TeamSTEPPS™

Team Strategies & Tools to Enhance Performance & Patient Safety

Enhancing Safety for Patients with Limited English Proficiency Train-the-Trainer Instructor Guide

Pre-Work

LEP

Send pre-work materials to training participants at least two weeks before the training.

PREWORK TIME:

30 minutes

Dear TeamSTEPPS trainers,

We look forward to seeing you soon for the TeamSTEPPS training to improve the safety of patients with limited English Proficiency (LEP).

A while back, you completed a readiness assessment survey to check whether your institution was ready for this training. Now, we ask that you complete a brief site assessment to help us have a productive training.

The site assessment includes completing a site assessment questionnaire, completing a language process map, and making a copy of your hospital's or organization's policy on accessing language services to bring to the training. We estimate these tasks may take approximately 30 minutes.

Please do not hesitate to let us know if you have any questions.

Best regards,

[Trainer names, signature and contact information]

Pre-Work: Site Assessment for Trainers

Please take a moment to answer the questions below. This will help you to customize the training module to your audience's needs.

1. What percentage of your patients have limited English proficiency?

2. What are the most common languages spoken by your patients?

3. How do staff in your clinical area…
   a. Identify patient language needs
   b. Contact an interpreter
   c. Ensure that the interpreter is present for the entire encounter
   d. Ensure that the interpreter is fully informed and integrated into the team?

   To answer these questions, please complete the attached Patient Language Process Map, with information for your unit, and mark the areas of risk or areas needing improvement

4. Please attach a copy of your hospital or organization's policies for calling an interpreter.

   What are your contingency plans: what happens when the interpreter is unavailable, late, or cannot stay for the entire patient encounter?

5. List some examples of real situations from your hospital/clinical area in which LEP patients were at risk due to language barriers and/or not having an interpreter available (use the reverse side of this sheet if needed).

Patient Language Process Map

Identify language/cultural needs	
Who?	How?
Contact interpreter	
Who?	How? List various methods. Note contingency plans.
Ensure that interpreter is present for entire encounter	
Who?	How?
Ensure that interpreter is fully informed and integrated into team	
Who?	How?

Train-the-Trainer Session Agenda

TRAIN-THE-TRAINERS

SESSION TIME:

4.5 hours

- Experience the pre-training evaluation questionnaires as intended for students (15 mn)
- Experience the module as intended for students (60 mn)
- Experience the post-training evaluation questionnaires as intended for students (15 mn)

~ Break – 10 minutes ~

- Debrief on teaching points and areas for customization (15 mn)
- Review pre-work assignments (35 minutes)
- Conduct Implementation planning (45 minutes)

~ Lunch – 20 minutes ~

- Practice teaching parts of the module (40 minutes)
- Wrap-up and Q&A and evaluation (15 minutes)

MATERIALS:

- Training Module slides
- Videos
- Module Exercise worksheets
- Pens
- Implementation slides
- Evaluation Guide
- Implementation worksheets
- Process maps prepared in pre-work
- Blank process maps
- Policies identified in pre-work
- Evaluation forms

LEARNING OBJECTIVES:

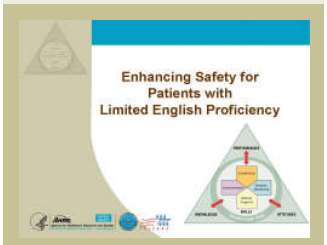
1. Understand the evidence on patient safety risks to LEP patients
2. Assemble the most appropriate and effective care team for LEP patients
3. Identify and raise patient communication issues
4. Use the site readiness assessment to customize training and implementation plans
5. Develop an implementation plan
6. Develop the ability to teach Objectives 1 – 3

INTRODUCTION

LEP

SAY:

We begin this Train-the-Trainer session with the module itself, just as you will present it to your participants. Please locate and use your slide handouts for the module "Enhancing Safety for Patients with Limited English Proficiency" and follow along, noting areas where you may wish to customize the material for your own group. The "script" of notes for these slides will be provided to you later in this session.



