Good morning and welcome to today's webinar, implementing TeamSTEPPS communication strategies and long-term care. This is Doreen from the New England QIN-QIO. I'll now put all lines on mute.

Good morning and thank you for joining the New England nursing home quality care collaborative. My name is Sarah with the New England QIN-QIO, and this is Part 1 of our two-part webinar series on implementing TeamSTEPPS communication strategies in long-term care. Before we begin the program, I have a few housekeeping items to review. This webinar will be recorded, and the presentation will be available within a few business days. The phone lines will be on mute for the duration of the presentation. We ask that you please do not put your line on hold. If you have a question at any point, please enter it into the chat panel to the right of your screen. Please make sure to send your comments to all participants. Doreen will be monitoring and responding to questions and comments in the chat. We will have plenty of time for questions at the end of the presentation and will open up the lines after that. Lastly, if you find that the presentation is a little cut off, please use the plus or minus icons in the top right of the presentation window to adjust your screen accordingly.

Now I would like to introduce today's speaker, Ann Spenard, who is Vice President and Principal at Qualidigm leading and directing business operations and quality improvement initiatives in the nursing home and long-term care settings. Her career has been focused on long-term care and geriatrics and leading national quality patient safety and data validation projects. She also teaches nationally to provider groups and providers of Medicare and Medicaid services. She is also involved in multiple research projects and has published many related topics to patient safety and health care quality improvement. She currently works and provides managerial oversight to the New England QIN-QIO in the quality improvement teams. I will now turn it over to you.

Good morning, everyone. This is Ann Spenard, and I'm excited to present today on TeamSTEPPS in long-term care. We work as a team for me to be able to present the slides. I hope by the time we finish the program today that you will understand and be able to describe TeamSTEPPS for long-term care and the importance of communication related to patient safety. We will address the issue around recognizing the connection between communication and medical errors and be able to define communication and discuss standards for effective communication. We will talk about strategies for information exchange, and we will wrap up with identifying barriers, tools, strategies, and outcomes to improve communication.

What is TeamSTEPPS? TeamSTEPPS is team strategies and tools to enhance performance and patient safety. This initiative is based on evidence derived from team performance leveraging more than 25 years of research coming out of the military and aviation, nuclear power, business, and industry to acquire team competencies. The idea behind this is all the work that was done in crew resource management and aviation where there were a lot of plane crashes and people dying and certainly
coming out of the Department of Defense, so there were all of these high-risk situations. The idea came from the aviation industry and the Department of Defense who were using these wonderful tools and concepts. Could we, in theory, apply some of this to healthcare? Out of that Genesis was born this idea around TeamSTEPPS. It was a collaboration between the Department of Defense and the Agencies for Health Research and Quality and a whole variety of people that worked together to develop the initial TeamSTEPPS. We can see here it was the Agency for Healthcare Research and Quality, research organizations, universities, business schools, nursing homes, all of these things came together to develop TeamSTEPPS. It was introduced into the hospitals around 2006. TeamSTEPPS was quite successful and continues to be successful in its strategies used in the hospital setting. In November 2012 it was adapted and put out for long-term care. The idea was the evidence in key concepts which were proven and works well in the acute care setting then adapted by keeping the evidence behind it but changing the word from patient to resident and having specific scenarios that anyone working in the nursing home industry and long-term care would be able to say they can identify with that and see how it can be applied these key strategies in nursing home settings versus just having to see it in the acute care setting.

What I wanted to do was to give you an overview. If we were going to do the whole TeamSTEPPS program what are the key components or modules within that? You can see that there are basically seven modules that encompass the whole TeamSTEPPS program. It starts with a nice introduction and goes through a very encapsulated version of how TeamSTEPPS came to be, but it talks about the key concepts—why it was developed, how it was developed, and testing related to that. Then we go into, if you were taking the full program, talking about team structures, what teams are, what core teams are, what ancillary team support structures are, and what makes up the various people that you must work and communicate with. There is a module on leadership—the role of the leader, formal leader, and informal leader. There's a module on situational monitoring and a lot of great tools and concepts within that. There is one module around mutual support. How do we have each other’s back? Not to stab each other in the back, but to support each other so that we have the best outcomes in supporting each other and the best patient and resident outcomes.

