



Healthcare

ALERTBULLETIN®

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Treatment Teams: A Keystone of Healthcare Safety Culture

Nearly three decades ago, a safety-focused movement took root in the healthcare industry, helping to raise awareness of both the extent of medical errors and the systemic, process-related issues that contribute to poor patient/client outcomes. According to the Agency for Healthcare Research and Quality (AHRQ), reducing errors in healthcare settings requires a top-down commitment to creating and maintaining a safety culture. Such a culture is characterized by a set of safety-centered values, beliefs and norms, which is shared by everyone in the healthcare setting and shapes their behaviors and interactions. (For resources, strategies and tools designed to foster a culture of safety, visit the [AHRQ](#) website.)

One of the hallmarks of a safety culture is the notion of teamwork. By organizing providers and staff – including physicians, advanced practice providers, registered nurses and assistive personnel, as well as radiologists, pathologists and other ancillary service diagnosticians – into collaborative treatment teams, healthcare facilities and practices can help strengthen care delivery and protect patients/clients from injury.

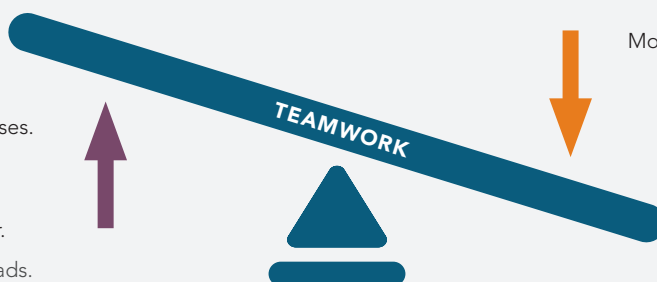
While the benefits of team structure – including enhanced outcomes, fewer errors and heightened morale – are widely acknowledged, adoption of effective team-based principles remains a challenge for many healthcare settings. (See “Teamwork: A Balancing Act” below.) The case scenario on [page 2](#) shows how the absence of team-oriented safety protocols, standardized communication formats, well-defined test ordering and tracking policies, and routine follow-up measures may result in clinical missteps with potentially serious consequences.

This edition of *AlertBulletin*® suggests ways to cultivate a team-driven safety culture; reviews specific clinical applications of teamwork concepts; and offers examples of innovative, team-oriented models of care designed to safeguard patients/clients and limit professional liability exposure.

Teamwork: A Balancing Act

Potential Benefits

- Enhanced patient safety.
- More thorough diagnostic processes.
- Improved information flow.
- Increased staff productivity.
- Reduced burnout and turnover.
- Balanced and predictable workloads.



Potential Challenges

- Unclear roles and expectations, contributing to fragmented care.
- More complex decision-making process.
- Interpersonal conflicts.
- Increased staffing needs.
- Less personal accountability and potential blame-shifting.
- New time pressures and workflow changes.

Stating the Case for Teamwork

The following scenario reveals how a lack of team-oriented processes, combined with ill-defined roles and expectations, can contribute to errors.

Death Due to Delayed Diagnosis

A 22-year-old, morbidly obese patient presented to a busy clinic with complaints of left calf pain and lower extremity swelling. A Doppler ultrasound was ordered to rule out a deep vein thrombosis (DVT). The order, which was intended to be carried out on the same day, was inadvertently entered in the patient's electronic healthcare record as a routine matter, and was consequently interpreted as "non-urgent" by a newly hired medical assistant (MA). The test took place a week later, and it confirmed a DVT at the left popliteal and femoral veins. While awaiting further testing at the hospital, the patient died of bilateral pulmonary emboli, secondary to the thrombus. A subsequent lawsuit asserted that an earlier diagnosis would have prevented the fatal emboli.

What risk control strategies might have averted this fatal outcome and associated litigation?

- **Adopting a team-based model of care** with clear practice directives for individual team members.
- **Implementing a formal office protocol for tracking pending diagnostic tests** and flagging time-sensitive procedures.
- **Training the MA in specific tasks and duties**, including following the healthcare facility's diagnostic imaging protocols.
- **Incorporating built-in "forcing functions" into the electronic healthcare record system**, which would have alerted the MA to the procedure's urgency.
- **Holding a treatment team huddle** for the purpose of summarizing the diagnostic work-up and clarifying further testing needs and time expectations.
- **Informing the patient of the procedure's urgency**, which would motivate the patient to request immediate testing.
- **Including informed-risk documentation in patient healthcare information records**, confirming that the provider has discussed DVT-related risks with the patient.

