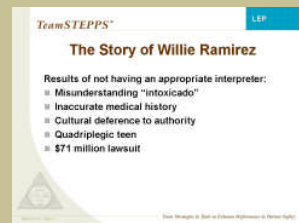
When the ER doctor told the family he would treat Willie for drug overdose, they said to one another, in Spanish, "that's impossible, he would never take drugs". Willie was an all-star baseball player and was opposed to drugs and drinking. However, the doctor did not understand what the family was saying. Willie's intracerebral hemorrhage kept bleeding for more than two days before a neurological consult was scheduled. By then, Willie was quadriplegic. The family sued the hospital, resulting in a $71 million settlement.

In a later interview, the ER doctor said, "If I had a Mom who said, "My son would NEVER use drugs," I may have thought differently." However, the family member who was interpreting did not share this information with the doctor, because cultural differences complicated the language issue. In some cultures, people never contradict an authority figure, like a doctor.

Neither the doctor nor the family asked for a professional medical interpreter because they thought they were communicating adequately. A professional interpreter could have facilitated mutual understanding by interpreting the doctor's and family's words to one another, asking questions to make sure they understood correctly, and speaking up when the family expressed doubts about the doctor's diagnosis.
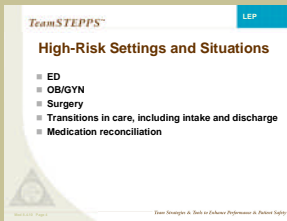
👁 **INSTRUCTOR NOTE:**

You may read the full story here:
http://healthaffairs.org/blog/2008/11/19/language-culture-and-medical-tragedy-the-case-of-willie-ramirez/

High-Risk Settings and Scenarios

Slide

SAY:

Research shows that Patient safety events that affect LEP patients tend to be more severe and more frequently due to communication errors compared to English-speaking patients.

While all patients are at greater risk in acute care settings, LEP patients may be even more vulnerable in interactions with the ED, OB/GYN or Surgical settings. In situations where care is time-sensitive and communication with the patient or their family is important, such as intake, transitions in care, discharge, and medication reconciliation, LEP patients may need additional supports to maintain safety.

INSTRUCTOR NOTE:

The points made above are supported by preliminary research conducted to develop this training module, and by these references:

Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Intl J Qual Health Care* 2006;18:383-388.

Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics 2003;111:6-14.

Added risk for LEP Patients

SAY:

Research also indicates that without a professional interpreter, medical interpretation errors are more common and significantly more likely to have potential clinical consequences.

When the care team asks family members or housekeeping staff to interpret, or when they rely on their own limited foreign language skills or the patient's limited English, they place LEP patients at risk for physical harm.

In addition, they place the ad hoc interpreter at risk for psychological harm. Imagine how you would feel if you made an error in interpretation that caused your family member to become quadriplegic.

Another risky situation is when the interpreter arrives after the encounter has already begun, or is called away before the encounter ends. Ideally, the interpreter should be present for the whole encounter. However, when this is not possible, the interpreter should be briefed when they arrive and there should be a backup plan in case they have to leave.

INSTRUCTOR NOTE:

The points made above are supported by preliminary research conducted to develop this training module, and by these references:

Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. Med Care Res Rev. 2005; 62(3):255-99.

Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics 2003;111:6-14.

Slide

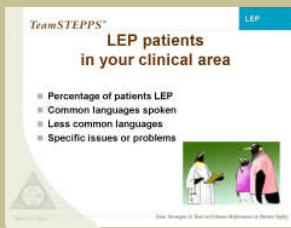## LEP Patients in your Clinical Area

👁 **INSTRUCTOR NOTE:**

The bullet-points in this slide should be replaced with information about LEP patients in the clinical area where you are conducting the training.

About the penguins: Graphic design used throughout TeamSTEPPS, including the cartoon penguins, is inspired by the 2006 book by John Kotter, "Our Iceberg is Melting: Changing and Succeeding Under Adverse Conditions". The book illustrates Kotter's Eight Stages of Change, a proposed set of steps to initiate and sustain change in an organization, through the story of a penguin colony faced with a melting iceberg.