Today we are going to talk about Module 6 which focuses on communication. Communication is so critical that I am pleased that this is the module that CMS has asked us to support within the work we are doing around improving quality of care and outcomes for our patients. Communication is critical in that. If you were taking the full course, Module 7 is pulling it all together and explains how you operationalize this within your organization. I wanted you to have an idea about the core pieces of TeamSTEPPS, and we are just doing one piece of that today.

Why do errors occur in the care that we provide? Well, there are workflow fluctuations so we can understand the ebb and flow for those of you who are nurses who get interrupted, get a call back from a doctor or practitioner and have to stop what you are doing to take the call and come back to the task. We know that is an issue so that is the interruption. We have at times in our work day that is very intense with lots of things going on. Then there are times in our day that may be a little quieter. Fatigue can play a major role in why errors occur. If you are doubling back and on your 12th shift in a row, you have not had any downtime. If you are dealing with family issues, a sick child, are tired and come in,
there have been studies done around sleep deprivation and driving. The fatigue factor is almost like being impaired by having drugs or alcohol. If you think about it, fatigue can be a factor in the work we do on a daily basis in caring for our patients and residents, and it doesn't matter whether you are a social worker, CNA, part of a maintenance team, dietary, etc.

Multitasking. We are asking people on a daily basis to do much more than just one thing. It is like do this and at the same time do that and observe this and whatnot. Our concentration or energy is being pulled in multiple directions. Failure to follow up is closing the communication loop and following through on things. We are going to talk in more detail about this. If I hand over care, even if it is when I'm going to lunch and leaving the unit and going to the cafeteria or lunchroom area and am handing my care whether it be to a CNA or a nurse, I am leaving myself from that unit and handing off my resident(s). If I don't communicate that handoff very clearly, there is great risk. We have handoffs from shift to shift and unit to unit and facility to facility. There are lots of opportunities. We will talk about that and how critically important communication is around handoffs. We will talk about strategies around ineffective communication if we do not clearly articulate the information, giving too much information or not enough information. How do we streamline how we communicate so that we make sure as the center of the communication the person receiving the information is getting everything that we intended them to get? Certainly not following policies, procedures and protocols can be an issue around errors.

One of the things that has come into play if you were taking the full course is this idea of excessive professional courtesy. What does that mean? In the halo effect it goes together. What it is saying is I am not going to question you, the doctor, the PRN, the supervisor, even if my gut is telling me something is not right. The whole idea around TeamSTEPPS is that anyone can stop the line. If it is around patient safety, you not only have the right but you have the obligation to speak up. That is just globally giving you the concepts around this. I thought the idea of passenger syndrome was fascinating. Passenger syndrome is the attitude that ‘I am not driving, and I am just along for the ride meaning I don't care that I see that you are driving straight on into a lake, I'm going to let you do that and watch you fail.’ People with hidden agendas want to maybe not protect their coworker and allow them to fail. By allowing them to fail could actually hurt a resident or patient.

Complacency. I am burnt out and not going to put the effort into what I need to do. This can happen in nursing homes very easily. You take a well-educated licensed LPN and they put blinders on and push the pills or getting the treatments done instead of instead of thinking that when they go in to give medication, they are assessing everything: How the person greets me, how they communicate, what they look like, what their posture is, what their baseline is to compare to what I am seeing. People are going in and just doing a task and not being a good observer of everything going on around them.

