TEAMWORK AND COLLABORATION

Annotated Bibliography

Apker, J., Propp, K. M., Ford, W. S. Z., & Hofmeister, N. (2006). Collaboration, credibility, compassion, and coordination: Professional nurse communication skill sets in health care team interactions. *Journal of professional nursing: Official journal of the American Association of Colleges of Nursing, 22*(3), 180-189.

This study explored how nurses communicate professionalism in interactions with members of their health care teams. Extant research shows that effective team communication is a vital aspect of a positive nursing practice environment, a setting that has been linked to enhanced patient outcomes. Although communication principles are emphasized in nursing education as an important component of professional nursing practice, actual nurse interaction skills in team-based health care delivery remain understudied. Qualitative analysis of interview transcripts with 50 participants at a large tertiary hospital revealed four communicative skill sets exemplified by nursing professionals: collaboration, credibility, compassion, and coordination. Study findings highlight specific communicative behaviors associated with each skill set that exemplify nurse professionalism to members of health care teams. Theoretical and pragmatic conclusions are drawn regarding the communicative responsibilities of professional nurses in health care teams. Specific interaction techniques that nurses could use in nurse-team communication are then offered for use in baccalaureate curriculum and organizational in-service education. (Source: PubMed)

Arford, P. H. (2005). Nurse-physician communication: An organizational accountability. *Nursing economic$, 23*(2), 72-7, 55.

Dysfunctional nurse-physician communication has been linked to medication errors, patient injuries, and patient deaths. The organization is accountable for providing a context that supports effective nurse-physician communication. Organizational strategies to create such a context are synthesized from the structural, human resource, political, and cultural frameworks of organizational behavior. (Source: PubMed)

Bender, D. G., & Buckner, S. K. (2005). Interdisciplinary patient care skills module. *The Journal of nursing education, 44*(6), 291-292.
The literature suggests that an interdisciplinary team model may offer the best opportunity for hospitals to decrease health care expenditures, while still maintaining high-quality patient care. An interdisciplinary approach coordinates care, so services are provided at a level that adequately addresses patient needs without wasting time and energy due to costly overlap of services. This results in the delivery of comprehensive, patient-centered care. This article describes an interdisciplinary module that involved entry-level nursing, physical therapist, and occupational therapist students. The module's primary objective was to provide an opportunity for students to experience working together to meet a patient's needs. Involving nursing, physical therapist, and occupational therapist students in a hands-on, interdisciplinary learning experience at the start of their educations achieved the secondary objective of emphasizing the value our programs place on teamwork in patient care. (Source: Publisher)

Bianchi-Sand, S. (2003). It takes a team to prevent errors. *The American journal of nursing, 103*(12), 89-90.
This article details the necessity of better communication among health care providers to mitigate medical errors. Programs such as crew resource management (CRM) training could promote teamwork

and collaboration thus increasing the likelihood of preventing errors. (Source: QSEN Team)

Burke, M., Boal, J., & Mitchell, R. (2004). A new look at the old. Communicating for better care: Improving nurse-physician communication. *American journal of nursing, 104*(12), 40-48.
Effective nurse--physician communication is essential to care, especially that of older adults, who often have comorbidities that can lead to frequent moves between care settings. This article examines the current state of nurse--physician communication and presents suggestions on how to improve it, including developing relationships, defining communication strategies, and packaging information for clarity. (Source: Publisher)

Caramanica, L., Cousino, J. A., & Petersen, S. (2003). Four elements of a successful quality program. Alignment, collaboration, evidence-based practice, and excellence. *Nursing administration quarterly, 27*(4), 336-343.
The nurse's role in quality improvement and assurance is well established, but this is particularly true as hospitals engage in a culture of patient safety and view quality-related activities as important "safety checks." The role of the nurse in ensuring quality related to patient care and safety cannot be overstated. The achievement of quality and safety in patient care is the result of caregivers doing the right thing the right way the first time. Nurses serve as a critical link to the best quality health care organizations have to offer. This article describes four elements of a successful quality program in a large tertiary health care setting (alignment, collaboration, evidence-based practice, and excellence) and makes the connection between quality and safety in the provision of exemplary patient care. Three examples are provided that show how nurses and other members of the health care team grouped together as a governing council for quality (Performance Improvement

Council) and at the bedside as direct caregivers in ensuring patient safety and quality patient care. (Source: PubMed)

D'Amour, D., Ferrada-Videla, M., Rodriguez, L. S. M., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of interprofessional care, 19*, 116-131.