Creating a Foundation for Teamwork

As noted in the [Sentinel Event Alert 57](#) from The Joint Commission®, committed leadership is the key to implementing a culture of patient/client safety and fostering a team-driven clinical environment. The following clinical care initiatives, among others, can help lay the groundwork for effective teamwork:

- **Improve the work environment and morale** by ensuring that workloads are balanced and safe, offering staff wellness programs and monitoring employee satisfaction levels.
- **Define care standards** by patient/client diagnosis, age and/or risk grouping.
- **Reengineer clinical processes**, assigning responsibility for specific tasks to individual team members.
- **Update job descriptions** to align with team-based roles and train staff in job-specific tasks.
- **Decentralize decision-making** by including all members of the treatment team in diagnostic and treatment planning sessions.
- **Enhance diagnostic accuracy** by encouraging providers to repeat diagnostic tests when team members' clinical impressions diverge.
- **Encourage constructive feedback among team members** by implementing [closed loop communication](#) at critical points of care – e.g., when transferring patient/client care, administering high-alert medications and reporting critical test results.
- **Monitor task performance** via regular performance reviews and dashboard monitoring of clinical, quality and cost metrics.
- **Routinely perform root cause analysis of errors and near misses**, when clinically indicated, and communicate findings via safety reports that emphasize error-reduction practices and principles.

(To help gauge organizational readiness for change, see the AHRQ's [Surveys on Patient Safety Culture®](#) [SOPS®].)

Core Characteristics of the Teamwork Model of Care



Applying Teamwork Concepts



Communication. High-performing healthcare teams rely upon open, two-way communication, both face-to-face and digital, to facilitate constructive feedback and sharing of information and ideas. In addition to creating spaces for discussion, such as team huddles and clinical debriefings, leaders should promote use of standardized tools – such as the [SBAR reporting format](#) and [handoff communication protocols](#) – to help clarify situations and expectations, while reinforcing accountability. (For guidance in training team members in communication and teamwork skills, see AHRQ [TeamSTEPPS 3.0](#).)



Test result management. An effective test result management program can help reduce the risk of misdiagnosis, delayed diagnosis, discontinuity of care and other occurrences. Written protocols should formalize the communication-related duties of ordering providers and team members, stressing the need to share incidental findings and critical test results from imaging or pathology reports, as well as other clinical data that, if not communicated promptly to colleagues and patients/clients, may impede diagnosis. By establishing consistent procedures for tracking ordered tests, healthcare facilities and providers can help ensure that every team member is aware of their responsibility to review data in a timely manner and scrutinize any incomplete or questionable findings.

Technology plays an important part in improving test result management. The ordering and reconciliation process for laboratory and diagnostic testing should be systematized through the use of digitally enabled checklists, action cues and other electronic reminders. In addition, “forcing functions” should be built into test-ordering IT systems, in order to remind team members to follow safety guidelines and double-check questionable orders. (For more strategies on how to enhance testing, reporting and follow-up procedures, see *AlertBulletin*®, “[Test Result Management: Toward a Systematic Reporting Process](#),” republished in 2023.)



Diagnostic time-outs. Periodic pauses in the diagnostic process encourage wider consultation and more comprehensive analysis of findings, thereby reducing the likelihood of error. Timeouts also may be used to ensure that the rationale for ruling out certain diagnostic possibilities is documented in the patient/client healthcare information record. (For additional measures aimed at reducing misdiagnosis, see *inBrief*® 2022-Issue 2, “[Diagnostic Errors: Common Causes, Effective Countermeasures](#).”)



Distraction-free zones. Dedicated no-interruption zones in units and areas where critical tasks – such as medication preparation or infusion/injectable drug administration – are carried out can help prevent distractions that may lead to medical errors. Conspicuous signage, colored boundaries or walls, or other markers can be used to identify spaces where such tasks take place. Team members should also be instructed to reduce unnecessary interruptions by silencing or storing cell phones and other personal devices when performing higher-risk duties.



Care transitions and referrals. In order to function smoothly, healthcare teams should establish protocols governing the transmittal of patient/client care data at key transition points, such as provider handoffs, referrals and consultations. The following strategies are designed to help teams enhance continuity of care and reduce errors by clarifying provider and staff responsibilities:

- **Track referrals.** Patient/client healthcare information records should be flagged for pending referrals/consultations. Digital referral forms should convey, at a minimum, why the referral is necessary, when results are due, whether emergent or urgent care may be required, and who is responsible for following up with the patient/client.
- **Standardize reporting methods.** At a minimum, handoff and referral formats should summarize the patient's/client's current medical condition, recent laboratory values, allergies and the reason for the referral. In the case of a provider handoff, the form should also note outstanding diagnoses and a pending to-do list. By keeping transition reports clear, succinct and focused on patient/client needs, treatment teams can better convey expectations regarding monitoring and follow-up care.
- **Appoint a transition coordinator.** By making one team member responsible for coordinating contact and follow-up care, healthcare facilities and providers can help ensure that all necessary referral-related information is sent to the receiving party and that receipt is confirmed and documented in a timely manner.

Quick Links to CNA Resources

- *Vantage Point*® 2024-Issue 1, “[Medical Error Prevention: Reinvigorating Patient Safety Measures](#).”
- *Vantage Point*® 2023-Issue 2, “[Evolving Models of Care: New Delivery Methods Present New Risks](#).”