What are the components of resident safety? I'm giving you this umbrella that we will take it down into the components around communication. In the center you see the resident or person-centered care. There is a circle around them which is the idea around a culture of safety. You can actually measure the culture of safety in your organization. The Agency for Health Research and Quality has the survey. If you have never had the opportunity to be part of that, it is free. You can get the electronic tool. They will do the data analysis with a robust back end that will give you feedback reports on how your staff within the
organization perceives the culture of safety in your organization. It is very, very informative. As a leader, that is something that organizations may want to do. It will tell you where there are opportunities and where the staff's perception may be different than the leadership's perception. I can tell you that the research out there shows that leaders in organizations, specifically long-term care organizations, rate the culture of safety much higher than the staff perception of it. There is a disconnect, and I think there is an opportunity there.

Around this culture of safety we have team training which is what we're going to be talking about today, or one piece of it. We have innovations and lessons learned. What does current evidence tell us about the care we are providing? Education for all staff, education for residents and families, organizational sharing, and collaboration is this environment that you have within the New England QIN QIO. There are great innovations happening within various states. I think the New England QIN QIO has done a great job about sharing best practices and innovations that have happened. That is a wonderful part about being part of this group—process improvement and all around quality improvement. That is what we as the New England QIN QIO to on a regular basis. We have regulatory compliance. The rules and regulations are there, often not to stymie how we care and provide daily services to our resident, but they are there to safeguard, also (infection control policies and procedures and whatnot).

Now we are going to start to delve in a little into communication. Teamwork is all around us. If you are playing on a team or part of the military, in healthcare definitely we are part of teams. You may be part of teams in other organizations that you belong to. Maybe you are part of a group or pseudo-team within whatever religion that you practice. You should always reflect on all of these times when you are working with groups of people. How do we communicate? A lot of the skills we will talk about today can apply to your life. How does your family unit work? What are the strengths and weaknesses of the various groups that I am in and what can I learn on how they communicate?

The format of these slides come is from the curriculum from the Agency for Health Research and Quality. If you search TeamSTEPPS long-term-care, it will take you to the website and you can pull down all of these training materials. You can pull down the instructional design which will tell you how to do a train-the-trainer or do initial training in your facilities. There are videos that I hoped to embed as we went along which didn’t work out, but you can access those and look at those examples of various skills. I think it is one thing to talk about them and another thing to see them in action. You can reflect in your own organization how this would happen. What comprises team performance? It is the knowledge or cognition or thinking piece of it. It is the attitudes, the affect or feel, and the skills and behaviors with knowledge, attitude, and skill built in around that. If you look at this triangle around here, you have the patient care team surrounding it. In the center there are some of the core competencies and communication being the one to the left or in purple as being one of the core competencies. For everything that we talk about we are going to think about the knowledge, attitudes, and skills that each staff member may have around that.

Some of the outcomes of team competencies are knowledge. If you were going through the whole TeamSTEPPS program you would talk about a shared mental model. That means if I am describing or communicating to you about a type of fish, by the end of that you would understand that it was a
salmon and maybe a very particular type of salmon. You as a receiver would say I am getting this. It is a fish and it is a salmon. You are not thinking of a river trout when I am trying to describe a salmon to you. In that communication we both understand what we're talking about to mean the same thing. That shared mental model is important.

Attitudes. Trust is a big piece of this. To be part of a well-functioning team, we need to have mutual trust and understanding. Team orientation. Part of this is understanding how to fit in the team and what my roles and responsibilities are within the team and what my obligations are within the team. Part of that team is in your resident and the family. We've got to think about that also. Performance, adaptability, accuracy, productivity, efficiency and safety all fall into these.

The importance of communication. Ineffective communication is a recall of nearly 66% of all sentinel events reported. This came out of a paper that the Joint Commission wrote. What they did is in a sentinel event. There are certain events that happen, especially if someone dies. If you are a Joint Commission accredited organization you have to report to the Joint Commission. This is only based on those organizations that are part of Joint Commission and meet this very narrow tip of an iceberg—the very tip, very narrow definition of what must get reported as a sentinel event to the Joint Commission.

That being said, as I am describing this, this is a small percentage of all the potential issues and concerns happening in all of our healthcare organizations. A root cause analysis says let me ask the question why. I think you have been oriented to that to ask the question why at least nine times, and it may be more than that so that you can figure out down to the root what impacted why something happened. It is usually multifactorial. One of the things they found is that communication played a role in nearly 66% of all sentinel events reported. If you are looking at a system failure within your organization, more likely than not you're going to find some sort of failure around communication. It is critically important.