Interprofessional collaboration is a key factor in initiatives designed to increase the effectiveness of health services currently offered to the public. It is important that the concept of collaboration be well understood, because although the increasingly complex health problems faced by health professionals are creating more interdependencies among them, we still have limited knowledge of the complexity of interprofessional relationships. The goal of this literature review was to identify conceptual frameworks that could improve our understanding of this important aspect of health organizations. To this end, we have identified and taken into consideration: (A) the various definitions proposed in the literature and the various concepts associated with collaboration, and (B) the various theoretical frameworks of collaboration. Our results demonstrate that: (1) the concept of collaboration is commonly defined through five underlying concepts: sharing, partnership, power, interdependency and process; (2) the most complete models of collaboration seem to be those based on a strong theoretical background, either in organizational theory or in organizational sociology and on empirical data; (3) there is a significant amount of diversity in the way the various authors conceptualized collaboration and in the factors influencing collaboration; (4) these frameworks do not establish clear links between the elements in the models and the outputs; and (5) the literature does not provide a serious attempt to determine how patients could be integrated into the health care

team, despite the fact that patients are recognized as the ultimate justification for providing collaborative care. (Source: PubMed)

Dayton, E., & Henriksen, K. (2007). Communication failure: Basic components, contributing factors, and the call for structure. *Joint Commission journal on quality and patient safety, 33*(1), 34-47. BACKGROUND: Communication is a taken-for-granted human activity that is recognized as important once it has failed. Communication failures are a major contributor to adverse events in health care. BASIC COMMUNICATION COMPONENTS AND PROCESSES: The components and processes of communication converge in an intricate manner, creating opportunities for misunderstanding along the way. When a patient's safety is at risk, providers should speak up (that is, initiate a message) to draw attention to the situation before harm is caused. They should also clearly explain (encode) and understand (decode) each other's diagnosis and recommendations to ensure well coordinated delivery of care. INDIVIDUAL, GROUP, AND ORGANIZATIONAL FACTORS: Beyond basic dyadic communication exchanges, an intricate web of individual, group, and organizational factors--more specifically, cognitive workload, implicit assumptions, authority gradients, diffusion of responsibility, and transitions of care--complicate communication. THE CALL FOR STRUCTURE: More structured and explicitly designed forms of communication have been recommended to reduce ambiguity, enhance clarity, and send an unequivocal signal, when needed, that a different action is required. Read-backs, Situation-Background-Assessment-Recommendation, critical assertions, briefings, and debriefings are seeing increasing use in health care. CODA: Although structured forms of communication have good potential to enhance clarity, they are not fail-safe. Providers need to be sensitive to unexpected consequences regarding their use. (Source: PubMed)

DiMeglio, K., Padula, C., Piatek, C., Korber, S., Barrett, A., & Ducharme, M., et al. (2005). Group cohesion and nurse satisfaction: Examination of a team-building approach. *The Journal of nursing administration, 35*(3), 110-120.

OBJECTIVES: The purpose of this study was to determine the impact of a team-building intervention on group cohesion, nurse satisfaction, and turnover rates. BACKGROUND: Creating an environment that supports and retains nurses represents a formidable challenge for nursing leaders. Research related to strategies that positively impact the culture in which nurses practice, thus potentially improving nurse satisfaction and reducing turnover, is critically needed. METHODS: Registered nurses (RNs) employed on inpatient units in a 247-bed, private acute care Magnet teaching hospital participated in this quasi experimental preintervention and postintervention design. The RN-RN interaction subscale from the National Database of Nursing Quality Indicators Adapted Index of Work Satisfaction, the National Database of Nursing Quality Indicators Adapted Index of Job Enjoyment, the Group Cohesion Scale, and a facilitator-developed measure were completed preimplementation and postimplementation of unit-tailored intervention strategies, which took place over a 12-month period. Turnover rates were collected 6 month preintervention and postintervention. RESULTS: Improvement in group cohesion, RN-RN interaction, job enjoyment, and turnover was demonstrated. CONCLUSION: Targeted, unit-based strategies can be an effective means of reducing turnover rates and improving group cohesion and nurse satisfaction. (Source: PubMed)