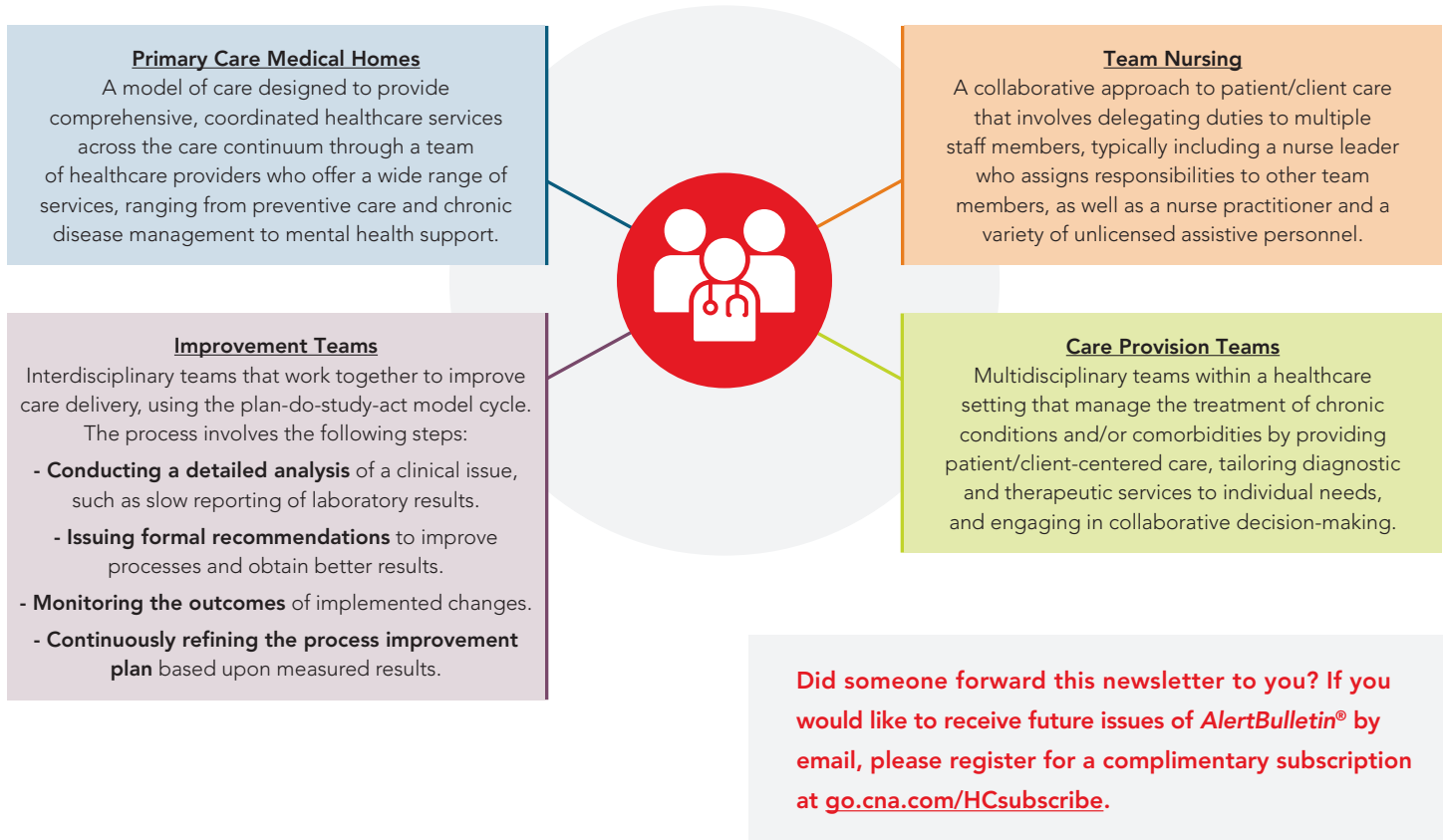
Teamwork in Practice

The diagram below highlights common applications of team-based care. Although the collaborative care model can bolster health-care delivery by improving clinical outcomes, enhancing efficiency, increasing patient/client engagement and lessening provider burnout, successful implementation requires that all team members demonstrate appropriate education and licensure, receive training on team management concepts and utilize clinical tools designed to safeguard patient/client care.

Conclusion

A high-functioning clinical team, in which everyone is alert to hazards and takes responsibility for patient/client safety, is key to quality and error-reduction in healthcare settings. By becoming aware of what sustains a safety culture, and taking measures to enhance communication and continuity of care, leaders and providers can help improve outcomes and efficiency while reducing liability exposures and staff burnout.

Examples of Teamwork Models



For more information, please call us at 888-288-3534 or visit www.nso.com or www.hpso.com.



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