

Foundations of Teams and Teamwork

Learning Outcomes

After studying this chapter, you will be able to:

1. 1. Distinguish the characteristics of true teams from those of groups or pseudoteams.
2. 2. Identify the relationship of effective teamwork to the provision of patient-centered care and optimization of healthcare outcomes.
3. 3. Describe the characteristics of effective teams.
4. 4. Identify factors that contribute to collaborative leadership practices for healthcare teams.
5. 5. Describe strategies for performance appraisal for individuals and teams.
6. 6. Apply process improvement strategies to individual and team performance.

This chapter presents the basic elements of groups and group dynamics to inform the process of team development and collaborative teamwork in health care. Effective teamwork is the foundation of Interprofessional Collaborative Practice. Classic views of team leadership are addressed in this chapter. Key concepts of effective decision making, conflict management, shared problem solving and shared accountability are introduced. The processes of quality improvement and outcome

evaluation are explored through the lens of individual and team performance evaluation. Strategies to improve individual and team performance are presented.

Why Is Teamwork Important in Health Care?

In the complex environment of health care, team members must rely on one another's expertise to provide optimal patient-centered care. In 1999 the Institute of Medicine (IOM) published a report titled "To Err Is Human: Building a Safer Health System" (Kohn et al., 1999). The IOM estimated that 98,000 preventable deaths occurred annually because of medical errors. Further studies reported the impact of these concerns, with 70% of medical errors attributed to poor teamwork (Studdert et al., 2002). Consequently, improved teamwork and communication have become priorities for the US government and accreditation agencies such as The Joint Commission for Hospital Accreditation Organization (JCHAO) and the Agency for Healthcare Research and Quality (AHRQ) (AHRQ, 2008; King et al., 2008; Plonien & Williams, 2015).

Interprofessional Collaborative Practice is not only a national issue but also was identified as a priority of the World Health Organization (WHO, 2010). Frankel and colleagues noted that "we can assure our patients that their care is always provided by a team of experts, but we cannot assure our patients that their care is always provided by expert teams" (Frankel, Leonard, & Denham, 2006, p. 1690). Effective teamwork reduces errors and reduces mortality and morbidity, thus improving

West and Lyubovnikova (2013) used the term *pseudo teams* to describe groups of individuals working together but lacking these essential characteristics.

Related terms describing the work of healthcare providers are *multidisciplinary* or *multiprofessional teams*, *interdisciplinary teams*, and *interprofessional teams*. Although these terms were used interchangeably in the past, there is increasing agreement about their distinctions (Thistlethwaite, 2012). Thistlethwaite (2012) described the distinction: "Multi, with its connotations of many, leads to a definition of multiprofessional as: two or more professionals working side by side, without any particular cooperation or collaboration" (p. 18). This means that the multidisciplinary "team" consists of multiple professionals working independently, or in parallel (D'Amour et al., 2005). Multidisciplinary teams often lack the level of communication and collaboration needed for delivery of coordinated patient care. In essence, they are a group of providers, each offering individual contributions to patient care.

In contrast, an interdisciplinary team involves collaboration among team members toward achieving a common goal and integration of the knowledge and expertise of each professional within a shared decision-making process (D'Amour et al., 2005). A foundation of mutual trust and respect supports collaborative relationships in which each member understands and values the contributions and perspective of other professionals. These characteristics closely align with today's definition of Interprofessional Collaborative Practice: "when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care" (WHO, 2010).

Thistlethwaite (2012) echoed this distinction between interprofessional and multiprofessional teamwork: "As inter means

patient safety and care (Neily et al., 2010). Hospitals with high teamwork ratings reap the benefits of higher patient satisfaction, greater staff retention, and lower costs (O'Leary et al., 2012). This chapter explores factors that characterize effective teamwork in health care.

The Healthcare Team

What is a team? Grumbach and Bodenheimer (2004) defined a team as "a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members" (p. 1247). Healthcare services are frequently delivered by individuals from different professions. Traditionally, groups of healthcare personnel are called *teams*, whether or not they collaborate in providing care. One key difference between a healthcare team and a group of providers delivering care, however, is intentional collaboration. A team works together, with shared responsibility for making decisions, planning, and delivering care (D'Amour et al., 2005; Grumbach & Bodenheimer, 2004). A sense of shared commitment and mutual accountability also characterize teams (Katzenbach & Smith, 1993). In contrast, a group of individuals from different professions providing care for a patient does not (Dufour & Lucy, 2010). In the latter circumstance, providers focus on individual contributions and accountability rather than combined performance of the group (Katzenbach & Smith, 1993).

