Patient Safety is Enhanced by Teamwork

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A trend evident during my liaison visits is that healthcare providers seek tools to maintain effective teams and foster team interaction. Team interaction has been shown to be helpful in advancing patient safety by emphasizing improved communication and outcomes. To that end, some facilities in south central Pennsylvania plan to participate in teamwork training to improve patient safety and communication. In an effort to provide Pennsylvania facilities with an additional resource on teamwork training, the Pennsylvania Patient Safety Authority’s patient safety liaisons will be attending a teamwork training session this year.

According to research compiled by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD), evidence of the benefits of improved team performance can be seen within the military. In the mid-1980s, 147 aviation fatalities occurred in the U.S. Army. The failures were attributed to errors in crew communication, workload management, and task prioritization. The army developed a coordination training and evaluation system that saved 15 lives and $30 million annually. In 1990, the Navy studied teamwork and team training interventions using a program known as TADMUS (Tactical Decision Making Under Stress). This program increased understanding of team knowledge, skill, and attitude requirements; provided reliable and valid measures of team processes and outcomes; and developed new training strategies for enhancing teamwork. Healthcare facilities can learn from these methods and lessons learned about using teamwork strategies.

Much like the military, healthcare performance relies on communication and teamwork. In Pennsylvania, facilities have been required to report Incidents and Serious Events to the Authority since June 2004. In a review of the event reports submitted in 2009, 1,300 reports included the following key terms in the context of the report: teamwork, communication, team, SBAR (Situation, Background, Assessment, Recommendation), and handoff communication. Each of these processes plays an integral part in patient safety and is included within teamwork training. Some of the comments from these reports include the following:

There needs to be better communication between departments when transferring patients . . .
Improve SBAR communication . . .

Better communication . . .
Patient came down to radiology for x-rays. Isolation was not selected on the handoff communication form . . .

Extra dose to patient—process not followed for handoff communication between nursing . . .

Statistics have shown that teamwork can improve patient safety. One healthcare facility that has implemented teamwork initiatives decreased their clinical error rate from 30.9% to 4.4%. Another facility had a 50% reduction in adverse outcomes after team training. Team Strategies and Tools to Enhance Performance and Patient Safety™ (TeamSTEPPS™), a program offered by AHRQ and DoD, offers tools and strategies for improving communication and teamwork, reducing chance of error, and providing safer patient care. According to Clancy and Tornberg, TeamSTEPPS is composed of four teachable-learnable skills:

1. Leadership is the ability to direct and coordinate activities of team members, assess team performance, assign tasks, develop team knowledge and skills, motivate team members, plan and organize, and establish a positive team atmosphere.
2. Mutual support is the ability to anticipate other team members’ needs and to shift workload among members to achieve balance.
3. Situation monitoring is the capacity to develop common understandings of the team environment and apply appropriate strategies to monitor team performance accurately.
4. Communication includes the efficient exchange of information and consultation with other team members.

Lewis B. Ergen stated, “The ratio of We’s to I’s is the best indicator of the development of a team.”

Team structure is the first step in implementing a teamwork system, as a properly structured team is an integral part of the teamwork process. Team structure is the glue that holds together an effective strategy for ensuring patient safety and reducing medical error. TeamSTEPPS promotes partnering with the patient as part of the team structure. Roles change from individual to team, as depicted in the Figure, and can show the importance of team structure.

Teamwork in healthcare can be a means to reduce clinical errors, improve patient and process outcomes, and increase patient and staff satisfaction. A team interacts dynamically, interdependently, and adaptively towards a common and valued goal. Characteristics of a well-performing team include shared vision, clear roles and responsibilities, common purpose, strong team leadership, and the ability to manage and optimize performance outcomes.

Shared understanding of important information can be exchanged during team interactions such as briefs,
huddles, and debriefs. A brief is a short meeting to discuss essential team information like team roles, clinical status of the patient, team goals and barriers, and issues affecting team operations. A huddle is used to reinforce the plans in place. This is also known as an information update and can occur at any time when necessary. A debrief recounts what happened during the event and extracts lessons learned, as well as establishes a method to formally change the existing plan to incorporate lessons learned. (An example of a tool useful for brief or debrief interactions is the World Health Organization surgical safety checklist, which can be found at http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html.)

A successful team has good communication. TeamSTEPPS offers tools and strategies to improve the effectiveness and promote the sharing of information. According to the Joint Commission’s Sentinel Event data, inadequate communication was the root cause for approximately 66% of reported errors between 1995 and 2005. According to Salas and McIntyre, communication can be defined as the exchange of information between a sender and a receiver. Communication should be complete, clear, brief, and timely.

Strategies to improve communication and information exchange include the following:1

- **SBAR**, a standard method to communicate information about a patient’s condition. An example of a situation in which to use SBAR would be when calling a physician to update him or her on a patient condition and receive new orders for care.

- **Call-out**, which is used to communicate critical information during an emergent event. An example of when to use a call-out would be during an arrest situation when the nurse “calls-out” what medication he or she is giving to the patient.

- **Check-back**, which is used to close the loop of communication and verify and validate exchanged information. An example of a check-back would be when the laboratory calls a critical laboratory result, and the nurse repeats all the information back to verify that it was correct.

- **Hand-off**, which allows for the exchange of necessary information during transitions in care. An example of this would be the report from the emergency room to the medical floor where the patient is being admitted.

Many of these strategies are currently being used by hospitals across the country; however, it is important to evaluate the use of these strategies in your facility specifically to ensure that staff are utilizing the tools properly.1

Throughout my visits with facilities in the south central region of Pennsylvania, I have had many staff members tell me that they use tools such as SBAR, handoff communication, and checkbacks. Other facilities are looking at improving the use of these tools to facilitate better communication among employees. One hospital in my region, Waynesboro Hospital, has incorporated the TeamSTEPPS program.

Waynesboro Hospital is a 64-bed, acute care, nonprofit, community hospital in south central Pennsylvania. The facility has used TeamSTEPPS as the core program to help nursing staff improve communication. After looking into different teamwork training programs, the facility felt that this was the most comprehensive program. The training took approximately one year to complete and required a commitment from nursing staff and administration. Waynesboro believes the program has helped empower their nurses to use phrases such as “I need clarity” to improve communication as well as attain new tools to use in their daily practice. Many of the nurses found this training helpful and fun. Currently, Waynesboro Hospital is planning to modify some of the TeamSTEPPS tools to apply them throughout the entire facility.

TeamSTEPPS is a foundation that facilities can use to help provide healthcare workers with the necessary strategies and tools to reduce errors. Determine the readiness of your facility to accept and implement these strategies and tools. Determine the barriers that might obstruct effective teamwork. After attending the teamwork training in 2010, the patient safety liaisons will be able to increase awareness of the TeamSTEPPS program and provide Pennsylvania facilities with these tools and strategies. (To learn more about teamwork tools and TeamSTEPPS, contact Christina Hunt at 717-395-0713 or chrhunt@state.pa.us.)

**Notes**