In these slides you will see these Emperor penguins. These Emperor penguins came out of a book called, “My Iceberg is Melting.” It took the idea of Kotter's theory of change. He wrote this very fun, quick read, but very impactful book around all the skills and strategies that you must have to change culture in an organization. They took that change theory and wove it into everything that is done related to TeamSTEPPS. An interesting thing as this was adapted for long-term care, we were part of a team that adapted these materials. We actually had to get some new penguins drawn. It was more reflective of some of the roles and responsibilities in nursing homes and what would be equivalent to the patient in long-term care, so we put in them in walkers and wheelchairs and some of the things that are reflective of us. In this situation we're looking at the source who is giving a message to a receiver who then receives it and hopefully gives feedback that they, in fact, received the accurate message. In the middle you see those ice blocks. They could be a potential wall or areas that could impact the source of the message getting over to the receiver and the receiver getting the proper message in return. You have things like assumptions. I assume I know what you're saying and I am jumping to conclusions and I already know it and I'm going to take off and run and I didn't listen to what you were telling me. I assumed I already knew what you were going to say so I didn't listen. Fatigue. I'm not paying attention to the task as clearly as I need to. Distractions. There is lots of other stuff going on so I am not listening to you. I am kind of half listening, and I think we can all relate to that on a daily basis. Another thing is partial information because we are trying to either properly interpret it or we are misinterpreting and
not clearly communicating to someone who would be authorized to receive information and be able to carry out and care for the residents.

Communication is a process in which information is exchanged between individuals, departments, or organizations. If we are communicating to an ambulance picking up someone going to a specialty office when sending a resident out for care and transporting someone to the emergency room or if we are sending someone back home, now we are communicating with the family and maybe the home care agency. Communication is the lifeline of the core team, and that is everyone caring for someone on a daily basis. We have to clearly communicate on a daily basis. It is effective when it permeates every aspect of an organization. The idea here is you want to almost over communicate but you don't want to do it so that it becomes noise. It has to be purposeful communication. It has to be clear and concise, and I will go through more of that as we move along.

There are standards of effective communication. It is complete, communicating all relevant information, and clear. We can convey information that is plainly understood and are not adding superfluous information that does not need to be there. It is brief, and it communicates the information in a concise manner so that if I have the time to listen to you, I will get the message and get the key concepts within the message. It is timely. It offers the information in an appropriate timeframe. You can verify the authenticity of it so that you know you are getting it from a primary source where you can and are validating or acknowledging the information. If you're taking a physician order, you are writing down the order into the medical record and reading that order back to a practitioner so that you are validating that you heard exactly what they are saying.

Here is a pictorial which comes out of the, “My Iceberg is Melting Book.” There is a sign here that says, ‘Public Water is Currently Closed Because it is Not Open... Management.’ There were a lot of words. What was the key message there? Then we have a somewhat timely sign going up saying that, ‘Seals in the Water Don't Swim,’ yet they have people or penguins already in the water. The message did not get out in time to potentially save them or impact them, so how clear did we communicate? I think that is one thing we can all work on.

Many of you on the phone who have done any of the interactive work that has happened over the last couple of years know about SBAR. I will not spend a whole a lot of time, but SBAR came from the military. Can you imagine if you are under fire and you are able to communicate back to your support forces saying, here is what is going on. We are taking direct fire and were tasked to move into this particular area and do these things whenever necessary. Here is my current assessment and what you need to do. You need to open an area that we can escape from, and here are our recommendations. I'm not military so I apologize to anyone out there who is military. You can talk about that but those are some examples we can certainly use in healthcare. One thing I found in long-term care is that a lot of nurses in long-term care are not strong as I think they could be in the recommendation to a practitioner. Often we are calling so we don't have eyes on, we don't have body language or anything. If you have eyes on that patient or resident in fighting a practitioner, how toxic does that person look? Do you think this person needs to go out or do you think they need to be seen in the next 24 hours or whatever? Be
very clear in what you see and feel and what you think should happen. Could we do watchful waiting? Something is not quite right. We can monitor vital signs and then get back to the practitioner.