Firth-Cozens, J. (2001). Cultures for improving patient safety through learning: The role of teamwork. *Quality in health care: QHC,* 10 Suppl 2, ii26-31.

Improvements in patient safety result primarily from organisational and individual learning. This paper discusses the learning that can

take place within organisations and the cultural change necessary to encourage it. It focuses on teams and team leaders as potentially powerful forces for bringing about the management of patient safety and better quality of care. (Source: PubMed)

Gardner, D. B. (2005). Ten lessons in collaboration. *Online journal of issues in nursing, 10*(1), 15p. From http://www.nursingworld.org/ojin/topic26/tpc26_1.htm
Collaboration is a substantive idea repeatedly discussed in health care circles. The benefits are well validated. Yet collaboration is seldom practiced. So what is the problem? The lack of a shared definition is one barrier. Additionally, the complexity of collaboration and the skills required to facilitate the process are formidable. Much of the literature on collaboration describes what it should look like as an outcome, but little is written describing how to approach the developmental process of collaboration. In an attempt to remedy the all too familiar riddle of matching ends with means, this article offers key lessons to bridge the discourse on collaboration with the practice of collaboration. These lessons can benefit clinical nurse managers and all nurses who operate in an organizational setting that requires complex problem solving. (Source: PubMed)

Gassert, C. A., Peay, W. J., & Mitchell, J. A. (2006). A model of interprofessional informatics education. *Studies in health technology and informatics, 122*, 149-152.
An emphasis on patient safety and an administrative mandate to have information systems in place in most health care agencies in the USA by 2014 has put pressure on nursing informatics programs to increase the number of graduates. At the same time a need for change in health professions education was emphasized at an educational summit sponsored by the Institute of Medicine. Interprofessional education (IPE) will help to provide needed educational reform in informatics and is defined as planned occasions

when two or more professions learn from each other and about each other in a structured manner. This paper discusses an evolving interprofessional (IPE) model of informatics education that has been developed at the University of Utah. Because of interprofessional collaboration, faculty, students, and support staff from both the medical and nursing informatics programs moved into a suite on the fifth floor of a state-of-art technology-rich health sciences education building. The co-located space has enabled the informatics programs to increase activities that promote interprofessional education. (Source: PubMed)

Greiner, A. C., Knebel, E., & Institute of Medicine Committee on the Health Professions Education Summitt (Eds.). (2003). *Health professions education: A bridge to quality*. Washington, D.C.: National Academies Press.

On June 17-18, 2002, over 150 leaders and experts from health professions education, regulation, policy, advocacy, quality, and industry attended the Health Professions Education Summit to discuss and help the committee develop strategies for restructuring clinical education to be consistent with the principles of the 21st-century health system. The report says that doctors, nurses, pharmacists and other health professionals are not being adequately prepared to provide the highest quality and safest medical care possible, and there is insufficient assessment of their ongoing proficiency. Educators and accreditation, licensing and certification organizations should ensure that students and working professionals develop and maintain proficiency in five core areas: delivering patient-centered care, working as part of interdisciplinary teams, practicing evidence-based medicine, focusing on quality improvement and using information technology. (Source: Publisher)

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of interprofessional care, 19*, 188-196.