Slide

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).

MODULE TIME:

60 minutes

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 10 minutes to complete these surveys.

(Collect baseline surveys and thank participants).

EVALUATION:

15 minutes pre-training

15 minutes post-training

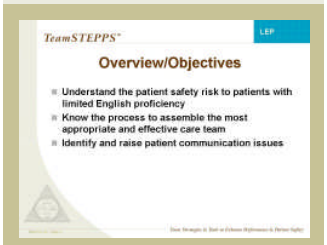
INSTRUCTOR NOTE:

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.

MATERIALS:

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

Overview/Objectives



Slide

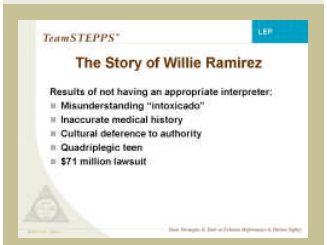
SAY:

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

LEP



Slide

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.

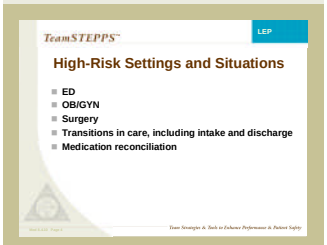
In a later interview, the ER doctor said, "If I had a Mom who said, "My son would NEVER use drugs," I may have thought differently." However, the family member who was interpreting did not share this information with the doctor, because cultural differences complicated the language issue. In some cultures,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

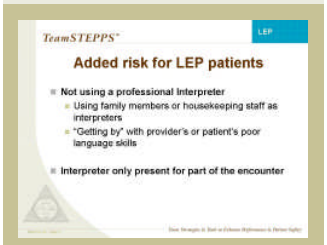
The points made above are supported by preliminary research conducted to develop this training module, and by these references:

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

LEP



Slide

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.

LEP Patients in your Clinical Area

Slide

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.

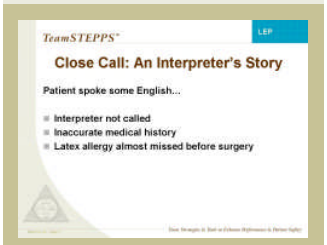
About the penguins: Graphic design used throughout TeamSTEPPS, including the cartoon penguins, is inspired by the 2006 book by John Kotter, “Our Iceberg is Melting: Changing and Succeeding Under Adverse Conditions”. The book illustrates Kotter’s Eight Stages of Change, a proposed set of steps to initiate 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

LEP



Slide

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.

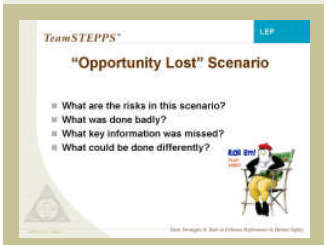
If you do not have a local story to share, you may use the example above and say:

"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"

Scenario



Slide

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?

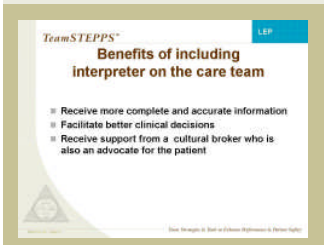
At what point should a professional interpreter have been called in?

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

LEP



Slide

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.

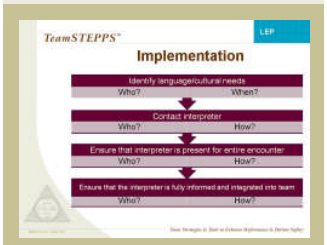
The presence of a professional interpreter also has significant benefits to the care team, ensuring that the the care team has more accurate and more complete information, and facilitating decision-making.

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:

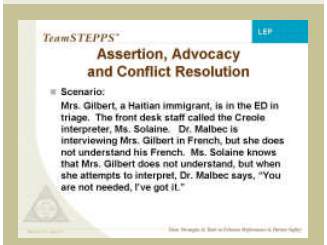
What is the process for obtaining an interpreter in your clinical area?

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



Slide

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).