Reference:

Kotter, J, Rathgeber H., Mueller P. 2006. Our Iceberg is Melting: Changing and Succeeding Under Adverse Conditions. St Martin's Press.

Close Call: An Interpreter's Story

SAY:

Here is an example of a close call that we experienced here. This story comes from (specify source, eg: interpreter services, nursing, or patient safety, etc.)

"The patient came to the surgery, and it was assumed that the patient did speak English. After the whole assessment was done, the patient answered inappropriately, and that made the nurse doubt. She called interpreters, and I arrived. And the nurse said 'you said you're not allergic to medicine….drug or latex' And when I interpreted, [the patient] said, 'I am allergic to latex'. …And the nurse kept saying, 'Are you sure?' and she said, 'Yeah…' 'And what happens to you?'' Well they put the latex band…it was itchy, it was red, and it was swollen.' So she had to stop, run, call the OR, put on the latex sensitivity. They had to move everything from the OR."

👁 INSTRUCTOR NOTE:

Please replace this story with a local story from one of your clinical settings, in which an LEP patient was at risk or was harmed due to problems with cultural differences or missed communication. You will likely discover stories of close calls or risky situations if you speak to frontline staff members or leaders in nursing, interpreter services, or patient safety.

If you do not have a local story to share, you may use the example above and say:
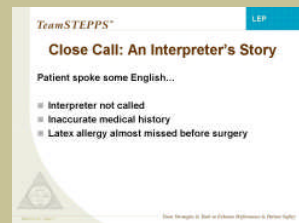
"As part of the preliminary research that was done for this Training Module, 18 persons were interviewed in 3 hospitals among frontline staff and leaders in interpreter services, nursing and patient safety. All 18 persons reported situations where an interpreter was needed but was not present. In several cases, this led to "close calls" like the one described on this slide".

Here is another possible example you could use instead of the one in the slide:

LEP Patients at Risk – A Nurse's Story
"I have noticed that the patients come back to the hospital, to the same units where they have already been discharged. So you give the paperwork to the patient the day that they are going home. The patient actually said, "yes yes yes yes I understand everything". And then you find the patient back a few days later, a week later…the same patient. And then, that's when I find out that every discharge instruction that was given to the patient was totally misunderstood"
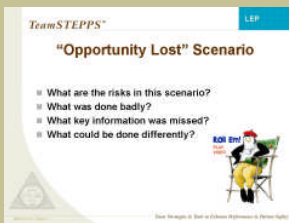

LEP

TeamSTEPPS
Close Call: An Interpreter's Story
Patient spoke some English…

- Interpreter not called
- Inaccurate medical history
- Latex allergy almost missed before surgery

Slide

Limited English Proficiency

Slide

Scenario

SAY:

This video gives us an example situation in which a patient with limited English proficiency is at risk.

VIDEO TIME:

4 minutes

DO: Show the "opportunity" video.

DISCUSS:

Ask participants: What are the risks in this situation? What was handled badly? What important information was missed? What could be done differently? Allow them the opportunity to discuss and respond. If they do not respond, prompt them with suggestions:

Let's start with the front desk –

What might the triage nurse have known about words that sound familiar in foreign languages?

At what point should a professional interpreter have been called in?

At what other points were there missed opportunities to call an interpreter?

What else could the care team have done to better communicate with the patient and his wife?

Benefits of including interpreter on the care team

SAY:
When we include a professional interpreter as a member of the care team, there are significant benefits to the patient.

Of course, the interpreter can interpret the words spoken or translate written words. The interpreter can also serve as a cultural broker, helping healthcare providers understand the cultural perceptions and expectations of the patient as well as helping the patient understand the expectations and culture of healthcare. Finally, the interpreter can also serve as an advocate, speaking up when they feel the patient or provider may have missed important information.

The presence of a professional interpreter also has significant benefits to the care team, ensuring that the the care team has more accurate and more complete information, and facilitating decision-making.