Each health care profession has a different culture which includes values, beliefs, attitudes, customs and behaviours. Professional cultures evolved as the different professions developed, reflecting historic factors, as well as social class and gender issues. Educational experiences and the socialization process that occur during the training of each health professional reinforce the common values, problem-solving approaches and language/jargon of each profession. Increasing specialization has lead to even further immersion of the learners into the knowledge and culture of their own professional group. These professional cultures contribute to the challenges of effective interprofessional teamwork. Insight into the educational, systemic and personal factors which contribute to the culture of the professions can help guide the development of innovative educational methodologies to improve interprofessional collaborative practice. (Source: PubMed)

Hamilton, P., Gemeinhardt, G., Mancuso, P., Sahlin, C. L., & Ivy, L. (2006). SBAR and nurse-physician communication: Pilot testing an educational intervention... situation, background, assessment, and recommendation. *Nursing administration quarterly, 30*(3), 295-299. Poor communication in hospitals leads to medical errors and adverse events, which can jeopardize patient safety and threaten nurse retention. SBAR was introduced in 2004 as a tool to improve communication primarily between nurses and physicians in hospitals. SBAR stands for Situation, Background, Assessment, and Recommendation and is a helpful framework for organizing information that must be communicated rapidly and concisely. In less than 2 years, SBAR has entered healthcare vernacular and is now considered "best practice" for use in rapid transmission of information in hospitals. However, there is very little evidence as to the effect of SBAR on quality of communication between nurses and physicians and even less evidence of its impact on patient outcomes.

SBAR is typically introduced in hospitals using some form of classroom training. The study described here was a pilot test to assess the effect of classroom-only SBAR training and to lay the foundation for a subsequent full-scale test of SBAR's efficacy and effectiveness. (Source: Publisher)

Hammond, K., Bandak, A., & Williams, M. (1999). Nurse, physician, and consumer role responsibility perceived by health care providers. *Holistic nursing practice, 13*(2), 28-37.

The article describes a study that addressed perceptions of unilateral and egalitarian role functions for nurses, physicians, and consumers in a long-term, 345-bed psychiatric facility in the western United States. Findings indicated that physicians desired to retain authority for health care decisions and that nurses, social workers, and hospital administrators preferred collaborative practice. Support for shared responsibility increased among psychiatric technicians with years of experience. Experience did not alter the attitudes of physicians, occupational therapists, and recreational therapists for physician dominance. With experience, nurses increased their belief in nurse responsibility. Despite evidence for collaborative decision making, results of this study indicate that attitudes of health care providers may prevent this tenet from being actualized. (Source: PubMed)

Holden, J. (2006). How can we improve the nursing work environment? *MCN. The American journal of maternal and child nursing, 31*(1), 34-38.

It has been suggested by many recently that the nursing work environment needs to be altered to make it more responsive to both nurse and patient needs. One essential aspect of this change would be to increase patient safety. This article suggests that to improve patient safety as well as satisfaction of nurses, the culture of the nursing organization should be transformed into one of a "learning

organization." Using this model of an organization, every member of the nursing organization would be encouraged to reach his or her greatest potential, the welfare of the team would become paramount, and a shared vision of where the organization needs to go would emerge, thus maximizing productivity, safety, and job satisfaction for all healthcare team members. This transformation could mean that the terms "Nursing Organizations" and "Learning Organizations" would not have to be oxymorons. (Source: PubMed)

Ironside, P. M. (2005). Working together, creating excellence: The experiences of nursing teachers, students, and clinicians. *Nursing education perspectives, 26*(2), 78-85.
This study, conducted to inform the development and implementation of the National League for Nursing Centers of Excellence in Nursing Education Program, provides a hermeneutical analysis of the common experiences and shared meanings of excellence as described by nursing students, teachers, and clinicians. Findings highlight how excellence resides in students and teachers working and learning together through enacting new pedagogies. Two themes are reported: "Working Together: Creating New Partnerships Between and Among Teachers and Students" and "Learning Together: Creating Excellence and Shaping the Future of Nursing Education Through Enacting New Pedagogies". (Source: PubMed)