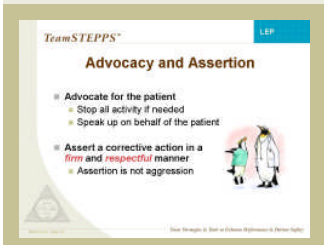
SAY:

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.

Advocacy and Assertion



Slide

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

LEP

Slide

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)

VIDEO TIME:

15-30 seconds

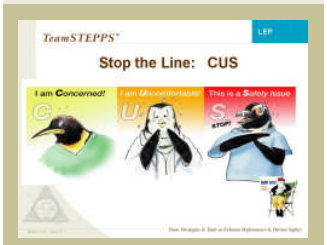
DISCUSS:

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?

Stop the Line: CUS



Slide

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…

LEP

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

Briefs

Slide

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

VIDEO TIME:

30 seconds

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?

Psychological Safety

LEP

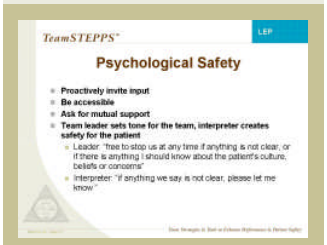
SAY:

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.

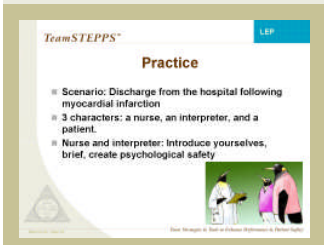
Leaders invite comments by calling on team members by name and by role: “Gerardo, as the interpreter, do you see anything here that we’ve missed or that Mr. Ruiz may not understand?” or “Jane, as Mrs. Ruiz’s nurse, do you have anything to add?”

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

Practice



Slide

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

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…

LEP

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.

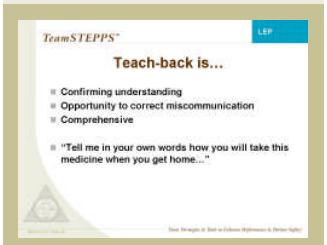
In the video, you will see a provider using check-back to confirm their understanding of what the patient was saying.

Slide

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

VIDEO TIME:
15-30 seconds

Teach-back is…



Slide

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

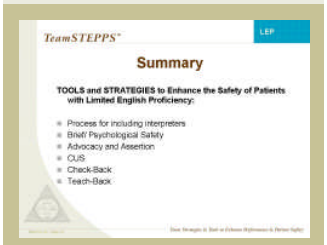
LEP

Slide

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

VIDEO TIME: 4.5 minutes

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?



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

LEP

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

Review the Teaching Points

10 minutes

Discuss:

Having experienced the module, what questions do you have about the content?

What parts will be easiest for you to teach?

Which parts will be harder to teach? Why?

Where will you want to customize the module for your group?

What concerns were raised for you as you experienced the module?

Review the Instructor Guides

LEP

DO:

Hand out the module Instructor Guides to participants, or direct them to that segment of their packet.

5 minutes

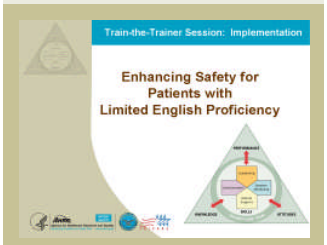
SAY:

This guide provides you with a possible script to accompany the slides, and also indicates areas where you can customize the material. Additional resources and references are also provided. As we go through the guide, please note the places where you would want to customize the content.

DO:

Go through the guide briefly, answering questions and clarifying symbols.

Implementation



Slide

NOTE:

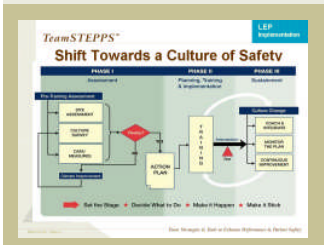
The TeamSTEPPS LEP implementation slides are used in the following segment, which will take about 35 minutes to complete.

SAY:

For this portion of the training, you need to be in groups with the others from your organization, so that you can work together on the activities and worksheets.