Although the vast majority of health services staff reported that they work within a team, only 40% reported the presence of essential characteristics that define a true team (West & Lyubovnikova, 2013). Three essential team characteristics are (1) having clear, shared objectives; (2) working closely and interdependently; and (3) reflecting, which means the team meets regularly and reviews its effectiveness.

between, among and mutually, the interprofessional approach to patient care may be defined as involving practitioners from different professional backgrounds delivering services and coordinating care programs to achieve different and often disparate service client needs. Ideally goals are set collaboratively (including the patient) with decision-making through consensus. The result should be an individualized patient care plan, which may be delivered by one or more professionals" (p. 18).

The Interprofessional Education Collaborative (IPEC) 2011 Report and 2016 Update provided operational definitions for interprofessional teamwork and interprofessional team-based care. *Interprofessional teamwork* is defined as "the levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care" (2016, p. 8). *Interprofessional team-based care* is defined as "care delivered by intentionally created, usually small work groups in health care who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients (e.g., rapid response team, palliative care team, primary care team, and operating room team)" (2016, p. 8). These definitions emphasize collaborative interprofessional teamwork for providing patient-centered care.

■ Global Perspectives

The Canadian Family Health Team initiative is part of a paradigm shift that extended the concept of primary care to that of primary health care. Primary health care includes services along the entire healthcare continuum, from health promotion to curative and/or rehabilitative care (WHO, 2002). The Canadian Family Health Team initiative specifically

addressed the need to establish interprofessional healthcare teams to improve the delivery of primary health care to meet the needs of local communities (Meuser et al., 2006; Ministry of Health and Long Term Care [MOHLTC], 2006). Inherent in this initiative was transforming the provision of services by groups of individual practitioners to collaborative team practice.

Healthcare Team Development

Creating and maintaining an effective team is challenging, dynamic, and ongoing. All members must be engaged in the process and committed to the overall success of the team in providing optimal patient outcomes. Healthcare leaders and administrators must foster this viewpoint and actively cultivate it as part of the organizational culture and structure. For example, administrators who model collaborative behavior set that expectation for teams (Gratton & Erickson, 2007). Supporting a sense of community fosters sharing of information among team members. Providing employee development activities on topics such as communication, relationship building, and conflict resolution fosters interpersonal skills needed for collaboration. Dedicating time for team members to build trusting relationships helps create an atmosphere of respect for all members' contributions.

Creating clearly defined, mutual goals provides direction for teams (Cooper-Duffy & Eaker, 2017; Gratton & Erickson, 2007). The processes with which to achieve patient-centered, team-based goals typically include developing a plan of care that integrates the expertise of individual members. Team members meet to discuss progress on the

need to know that their contributions to the plan of care are valued and supported by other team members. Developing a coordinated plan of care necessitates shifting role responsibilities within the team to best meet individual patient-care needs, rather than perpetuating a "siloed" approach with multiple disciplines working independently. Specifically, adopting "the view that a patient is 'ours' instead of 'mine' seems to encourage more interchangeability of responsibilities (where applicable) and also more interactions and knowledge exchanges to inform patient care" (MacNaughton et al., 2013). This mirrors language adopted in the original IPEC Report (2011):

Working in teams involves sharing one's expertise and relinquishing some professional autonomy to work closely with others, including patients and communities, to achieve better outcomes. Shared accountability, shared problem-solving, and shared decisions are characteristics of collaborative teamwork and working effectively in teams. (p. 24)

This means that in addition to developing a professional identity as part of one's training, healthcare providers also need to develop an interprofessional identity. The link between adopting an interprofessional identity and teamwork is described in [Box 13.1](#).

Box 13.1

Interprofessional Education Collaborative Report 2011

Learning to be interprofessional means learning to be a good team

player. Teamwork behaviors apply in any setting where health professionals interact on behalf of shared goals for care with patients or communities. Teamwork behaviors involve cooperating in the patient-centered delivery of care; coordinating one's care with other health professionals so that gaps, redundancies, and errors are avoided; and collaborating with others through shared problem-solving and shared decision-making, especially in circumstances of uncertainty (IPEC, 2011, p. 24).