Johnson, A. W., Potthoff, S. J., Carranza, L., Swenson, H. M., Platt, C. R., & Rathbun, J. R. (2006). CLARION: A novel interprofessional approach to health care education. *Academic medicine : Journal of the Association of American Medical Colleges, 81*(3), 252-256.
The authors describe the development and impact of CLARION, a student-run organization at the University of Minnesota founded in 2001 and dedicated to furthering interprofessional education for health professions students. CLARION's student founders recognized

that three recent reports from the Institute of Medicine will fuel significant changes in health professions education. Moreover, they deduced that targeted, interprofessional education in the preclinical years could provide fundamental skills and understanding needed to make today's patient care safer and more effective. By engaging health care professionals and faculty, CLARION creates and conducts extracurricular, interprofessional experiences for students that are reflective of the six IOM aims for health care. Student members are from four separate schools of the university's academic health center: medicine, nursing, pharmacy, and public health. The organization's capstone event, the Interprofessional Case Competition, challenges interprofessional teams of students to compete in conducting and presenting a root cause analysis of a fictitious sentinel event. The interprofessional organizational structure of the CLARION board models the kind of interprofessional equality needed to effectively solve problems in the health care system. The interaction among students from different health professions has led them to many new understandings about health care and the realization that many fundamental biases about other professions are firmly rooted in students before they enter the workplace. CLARION has enabled continued professional development of students, faculty, and practitioners, leading individual students to enhanced understanding of the health care system. It is a grassroots catalyst that has prompted faculty to reexamine traditional health professions curricula and look for ways to integrate more interprofessional opportunities into it. (Source: PubMed)

Kaissi, A., Johnson, T., & Kirschbaum, M. S. (2003). Measuring teamwork and patient safety attitudes of high-risk areas. *Nursing economic$, 21*(5), 211-8, 207.

Patient care leaders recognize that substantial reductions in health

care errors will not come until more attention is given to human solutions, such as improving teamwork in health care teams. The authors introduce a short, valid, and reliable instrument to measure teamwork and patient safety attitudes in hospital high-risk areas, namely the emergency department, the operating room, and the intensive care unit. The instrument was tested among nurses in four hospitals and the results showed that the nurses favored the team approach, while recognizing that teamwork in their departments is not very advanced and that communication with some key team members is problematic. This situation seems ideal for the design of a team training intervention in these settings. (Source: PubMed)

Kyrkjebo, J. M., & Hage, I. (2005). What we know and what they do: Nursing students' experiences of improvement knowledge in clinical practice. *Nurse education today, 25*(3), 167-175.
Nations around the world face mounting problems in health care, including rising costs, challenges to accessing services, and wide variations in safety and quality. Several reports and surveys have clearly demonstrated that adverse events and errors pose serious threats to patient safety. It has become obvious that future health professionals will need to address such problems in the quality of patient care. This article discuss a research study examining improvement knowledge in clinical practice as experienced by nursing students with respect to a patient-centred perspective, knowledge of health-care processes, the handling of adverse events, cross-professional collaboration, and the development of new knowledge. Six focus groups were conducted, comprising a total of 27 second-year students. The resulting discourses were recorded, coded and analysed. The findings indicate a deficiency in improvement knowledge in clinical practice, and a gap between what students learn about patient care and what they observe. In addition the findings suggest that there is a need to change the culture in

health care and health professional education, and to develop learning models that encourage reflection, openness, and scrutiny of underlying individual and organizational values and assumptions in health care. (Source: PubMed)

Larson, E. (1999). The impact of physician-nurse interaction on patient care. *Holistic nursing practice, 13*(2), 38-46.
The perceptions of physicians and nurses vary in a number of respects, including the extent to which collaboration and joint decision making are valued, the definition of what constitutes adequate and appropriate interprofessional communication, the quality of nurse-physician interactions, and the understanding of respective areas of responsibility as well as patient goals. Reasons for these differences have been attributed to gender, historical origins of the two professions, and disparities between physicians and nurses with regard to socioeconomic status, education, and socialization. Failure of physicians and nurses to interact in a coordinated and positive fashion results in unhealthy work environments and poor patient outcomes. Both professions must examine their will to improve interprofessional interactions. (Source: PubMed)