Implementation: Shift Towards a Culture of Safety

LEP



Slide

5 minutes

SAY:

This diagram provides an overview of the implementation of any culture change, and of any TeamSTEPPS intervention. If you have done other TeamSTEPPS work in your organization, you are probably familiar with this process. We'll review it very briefly: there are three phases of any successful implementation—Assessment, Planning/Training/Action, and Sustainment. You can think of it in simple terms by following the bottom of the diagram: Set the stage, Decide what to do, make it happen, make it stick.

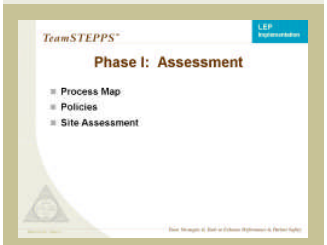
In phase I, assessment, you use what information you have to determine readiness and to inform you planning phase. For this intervention to improve the safety of LEP patients, you'll use the site assessment you completed prior to training, along with the data you have about LEP patients at your organization. You can include any culture survey data you might have, such as patient satisfaction survey information if it can be segmented by language or cultural needs. If the results of your assessment indicate readiness, then you move into action planning—and we will do that today in this module. You'll leave this session with an action plan for your implementation.

Only after assessment, review of the information, and action planning are you ready to plan your training. Just training, by itself, is not sufficient to implement a change in safety culture. Your staff probably won't be motivated to change their behavior in terms of accessing language services and integrating interpreters on the care team with just training. You have to build in a change in the way things are done…that's the intervention. Then you test your intervention, on a small scale, to see if it needs any adjustment prior to implementing. If you are changing the way you call for an interpreter, for example, do that in just one unit or on just a few days to see if the process you've decided upon really works well. Then, once it's been tested and improved, you can actually implement the change. Build your training to prepare people for the change in behavior and the change in practice.

Monitoring the measures you choose during assessment is a way of building in sustainment, and in making your changes stick. So is the use of coaches. We will provide you with some information about choosing and training your coaches later today….but this is the basic process you'll be using now to plan your changes and your training.

(5 min)

Implementation Phase I - Assessment



Slide

SAY:

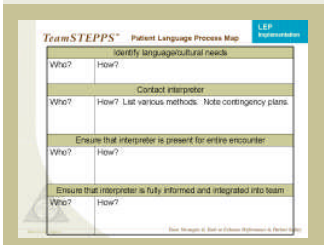
We will now work through the first phase, assessment, using your prework materials.

Implementation: Patient Language Process Map

LEP

SAY:

Let's start with your Patient Language Process Map. Take out the one from your prework assessment, as well as the one completed today when you experienced the LEP module. You have in your packet two blank worksheets of this map. On the first one, take five minutes minutes with your group to reach consensus on the current process in your clinical area. Complete the worksheet by answering these questions. (5 minutes)



Slide

SAY:

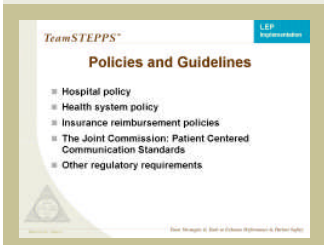
Next, based on what you have learned so far, now work together to create another process map of the ideal, safest process for meeting the language and cultural needs of your patients. Take 5 minutes to complete the worksheet as a group, writing in the way it could be once all the changes are complete. (5 minutes)

10 minutes

DISCUSS:

What are the gaps that you identified, and how will they be addressed in the ideal version of the process map?

Implementation: Policies and Guidelines



Slide

10 minutes

SAY:

Now we will consider policies that govern use of language services for your patients.

The **Patient-Centered Communication standards** from The Joint Commission were approved in December 2009 and released to the field in January 2010. The standards will be published in the *2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook*. Joint Commission surveyors will evaluate compliance with the Patient-Centered Communication standards beginning January 1, 2011; however, findings will not affect the accreditation decision. The information collected by Joint Commission surveyors and staff during this implementation pilot phase will be used to prepare the field for common implementation questions and concerns. Compliance with the Patient-Centered Communication standards will be included in the accreditation decision no earlier than January 2012.

