NQF Safe Practice #3: Teamwork Training and Skill Building

NQF# Not NQF Endorsed

Developer: TMIT

Data Source: Leapfrog Hospital Survey

Practice Statement: Healthcare organizations must establish a proactive, systematic organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.

Objective: Establish a proactive and systematic approach to developing team-based care through teamwork training and team-led performance improvement interventions that reduce preventable harm to patients.

Rationale: Care has become fragmented and requires successful team communication to prevent system failures. The frequency of medication errors, delays in treatment, and wrong-site surgeries is due primarily to communication failure, with this being the primary root cause of approximately 70 percent of sentinel events reported to The Joint Commission from 1995 to 2004. Breakdowns in team communication are also the second most frequently cited root cause of operative and postoperative events and fatal falls. The severity of harm resulting from teamwork failures can range from no harm to patient death. Common patient care errors resulting from such breakdowns include incorrect treatment, delays in treatment, and missed treatment. The preventability of team errors is not yet known; more evidence is needed to quantify the effectiveness of team training and skill building to improve patient safety.

Evidence for Rationale:

- Denham CR. Are you listening…are you really listening? J Patient Saf 2008 Sept; 4(3):148-161.
- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.
- Risser DT, Rice MM, Salisbury ML, et al. The potential for improved teamwork to reduce medical errors in the emergency department. The MedTeams Research Consortium. Ann Emerg Med 1999 Sep;24(3):373-83.
- Smith U, ed. The joint commission [TJC] Guide to Improving Staff Communication. Oak Brook (IL): Joint Commission Resources; 2005 Aug
- The Joint Commission. Sentinel Event Alert #30: Preventing infant death and injury during delivery. 2004 Jul 21.

Impact:

Evidence of High Impact:

- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.

Opportunity:

- Opportunity for improvement exists, based on the coefficient of variation for the measure.

Evidence:

- The preventability of team errors is unknown.
- More evidence is needed to quantify the effectiveness of team training and skill building to improve patient safety.

Citations for Evidence:

- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.

NQF. Safe practices for better healthcare-2010 update: A consensus report.