Leonard, M., Graham, S., & Bonacum, D. (2004). The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality & safety in health care, 13*, i85-90.
Effective communication and teamwork is essential for the delivery of high quality, safe patient care. Communication failures are an extremely common cause of inadvertent patient harm. The complexity of medical care, coupled with the inherent limitations of human performance, make it critically important that clinicians have standardised communication tools, create an environment in which individuals can speak up and express concerns, and share common "critical language" to alert team members to unsafe situations. All

too frequently, effective communication is situation or personality dependent. Other high reliability domains, such as commercial aviation, have shown that the adoption of standardised tools and behaviours is a very effective strategy in enhancing teamwork and reducing risk. We describe our ongoing patient safety implementation using this approach within Kaiser Permanente, a non-profit American healthcare system providing care for 8.3 million patients. We describe specific clinical experience in the application of surgical briefings, properties of high reliability perinatal care, the value of critical event training and simulation, and benefits of a standardised communication process in the care of patients transferred from hospitals to skilled nursing facilities. Additionally, lessons learned as to effective techniques in achieving cultural change, evidence of improving the quality of the work environment, practice transfer strategies, critical success factors, and the evolving methods of demonstrating the benefit of such work are described. (Source: PubMed)

Lingard, L., Espin, S., Rubin, B., Whyte, S., Colmenares, M., & Baker, G. R., et al. (2005). Getting teams to talk: Development and pilot implementation of a checklist to promote interprofessional communication in the OR. *Quality & safety in health care, 14*(5), 340-346.

BACKGROUND: Pilot studies of complex interventions such as a team checklist are an essential precursor to evaluating how these interventions affect quality and safety of care. We conducted a pilot implementation of a preoperative team communication checklist. The objectives of the study were to assess the feasibility of the checklist (that is, team members' willingness and ability to incorporate it into their work processes); to describe how the checklist tool was used by operating room (OR) teams; and to describe perceived functions of the checklist discussions. METHODS: A checklist prototype was

developed and OR team members were asked to implement it before 18 surgical procedures. A research assistant was present to prompt the participants, if necessary, to initiate each checklist discussion. Trained observers recorded ethnographic field notes and 11 brief feedback interviews were conducted. Observation and interview data were analyzed for trends. RESULTS: The checklist was implemented by the OR team in all 18 study cases. The rate of team participation was 100% (33 vascular surgery team members). The checklist discussions lasted 1-6 minutes (mean 3.5) and most commonly took place in the OR before the patient's arrival. Perceived functions of the checklist discussions included provision of detailed case related information, confirmation of details, articulation of concerns or ambiguities, team building, education, and decision making. Participants consistently valued the checklist discussions. The most significant barrier to undertaking the team checklist was variability in team members' preoperative workflow patterns, which sometimes presented a challenge to bringing the entire team together. CONCLUSIONS: The preoperative team checklist shows promise as a feasible and efficient tool that promotes information exchange and team cohesion. Further research is needed to determine the sustainability and generalizability of the checklist intervention, to fully integrate the checklist routine into workflow patterns, and to measure its impact on patient safety. (Source: PubMed)

Lingard, L., Espin, S., Whyte, S., Regehr, G., Baker, G. R., & Reznick, R., et al. (2004). Communication failures in the operating room: An observational classification of recurrent types and effects. *Quality & safety in health care, 13*(5), 330-334.

BACKGROUND: Ineffective team communication is frequently at the root of medical error. The objective of this study was to describe the characteristics of communication failures in the operating room (OR) and to classify their effects. This study was part of a larger project to