We already talked about this. Situation. What is going on with the resident? What is the clinical background or context? This is critically important. We need to know background related to everything you are communicating and whatever the issue is. Assessment. What do you think the problem is and give data. Was there a change in medication? What are your vital signs, what is going on? What have you done in your assessments of that patient? Articulate that to whoever you are talking to and provide recommendations. There are people out there that say introduce yourself first. That way they know exactly who you are talking to. You can say maybe I am the supervisor or director of nursing or whatever it is.

There are exercises you can do. If you were sitting in a small group, it is something you could practice during the unit meeting and ensure that people really understand how to use SBAR. As they are going through this, are they being concise in the situation? In the background are they giving too much information or not enough critical information? Let’s say for example the patient had a fall. You would want to make sure that you communicated that the patient was on Warfarin because practitioners will treat the patient a little differently than they would someone who had a fall and was not on Warfarin. That is just one example. The assessment. Is the person able to gather the right pieces of information and communicate that?

A call out. We will use call-outs in long-term care. It is a strategy used to communicate important or critical information to a group of people such as team members. It informs all team members simultaneously during an emergency situation and helps them anticipate next steps. What kind of situations would you do on a call-out? If you had a person who had a fall and are on the floor and you are assisting in determining if they had a fracture, do they pass out? Is there a sudden change in condition? You may have a few staff members in the room so a call-out could be blood pressure, pulse, applying oxygen. Everyone in the room knows what is going on and level setting. Paperwork is done, and 911 is called. It will be here. They are four minutes out, I have the elevator held, is there anything else anyone would need? You are informing the whole team instead of telling just one person and expecting everyone else to then repeat it. It is communicating vertical pieces of information. That is a call-out, and we can use that in various ways. I’m giving you clinical examples, but all of these strategies can be just as easily used in dietary or laundry or maintenance. It could be used when you have a weather event going on. Within TeamSTEPPS itself there are all kinds of tools. There are huddles, debriefs, and whatnot. I will not go through all of this today so I’m giving you a sampling of the tools around communication. Check-back is closing the loop on communication. So we have the sender (we talked a little bit about this in an earlier slide). The sender initiates the message, the receiver accepts the message meaning yes, I hurt you, but provides feedback and confirmation that they heard what you said. The message was that I should call Mr. Smith’s family and explain this. If that was the message I had given now, what the person has done is close the loop and said I hurt you. I was not distracted or fatigued but what happens is sometimes people only hear the first part of the message but not the second part. We wonder why things fall through the cracks. The communicator communicates, the receiver receives and accepts and closes the loop by saying they understand it. The original communicator is able to say, yes, that is the
message I have given. Think about that. These are things that should be the fabric of how you do things and become a good communicator. This can be in your family or can be part of any kind of team.

I was going to spend a couple of minutes on handoff. Handoff is probably the highest risk area that we have in healthcare. What is the handoff? It is a transfer of information, but it is more than just the transfer of information. It is the transfer of information along with the authority and responsibility. I gave the example early on around I am going to go to lunch. You are going to cover me. Sally is going to cover me while I go to lunch so I would handoff to you and give you waiting for Doctor Smith to call back on this patient and here is what is going on. Here is what is going on with Mrs. Jones. She is not feeling well. I have given you enough information but now you have accepted that because now you have the authority and the responsibility to care for my residents while I am at lunch or when we are sending them to the new unit or handing them off to another agency.

During the transition and care, handoff includes an opportunity to ask questions, clarify, and confirm. It is not that I am going to tell you this and run out. Part of a good handoff needs to be that if I need to ask a clarifying question you give me the time to clarify or confirm what I heard or delve a little bit more. Now I am taking authority and responsibility for that care so that is a critical part of the communication.