👁 **INSTRUCTOR NOTES:**

It can also be beneficial to use bilingual staff who are certified to provide care in non-English languages, or volunteers who are trained and certified to act as interpreters.
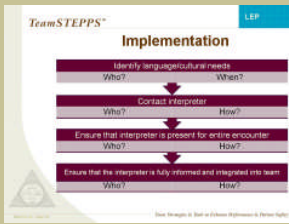
Some health care settings advocate a "Black Box" model, where the interpreter limits themselves to interpreting and translating words. However, patient safety can be enhanced when the interpreter is also allowed share important cultural information and raise patient safety concerns.
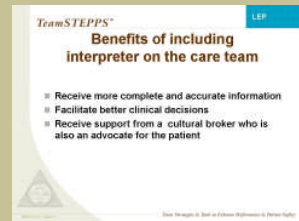
Implementation

Slide

SAY:

What is the process for obtaining an interpreter in your clinical area?

The basic steps include identifying the need for language or cultural support, contacting the interpreter, ensuring that the interpreter remains present during the entire patient encounter, and ensuring that the interpreter is fully informed and integrated into the patient care team. Also, there needs to be way of implementing contingency plans as needed, for example if the interpreter is late, or if the interpreter needs to leave before encounter is complete.

EXERCISE

EXERCISE:
Instruct participants to take out their worksheet (provided as part of the Training of Trainers) and to take five minutes to complete the map, adding any steps necessary at their site and noting who, when and how. If there is a team from one unit or area, they can work together to complete the worksheet, or they may use a flipchart for easy viewing by the whole group. Once they have completed the sheet, ask the groups to share their detailed maps with the full group, closely monitoring time (5 minutes).

Assertion, Advocacy and Conflict Resolution

DO:

Read the scenario

💬 **DISCUSS:**

What are the risks to the patient in this scenario?

What could go wrong?

What needs to happen to avoid problems? If you were Ms. Solaine, what could you do?

(Allow time for group to answer questions and discuss. If no one speaks up, call on a few people by name to encourage responses to these questions).

SAY:

Specific skills needed in this scenario include assertion, advocacy and conflict resolution. We will learn some structured methods of assertion that might help in situations like this.
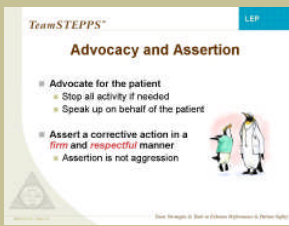
👁 **INSTRUCTOR NOTES:**

Two main languages are spoken in Haiti, Haitian Creole and French. Speaking French signals a higher social status. Thus, some patients may be reluctant to admit they do not understand it well.

Slide

Advocacy and Assertion

SAY:

Advocacy and assertion are useful for any team member whose viewpoint does not agree with that of a decision maker, or who notices a patient safety problem. In advocating for the patient and asserting a corrective action, the team member has an opportunity to correct or avoid errors. Failure to use advocacy and assertion has been frequently identified as a primary contributor to the clinical errors found in malpractice cases and sentinel events.

💬 **DISCUSS:**

When might you use advocacy and assertion for LEP patients?
• To make sure that patient language needs are assessed
• To make sure that an interpreter is called when needed
• To raise communication issues

SAY:

When advocating, assert your viewpoint in a firm and respectful manner. You should also be persistent and persuasive, providing evidence or data for your concerns. Appropriate assertion is a way of advocating for the patient. In the interest of safety, you may need to speak up to stop all patient care activity until a risk can be resolved or until the patient understands what is happening. In this session, we will show you structured language and gestures that can make it easier to be appropriately assertive.

It's helpful to note that assertion is not aggression: assertive statements respect and support authority.

💬 **DISCUSS:**

Why might it be difficult to speak up on behalf of the patient? (Allow the group to respond). Some possible reasons include the traditional hierarchy of healthcare, the strong personalities of some healthcare providers, previous negative experiences with speaking up—if you have tried it once and been "shot down" you tend to be very hesitant to speak up again even in a different setting with different people. Cultural differences are also a factor in the difficulty with assertion, because deference to authority is an important value in many cultures.