develop a team checklist to improve communication in the OR. METHODS: Trained observers recorded 90 hours of observation during 48 surgical procedures. Ninety four team members participated from anesthesia (16 staff, 6 fellows, 3 residents), surgery (14 staff, 8 fellows, 13 residents, 3 clerks), and nursing (31 staff). Field notes recording procedurally relevant communication events were analysed using a framework which considered the content, audience, purpose, and occasion of a communication exchange. A communication failure was defined as an event that was flawed in one or more of these dimensions. RESULTS: 421 communication events were noted, of which 129 were categorized as communication failures. Failure types included "occasion" (45.7% of instances) where timing was poor; "content" (35.7%) where information was missing or inaccurate, "purpose" (24.0%) where issues were not resolved, and "audience" (20.9%) where key individuals were excluded. 36.4% of failures resulted in visible effects on system processes including inefficiency, team tension, resource waste, workaround, delay, patient inconvenience and procedural error. CONCLUSION: Communication failures in the OR exhibited a common set of problems. They occurred in approximately 30% of team exchanges and a third of these resulted in effects which jeopardized patient safety by increasing cognitive load, interrupting routine and increasing tension in the OR. (Source: PubMed)

Mickan, S. M., & Rodger, S. A. (2005). Effective health care teams: A model of six characteristics developed from shared perceptions. *Journal of interprofessional care, 19*(4), 358-370.

This study into understanding health care teams began with listening to participants' teamwork experiences. It unfolded through a dialectic of iterations, analyses and critique towards a simplified model comprising six key characteristics of effective teams. Using the complementary theoretical perspectives of personal construct theory

and inductive theory building, three research methods were used to collect a range of participant perspectives. A purposive sample of 39 strategic informants participated in repertory grid interviews and clarification questionnaires. A further 202 health care practitioners completed a purpose designed Teamwork in Healthcare Inventory. All responses were transformed through three iterations of interactive data collection, analysis, reflection and interpretation. Unstructured participant perspectives were qualitatively categorised and analysed into hierarchies to determine comparative contributions to effective teamwork. Complex inter-relationships between conceptual categories were investigated to identify four interdependent emerging themes. Finally, a dynamic model of teamwork in health care organisations emerged that has functional utility for health care practitioners. This Healthy Teams Model can be utilised in conjunction with a Reflective Analysis and Team Building Guide to facilitate team members to critically evaluate and enhance their team functioning. (Source: PubMed)

Philippon, D. J., Pimlott, J. F., King, S., Day, R. A., & Cox, C. (2005). Preparing health science students to be effective health care team members: The InterProfessional initiative at the University of Alberta. *Journal of interprofessional care, 19*(3), 195-206.
The InterProfessional Initiative at the University of Alberta in Edmonton, Alberta, Canada, provides learning strategies to be effective health care team members for over 800 undergraduate students in 14 health professions. This paper traces the evolution of the initiative over the past decade and describes future directions. Particular attention is given to the administrative and academic structures and processes required to launch, develop and sustain an initiative of this scale in a major research-intensive university. The paper concludes by reviewing the evaluative work underway and reflecting on the key success factors. (Source: PubMed)

Ross, A., King, N., & Firth, J. (2005). Interprofessional relationships and collaborative working: Encouraging reflective practice. *Online journal of issues in nursing, 10*(1), 12p from http://www.nursingworld.org/ojin/topic26/tpc26_3.htm.

A challenge for those involved in the education and professional development of health and social care practitioners is to find ways of encouraging and enabling them to critically reflect upon complex collaborative situations and consider how they might improve interprofessional relationships. To meet this challenge, we piloted and developed a reflective exercise derived from methods used in personal construct psychology, which has proved to be useful in three overlapping areas; research, professional development, and classroom teaching. To illustrate the technique, this paper presents a case study of one district nurse who used the method to help her examine complex interprofessional relationships when providing long-term community care. The reflective technique (which uses arrow-shaped cards displayed on large visual layouts) was found to provide a rich description of the individual's relationships. By employing the visual displays the district nurse was able to explore the meanings of professional identity and roles in terms of professional relationships, and to consider her intentions and actions within a complex multidisciplinary situation. (Source: PubMed)

Schofield, R. F., & Amodeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective? *Health & social work, 24*(3), 210-219.