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals is a monograph developed by The Joint Commission to inspire hospitals to integrate concepts from the communication, cultural competence, and patient- and family-centered care fields into their organizations. The *Roadmap for Hospitals* provides recommendations to help hospitals address unique patient needs, meet the new Patient-Centered Communication standards, and comply with existing Joint Commission requirements. Example practices, information on laws and regulations, and links to supplemental information, model policies, and educational tools are also included. The Patient-Centered Communication standards will be presented in a separate appendix that provides self-assessment guidelines and example practices for each standard. Additional information about the *Roadmap for Hospitals* is available from the project Web site: http://www.jointcommission.org/patientsafety/hlc/.

Consider these requirements along with your hospital policies which you have included in your prework site assessment. Take five minutes to review the policies with your group and make notes of any changes in policy that would be needed if your ideal process for meeting patient language and cultural needs were implemented. Also make notes of any relevant current policies that are not being followed in your current process. (5 minutes)

DISCUSS:

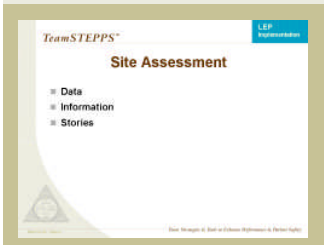
Did you identify any relevant policies that are not being followed right now? What are some examples of policy changes that would be needed if your ideal process were implemented?

Site Assessment

LEP

SAY:

In your planning you will need to consider your data—for example, the percentage of your patients who have limited English proficiency or the most common languages spoken by your patients. You'll also want to consider additional information about your hospital, your unit, and your patients with LEP, information that may not show up in the data. These may be stories or examples of specific incidents involving LEP patients, particular patterns of cultural bias or conflict in your area, and general attitudes about diversity and inclusion.



Slide

ASK:

5 minutes

What other information needs to be included in planning changes for your process of meeting the language and cultural needs of your patients? Take five minutes to discuss with your group any other information from your prework that needs to be considered as you plan. Also make notes of any additional information that you may need to collect. (5 minutes)

DISCUSS:

What other information will you need to consider?

Phase II: Planning, Training, Implementing

Slide

SAY:

Now we move into planning the changes and the training.

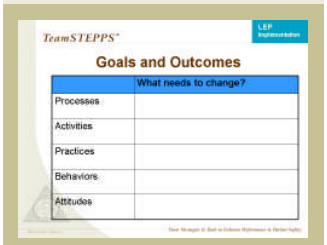
You will define your goals and identify measures that will indicate progress toward those goals. You will target specifically what processes and behaviors need to change, and strategies for making those changes, and you'll plan the logistics and customization of your training.

Goals and Outcomes

LEP

SAY:

Return to your process maps of the current process and the ideal process. Using those in your group, take five minutes to identify specific changes that are needed, and to write them on the worksheet.



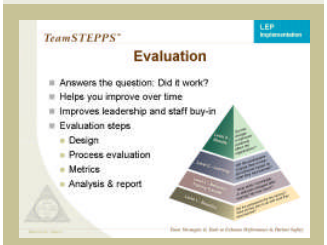
Slide

5 minutes

MATERIALS:

- Worksheet handouts of this page
- Process maps completed earlier

Evaluation



Slide

SAY:

Evaluating your TeamSTEPPS module can help you to figure out if the training did what it was supposed to do, and if not, it can help you improve the training over time. A good evaluation will document your efforts and the efforts of all staff involved, describe any ways in which you may have adapted the Module to your hospital's needs, test whether the intervention worked, help you find ways to improve the intervention, and help you increase buy-in from staff members and senior leaders. It is a very important step toward the sustainment of your TeamSTEPPS intervention.