Assertion at Work

Slide

![cog icon] **DO :**

Play the Assertion video (this is the segment of the success LEP video that involves the interpreter putting up hands to stop the conversation, stating that there is a misunderstanding of the word fatiga, and clarifying what the patient is saying)

![clock icon] **VIDEO TIME:**

15-30 seconds

![discuss icon] **DISCUSS:**

Was the assertion respectful? Did it follow the steps listed here?

- Make an opening: using the hand signal agreed upon to mean "please stop and listen"
- State the concern: "I think there's a misunderstanding"
- State the problem: "You are interpreting 'fatiga' as fatigue but I think he means shortness of breath"
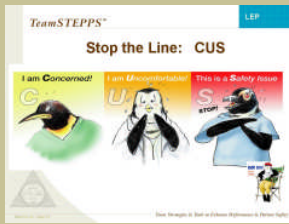- Offer a solution: "Let me check with him to clarify"
- Reach an agreement: "OK?"

What do you think will be the result of this assertion?
What risks might it prevent?

Slide

Stop the Line: CUS

SAY:

Structured language can make it easier to speak up and be assertive when it's needed. By using a "script" of set phrases that the team has agreed upon in advance, interactions are more predictable and less "personal".

In TeamSTEPPS when we need to "stop the line" to ensure safety, we "CUS". The team understands that when any member of the team says, "I'm concerned…I'm uncomfortable…"This is a safety issue" it means that we need to pause and make sure that there are no unnecessary safety risks happening, and that the entire team understands the plan.

The phrases function as a signal, similar to calling a code. Hand signals or gestures are also useful as "code" language for interpreters (or others) to indicate a need to stop and listen. Raising the hands in front of yourself, palms out, can be an agreed-upon gesture to "stop the line" for interpreters. Here's an example:

VIDEO TIME:

15-30 seconds

DO: Show CUS video clip *(this will be a 15-30 second clip from the video we will produce).*

DISCUSS:

Was the use of CUS effective? Why?

SAY:

You can also use these signal phrases to escalate a concern. first state that you are concerned, then if there is no response, you can go on to say you are uncomfortable or that this is a safety problem. It's important to give as much information as you can regarding why you are concerned, and what you are seeing or hearing that is making you uncomfortable.

When Initial Assertion is Ignored…

SAY:

It is important to voice your concern by advocating and asserting your statement at least twice if the initial assertion is ignored (sometimes it is called the "Two-Challenge rule"). These two attempts may come from the same person or two different team members. The first challenge should be in the form of a question or initial concern. The second challenge should provide some support for your concern. Remember this is about advocating for the patient. This "two-challenge" tactic ensures that an expressed concern has been heard, understood, and acknowledged. If, after two attempts to clearly assert your concern, there is no resolution of the problem, you may then seek assistance from an additional resource, such as a charge nurse or other physician.

Slide

Slide

Briefs

SAY:

Once the full team is present and engaged, it's necessary to ensure all are informed. This includes the interpreter. Briefs are a communication and team tool for planning purposes. During a brief, which is sometimes referred to as a team meeting, complete the tasks listed on this slide.

The team leader is responsible for organizing a short briefing to discuss essential team information and to establish an environment in which the team, including the interpreter and the patient, are comfortable speaking up and participating. The following information should be discussed in a brief:

- Team membership and roles—who is on the team (including the interpreter) and who is the designated team leader

- Encouragement to speak up and share any relevant information or concerns

- Team goals, plans and risks—what is to be accomplished and who is to do it, what are the potential risks

DO:

Play the video by clicking the director icon on the slide.

(Use the segment of the success LEP video in which the brief occurs, including the interpreter)

DISCUSS:

- Who is the team leader?

- How did the leader establish psychological safety for the team?

- Did the team develop a plan for the patient?

- Did everyone understand the plan?

VIDEO TIME:

30 seconds

Psychological Safety

SAY:

The team leader establishes psychological safety for the group: the INTERPRETER establishes this for the patient . This is the way we create an environment in which is is safe to speak up.

Traditional hierarchy, status differences, and cultural differences can create real barriers to effective team communication. It is up to the leaders of a team to overcome that through these strategies.