Empirical evidence for the efficacy of interdisciplinary teams is essential in the current context of managed care. Because careful assessment of the interdisciplinary team has important implications for patients and health care professionals, as well as employers, the authors read over 2,200 abstracts and analyzed 224 articles from four databases in eight health-related fields. Articles were grouped

by the type of analysis engaged in by their authors (descriptive, process-focused, empirical, or outcome), by methodology (none, general research, or quantitative), and by domains of interest (patient care, personnel, or management). Findings indicate significant weaknesses in terminology and research content. Directions for future research that would help ascertain the contribution of the interdisciplinary team are outlined. (Source: PubMed)

Shannon, S. E. (1997). The roots of interdisciplinary conflict around ethical issues. *Critical care nursing clinics of North America, 9*(1), 13-28.

Interdisciplinary conflict around ethical issues is an important problem. This article addresses some of the myths and stereotypes that hamper collaboration and suggests five reasons for interdisciplinary conflicts around care of the critically-ill patient that stem from professional training and socialization. These include differences in clinical judgment style, differences in calculating and valuing patient survival, differences in information from the patient and family, differences in perceptions of potential legal repercussions, and different views of patient advocacy and patient autonomy. The author concludes by making suggestions for changes in education and practice. (Source: Publisher)

Sherwood, G., Thomas, E., Bennett, D. S., & Lewis, P. (2002). A teamwork model to promote patient safety in critical care. *Critical care nursing clinics of North America, 14*(4), 333-340.

To create a safe health care system, providers must understand teamwork as a complementary relationship of interdependence. Continuing efforts to adopt the aviation model will enable health care providers to examine the role of human performance factors related to fatigue, leadership, and communication among all providers. The aviation model provides a basis for designing teamwork programs to

reduce error and introduces human factor principles and key skills to be learned. Health care providers need explicit instruction in communication and teamwork rather than learning by trial and error, which can instill unintended values, attitudes, and behaviors. The growing research base continues to examine the problem of health care safety and to test the most effective team training approaches. What is the most effective pattern and timing of communication among providers? What system level changes are needed in the critical care area to improve communication through teamwork and thus create a safer health care system? What are potential points of error in the daily operation that could be alleviated through effective teamwork? Continuing to test the model will ultimately change patient safety. (Source: PubMed)

Smetzer, J. L., & Cohen, M. R. (2005). Intimidation: Practitioners speak up about this unresolved problem. *Joint Commission journal on quality & patient safety, 31*(1), 594-599.
A 2003–2004 Institute for Safe Medication Practices (ISMP) survey of more than 2,000 health care providers from hospitals (1,565 nurses, 354 pharmacists, 176 others) confirmed that intimidating behaviors continue to be far from isolated events in health care—and are not necessarily limited to a few difficult physicians, or for that matter, to physicians alone. (Source: QSEN Team)

Sternas, K. A., O'Hare, P., Lehman, K., & Milligan, R. (1999). Nursing and medical student teaming for service learning in partnership with the community: An emerging holistic model for interdisciplinary education and practice. *Holistic nursing practice, 13*(2), 66-77.
To meet the health needs of communities today, health professionals need to be trained in working with persons from various cultural backgrounds, practicing disease prevention and health promotion in community-based settings, and working in teams with other professionals. The article focuses on interdisciplinary teaming for

education and practice. In this model, medical and nursing students partner with communities to plan and deliver health promotion education programs and activities. Four service learning projects providing collaborative teaming opportunities as part of the Health Professions Schools in Service to the Nation Program are described. Interdisciplinary service learning has benefits for the community, students, and faculty and will prepare nurses and physicians to have a positive impact on care through future interdisciplinary collaboration in community-based settings. (Source: PubMed)

Thomas, E. J., Sherwood, G. D., & Helmreich, R. L. (2003). Lessons from aviation: Teamwork to improve patient safety. *Nursing economic$, 21*(5), 241-243.

Medical errors may contribute to as many as 44,000 to 98,000 deaths per year. Effective teamwork may serve to avoid and manage error and also address increasing staff shortages, the growing need for cost reduction, and increasing patient expectations. The Institute of Medicine and others have encouraged health care providers to look to the aviation industry because of its long history of measuring and improving teamwork to prevent and mitigate errors. (Source: Publisher)

Last updated 4/2007