This is where organizations take their reports. That is a one-way piece of a handoff of information. There is no way for clarity, confirmation, or questioning. Think about your own organization and reflect on how you communicate and understand about efficiencies and overtime and everything else. When it comes to patient safety, we may need to ask if there is some sort of overlap even for a few minutes where someone can listen to a report the way you’re going to do it and have the ability in some way to get clarity or to confirm or ask questions? If not, I think it is a gap within your system in something that you may want to look at.

>> When we are doing handoff it optimizes information and responsibility. There are checklists you can use. Think about other ways such as checklists, IT support, and acknowledgment. This is where we have our greatest opportunity or our weakest link every time we handoff care. I tried to embed a video, but if you got to the website you can look at a variety of videos that give you examples on various skills. Whatever staff you are educating or training can relate to it.

Another skill. This one is a harder one. It is complex but it is around the handoff called I pass the baton. Not everyone has adapted and used all of these skills. Take pieces that seem to work for your particular organization, but I put this slide in there because I think it is important that when we are handing over care shift to shift, unit to unit, setting to setting, we make sure that we are addressing many of these steps in it. Introduce yourself and your role or job and then identify the patient, resident, age, sex, and complication that we have. Then we have assessed the relevant diagnosis benchmark -- current status. It could be elimination and input. It would include, especially if going to another level of care, a code status or comfort care and what is going on with them (level of uncertainty, recent changes or response to treatment). Anything you are concerned about you want to make sure is clearly articulated. Safety. Are there critical lab values or reports you are waiting for? We sent off a stat INR so that is an important piece of information if I’m going off shifts and we’re waiting for the lab results to come in. I would
probably want to keep an eye out so that if I have not heard back from the lab I am reaching out to them to get that information. It may be around allergies or alerts.

Then we have baton which is background, actions, what actions were taken or required or things that need to be followed up on, timing. What is the level of urgency that works with the timing or prioritization of an action? Meaning we have to hear back from Doctor Jones today by 6:00 where we are waiting to hear back from the family because then we need to take an action (timing or the urgency of it or can it wait until the next day?).

Ownership. Who is responsible including the patient or family what will happen? What are your anticipated changes? What is the plan? This is a more complex concept, but I think if you are teaching people the key concepts around doing a thorough handoff, especially shift to shift and definitely within organization to organization or 4 to 4 or unit to unit, these are key concepts that you want to make sure people understand. Within that question clarify and confirm. There has to be a two-way communication so that the receiver has the opportunity to get clarity from you, the center of the information.

>> Some of the challenges around communication. Language barriers, and this could be the language barrier for the patients, resident, or family. It could be a language barrier of accents with staff members. It could be with the practitioner, distractions, or physical proximity. It is easier if you to do face-to-face if you are standing right next to each other versus over the phone. Have you ever called the doctor and wanted to give them the key pieces of information even if you are trying to use SBAR and they cut you off and will not listen to everything you have to say, as they have this overbearing personality. Varying communication styles. What we found is that nurses communicate one-way and physicians another. That changes as they are doing a lot of mixed education meetings with physical therapists, occupational therapists, nurses, and students who are all learning together. A piece of that is to improve the communication. Certainly conflicts can be an issue or a challenge in communication. Lack of information or verification means going back and looking at orders.

As we’re winding down a getting to the point where we want ask questions, this is a slide if you were talking and working through using TeamSTEPPS. At the end of every module we talk about the barriers to a particular topic. Red is barriers and yellow is tools and strategies with in the tools of TeamSTEPPS. Think of it as a strategy or set of tools that could help improve communication. Not that we covered them today but if there is interest, we can cover them another time--what is a brief and how to use it, what is a huddle and debrief, what are some of the skills that could then help improve and mitigate some of the barriers that we have around communication? Green is the outcomes. What do we hope to get out of this communication if we have identified these barriers, but in the tools and strategies, what could be our outcomes? Hopefully that is around a shared mental model, adaptability of our staff, and their ability to communicate in a variety of different ways, team orientation, mutual trust, a well and high-functioning team and team performance. The biggest thing is resident safety on the back end of this which is really the ultimate outcome that we have.