Leaders invite comments by calling on team members by name and by role: "Gerardo, as the interpreter, do you see anything here that we've missed or that Mr. Ruiz may not understand?" or "Jane, as Mrs. Ruiz's nurse, do you have anything to add?"

Leaders also are perceived as more accessible and approachable if they validate the comments of the team. "Mr. Ruiz, it sounds like you are concerned about this." Leaders also recognize that all humans can make mistakes and they ask for mutual support to avoid error. You can do this in your own words, for example: "if you see anything that seems risky or that you don't understand, please let me know", or "feel free to stop us at any time if anything is not clear, or if there is anything I should know about the patient's culture, beliefs or concerns".
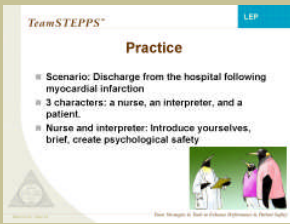
Slide

EXERCISE

Practice

SAY:

We're going to practice briefing, including creating psychological safety.

In this scenario, the patient is being discharged from the hospital after having a myocardial infarction. The interpreter introduces herself to the provider and the patient. The nurse asks the patient and interpreter to let her know if there is anything the patient does not understand, or anything that makes her concerned or uncomfortable. The interpreter interprets this and also asks the patient to let her know if there is anything he does not understand or is concerned about. You should feel free to rephrase this in your own words.

EXERCISE:

In small groups, practice (role play) the scenario, leading a briefing and using name and role activation and requesting direct input. Then debrief the exercise as a full group.

SAY:

Please note that in some cultures, the patient may prefer to have the provider and interpreter address a family member instead of addressing the patient directly. The interpreter should verify the patient's communication preferences and may provide guidance to the provider about whom to address and how.

Check Back is…

SAY:

A check-back is a closed-loop communication strategy used to verify and validate information exchanged. The strategy involves the sender initiating a message, the receiver accepting the message and confirming what was communicated, and the sender verifying that the message was received.

A simple example of this is in the coffee shop when you order a tall nonfat soy latte, and the cashier says aloud, "tall nonfat soy latte" and the barista repeats back "tall nonfat soy latte", and you verify, "that's correct".

A clinical example would be an information call-out "BP is falling, 80/48 down from 90/60." The sender expects the information to be verified (repeated aloud) and validated and to receive a follow-on order that must be acknowledged with a check-back.

In the video, you will see a provider using check-back to confirm their understanding of what the patient was saying.

DO: Play the video by clicking on the top director icon on the slide. (Use check-back clip from the "improvement" video)

Slide

VIDEO TIME:

15-30 seconds

Slide

Teach-back is…

SAY:

While check-back simply verifies accuracy of a simple communication, teach-back is a method to confirm understanding of larger concepts or processes. In a teach-back, you ask someone to tell you in their own words what they have learned or understood.

This technique can be most useful for interpreters, who can use the teach-back to correct any misinformation or missed communication.

Examples include asking the patient to tell how they will take their medication when they get home, or how they will explain their illness to their family.

Putting It All Together

🎞️ **DO: Play the "Opportunity Won" video by clicking on the picture**

💬 **DISCUSS**: What tools were used in this version that were not used in the first version of this scenario? How did the use of those tools change the outcome?
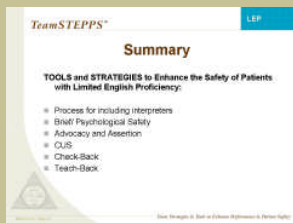

LEP

Slide

🕐 **VIDEO TIME:**

4.5 minutes

Slide

Summary

SAY:

In summary, here are tools and strategies which can enhance the safety of your patients with LEP:

- **Process for including interpreters**
- **Brief/ Psychological Safety**
- **Advocacy and Assertion**
- **CUS**
- **Check-Back**
- **Teach-Back**

Training Evaluation

SAY:

Thank you very much for your participation today. Please take a few minutes to complete the training evaluations that are in your training packets, then we will discuss this module. Everyone should complete two forms: the training participant satisfaction survey and the learning outcomes survey. We anticipate this will take you no more than 15 minutes.

POST-TRAINING EVALUATION TIME:

15 minutes