MATERIALS:

- Evaluation Guide
- Evaluation worksheet

As part of this training, we are sharing with you an evaluation guide that we hope will be helpful to you in your evaluation task. The guide discusses the purposes of evaluation, what options you have to design your evaluation, how to do a process evaluation, what metrics you can use to measure your success, and how to analyze the data. Over the next few weeks, we will follow up with you by phone to learn how useful the evaluation guide is or isn't, how it might need to be modified, and what kinds of support you might need to use it. The tool will be revised based on your experience, and in future trainings of trainers we will spend more time discussing it. For now, we will discuss a few highlights.

Evaluation

As part of your implementation process, you've defined one or more goals for your TeamSTEPPS intervention. Then, you will need to select an **evaluation design** that minimizes the likelihood of biased results. The evaluation guide explains several study design options you can use.

The best and most expensive study design is a randomized controlled trial, where you randomly select some units to get the interventions and others not to get it, and compare results for both implementers and non-implementers. A less rigorous but cheaper option is to implement the evaluation in one or more units, and compare results in those units to results in units that did not get the intervention. Finally, the cheapest and most common study design is where you implement the training in a single unit and collect data before and after the intervention. That study design is a little weak, because changes before and after the training could be caused by some outside factor other than your intervention. However, it may be the most feasible option for many change teams.

As part of your evaluation, you'll want to document to some degree the process that you're following to implement the module, for example by looking at what the costs are, how many people you're training, any challenges you've encountered, and anything else that's going on at the time of the intervention that may affect results. That is the **process evaluation**. There is a 1-page template in the evaluation guide that walks you through a basic process evaluation.

It's also important to collect and analyze quantitative data based on specific **metrics** to document your success. The metrics should be selected based on what you think you can accomplish as a result of the training. Typically, we look at four levels of evaluation metrics. Level 1 is trainees' immediate reactions; level 2 is trainees' level of knowledge; level 3 is staff behavior changes that happen as a result of the changes; and level 4 is the final result, which may include patient satisfaction, staff satisfaction, patient health outcomes, and other indicators of the quality and safety of care. The higher up you go in the evaluation levels, the stronger your evidence will be.

Evaluation

When you experienced the training module as intended for trainees, you completed evaluation forms to assess your reaction to the training (which is Level 1) and test your knowledge (which is Level 2). You can use these same metrics to evaluate your TeamSTEPPS intervention in your hospital. In addition to measuring reactions and learning, I encourage you to use the other metrics in the evaluation guide to measure behavior changes and patient outcomes resulting from the training.

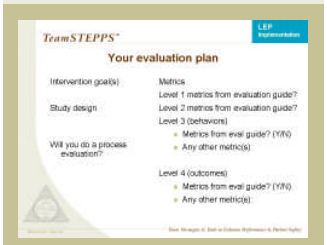
You can customize your evaluation to use other data you may have available at your hospital, such as existing patient or staff satisfaction surveys, interpreter utilization data, patient safety data, or data about specific health care outcomes you hope to change as a result of this training. The key is to choose indicators that are likely to improve as a result of your TeamSTEPPS intervention.

Your Evaluation Plan

LEP

SAY:

Now I'd like you to think about your own evaluation , and use this sheet to record your thoughts today.



Slide

Top left, what do you hope to accomplish by implementing the TeamSTEPPS module? That is your intervention goal.

10 minutes

Just below that, I'd like you to record what study design you think you can do. Most sites choose the single unit pre-post study design because it's the easiest and cheapest option, although the evidence that this produces is a little weak. However, if you will be implementing the Module in several units, you might consider using one or more comparison groups, which produces better evidence. Finally, if you will be implementing in many units, the evaluation is well-funded, and you want really solid results, you might consider a randomized controlled trial. Off the top of your head, which of these designs are you most likely to choose?

Next, will you do a process evaluation? Doing a process evaluation can help you tell the story of your TeamSTEPPS intervention, which is important to communicate with decision-makers at your hospital. The process evaluation can be a fairly simple record of the resources you invest, the activities you do (for example, how many trainings you do), your outputs (for example, how many people took the training), and your experience (how well it went). There's a 1-page template showing how to do this in the evaluation guide. Is this something you think you can do? If yes, write "yes" it down here.