>> Some of the actions that you can take. Communicate with team members in a brief, clear, and timely format. We give you tools to use around that. Seek information from all available sources, certainly
verbal communication, written communication, physician orders, progress notes that may help to communicate what is going on with a particular patient or resident and how do we communicate that. We have tools and strategies. There are 24-hour reports, shift reports that are written. There are other ones that may be taped and may be verbal. We want to get information from all of these sources. We want to verify and share information, what is critical, and make sure we communicate and practice communication tools and strategies daily. How do we implement this into our daily how we do business? We are seeing SBAR as one way that is becoming much more mainstream. It started the adoption in the hospital setting, and TeamSTEPPS came out in the hospital setting. It became pretty much the standard weight many people communicated in the hospital setting and is infiltrating and really starting to impact some communication within the skilled nursing or nursing facilities.

I just spoke for 45 minutes and I gave a lot of information. I am a master trainer in TeamSTEPPS, and my doctoral work was around implementing TeamSTEPPS in long-term care. I am incredibly passionate about this whole program and would like to open us up for communication. I would like to communicate with all of you and answer any questions you have and if in the chat box you want to put in other areas of interest around TeamSTEPPS that you may have, that would help inform us at the QIN QIO about other opportunities to bring this information forward to your organization.

Just a reminder to ask a question you can join us on the phone line by pressing #6 and taking you phone off mute. You can also ask a question by entering it into the chat box. The lines are open for questions.

We have a question from Tonya--when will a Part 2 of TeamSTEPPS be available as a webinar?

I was going to say that we have Part 2 scheduled so you can tell them when that date is.

Part 2 is on October 26 which is a Thursday at 11 a.m.

This is Morgan. Just to jump in. The thank you email that will be going out tomorrow will also contain a link to register for Part 2 so be on the lookout for that.

Just so everyone is aware, that webinar will actually feature a couple of facilities that have fully implemented a TeamSTEPPS program in their nursing homes, and they will talk about their experience, barriers, successes, and lessons learned so we are very excited about that.

We have another question from Carol Anne Hall. What is the next step to start TeamSTEPPS in your facility?

That is a great question. What I would suggest depending on your organization and where you are, we will certainly look to see if we can provide more information on it. I would go to our website. TeamSTEPPS long-term care will take you to the modules and all of the training materials and videos. Literally the materials are out there from a train-the-trainer perspective. I have taught this so much. The material informs you of the key concepts and how you implement it. There is a wealth of knowledge, and it is all free. This is out in the public domain. Some of it is free for anyone who wants to implement it within their organization.
Kathy, I just sent you the link for today's presentation to download it.

If we don't have other questions thank you very much to everyone for attending this session. If you were not able to ask a question, you can reach out to your nursing home state lead contact information on this screen.

Don't forget to mark your calendars for upcoming events and educational opportunities. Part 2 of this webinar takes place on October 26. On November 9th we will host a webinar on accessing your data reports from NHSN. On December 14th we will host a webinar on preventing and managing C. diff. Check out our website for more information and how to register. If you have not registered for the Dementia Care Symposium next week that is being hosted by the New England QIN QIO and Beth Israel Hospital, it is not too late. We have a few spots available, and we will include a link in the chat for you to register or check it out on our website.

If you have joined us on previous webinars, you will know that we frequently have contact to win free passes to a face-to-face training or other educational event. This month we are giving away two passes to next week’s Dementia Care Symposium. To enter “Like” and “Follow” us on Facebook. The winner will be announced on Facebook next Monday morning. Here is a link for you to find us on Facebook.

Following today's webinar you will be directed to a survey to provide feedback on the webinar. Your input helps improve these educational sessions and provide you with meaningful programs in the future. Also in a few business days an email will be sent that contains a link to both today's presentation and the recording of the webinar. Thank you all for attending today's webinar and have a great day.