Finally, what metrics will you use to assess whether you have reached your intervention goals? At the very least, we recommend you use the Level 1 and 2 metrics from the evaluation guide, which you experienced when we shared the module with you. Will you use these metrics? If so, write it down.

Evaluation Plan

SAY:

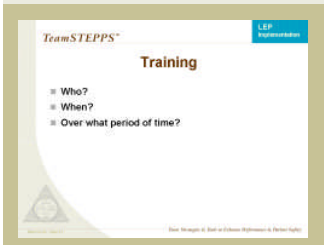
The examples of metrics and assessments listed here are available in your Evaluation Guide. Evaluation of your intervention will provide feedback that is helpful in sustaining change. Well-designed and well implemented evaluation plans may produce publishable results that will not only help your clinical area, but also healthcare across the U.S. The evaluation guide provides you with study designs that may be used to evaluate in this way. Now, take five minutes to write in the measures you will use to evaluate the effectiveness of your intervention.

Training

LEP

SAY:

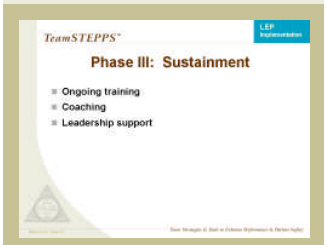
Now that you know what changes you want to implement and how to measure the success of those changes, you are ready to plan your training. Take 10 minutes with your group to discuss the logistics of your training. Who will be trained? Interdisciplinary teams? How will you get everyone together for the 60 minute session? How long will it take to cycle everyone through training? How will you handle training night shift?



Slide

10 minutes

Phase III: Sustainment



Slide

SAY:

Now consider how you will "make it stick". How will new staff be trained? How will these changes become "institutionalized" and permanent?

One element that can help support behavior change long term is the use of coaches: people within the unit representing the different professions and disciplines, including interpreters, who agree to help their peers use the new tools and processes. Internal coaches receive extra training and support, and are the ones who provide effective, respectful feedback in the midst of the work that can help keep the team on track. For example, a coach in a clinical area who works at the front desk as unit clerk might remind the nurse, "we agreed to call language services first when a patient comes in and we are unclear about their language needs, remember? Let's do that now…." Or a coach who is an interpreter might debrief with another interpreter, encouraging them to use assertion skills in future. There is a coaching module on your cd and in your packet that has been customized for use with this module on safety for patients with limited English proficiency, and we encourage you to use that to help you prepare for sustaining your changes and improvements.

Another element that can help with sustainment is planning to address possible barriers and objections. An additional resource for this is included in your handouts, taken from AHRQ's Informed Consent and Authorization toolkit.

Planning ongoing training and refresher courses also helps it "stick", as does consistent feedback and encouragement from leadership.

Action Planning

LEP

SAY:

Take 20 minutes in your group to complete your action plan for implementation, using all the information you have gathered and discussed so far. Include all the steps of the plan, who will be responsible for each step, and a target time frame for each step. Use the worksheet provided. We will be available to help your groups as you complete the action planning.

20 minutes

DO:

Ask the groups to share their action plans with each other.

Practice Teaching

40 minutes

SAY:

For our practice teaching segment, you will be assigned one slide from the LEP module, and you will have a few minutes to review the instructor guide for that slide and prepare to present that one slide to the group (or to a small group segment if there are more than 10 participants in the Train-the-Trainer session).

DO:

Assign each participant one slide from the set.

Allow them 10 minutes to work individually with their instructor guides preparing the material to present.

Then have them present their slides in order, with one minute per slide. Provide encouragement and suggestions, and give them assistance with navigating the cd and the slides.

Debrief with the group, praising good presentations with specific feedback.

Evaluation of the Train-the-Trainer Session

LEP

15 minutes

SAY:

This concludes our training of trainers for the LEP Patient Safety module. Thank you all for your participation. We would be very interested in your honest feedback, which will help us continue to improve this session.

DISCUSS:

What questions do you have about the training?

What worked in this training of trainers?

What could be improved?