Although teams or pseudoteams are common in the delivery of healthcare services, effective teamwork is "a goal that requires training and cultivation" (Clancy & Tornberg, 2007, p. 214). Simply bringing healthcare providers from different disciplines together within a team does not guarantee they will be able to integrate their services while providing care. There is often duplication of care and conflicting care if the responsibilities of members overlap and are not understood by all team members. Clearly defined team member roles and responsibilities improve collaboration (Cooper-Duffy & Eaker, 2017; Gratton & Erickson, 2007). All providers must be able to explain their own roles and responsibilities as well as those of other team members as a precursor to clarify how the team will work together in specific patient-care situations. A shared understanding of each member's contribution is particularly important in light of overlapping skill sets among professions in various work settings.

One challenge for interprofessional teams is the development of ways to share professional responsibilities against the backdrop of professional boundaries or territories. Cultivating the perspective that patient care is a team endeavor and not an individual responsibility is important because it influences the willingness to work collaboratively with others (MacNaughton et al., 2013). Collaborative healthcare teams demonstrate enhanced coordination and continuity of care. It is particularly important for patients and families to perceive that "providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future" (Haggerty et al., 2003, p. 1221). Providers

Development of interprofessional healthcare teams is an essential element of Interprofessional Collaborative Practice as defined by the World Health Organization and adopted by IPEC (2011, 2016): "When multiple health workers from different professional backgrounds work together with patients, families, [carers], and communities to deliver the highest quality of care" (IPEC, 2016, p. 8; WHO, 2010). The Core Competencies of Interprofessional Collaboration illustrate the "Integrated enactment of knowledge, skills, values and attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts" (IPEC, 2016, p. 8). Salas et al. (2008) advocated for explicit team training to improve overall effectiveness. Their model includes elements to develop team leadership, mutual performance monitoring, backup behavior, adaptability, and team orientation.

It is important to note that the Core Competencies explicitly include patients, families, and communities as members of the team. One example of an evidence-based training program to develop and optimize team performance in health care is *Team Strategies and Tools to Enhance Performance and Patient Safety* (TeamSTEPPS®) (AHRQ, 2010; AHRQ, 2013a). TeamSTEPPS® was developed by AHRQ to

improve safety and quality in health care (King et al., 2008). The curriculum is based on more than 25 years of research and evidence on team performance and can be adapted to any healthcare setting (Plonien & Williams, 2015). The training program includes tools to enhance communication within teams and improve patient outcomes (King et al., 2008). Training is focused on improving three types of teamwork outcomes: knowledge, attitudes, and performance, as depicted in Fig. 13.1. Knowledge refers to a shared understanding with team members working toward the same goal. Attitude encompasses mutual trust and a team orientation, meaning working as a team rather than as individuals. For example, team members consider “our patient” rather than “my patient” in providing team-based care (Plonien & Williams, 2015). Performance outcomes include improved efficiency, adaptability, safety, and productivity. The inner circle of the figure highlights teamwork skills of mutual support, situation monitoring, communication, and leadership (see Fig. 13.1). Each of these skills is part of the TeamSTEPPS® training curriculum (Curriculum Materials, AHRQ, 2013b). Integration of these skills leads to effective, team-based patient care. More information can be found in the [Additional Resources](#) section at the end of the chapter.



FIG. 13.1 TeamSTEPPS triangle model. (Reprinted with permission of the U.S. Agency for Healthcare Research and Quality. The suggested reference citation for TeamSTEPPS® 2.0 is: Team Strategies & Tools to Enhance Performance & Patient Safety (TeamSTEPPS®) 2.0. Agency for Healthcare Research and Quality; Rockville, MD. December 2012. <https://www.ahrq.gov/teamstepps/index.html>.)

Roles of Team Members and Group Dynamics

The topic of professional roles and responsibilities is presented at length in [Chapter 7](#) and operationalized in [Chapter 8](#). Stereotypes about perceived roles, or other member characteristics, can be a barrier to collaborative practice. This section emphasizes the relationship between

teamwork and interactions among group members.

One influence on group dynamics is the homogeneity versus heterogeneity of group membership. Homogenous groups share similar values, views, and beliefs. For example, a group of female healthcare providers of similar age and cultural background is likely to share similar perspectives. On the other hand, a group comprising men and women of different ages and cultural backgrounds is likely to have more diverse perspectives, values, and beliefs. Such differences must be acknowledged, appreciated, and navigated to provide effective team-based care. Different perspectives also lead to a wider range of solutions in providing patient-centered care.

Consider public stereotypes about generational characteristics as an example of group heterogeneity that may influence group dynamics. Today's healthcare workforce includes individuals from three generations: Baby Boomers, Generation X, and Generation Y, also known as millennials. Public stereotypes about generational characteristics may lead to misunderstandings and conflict among team members, between managers and employees, or between patients and providers (Clark, 2017). For example, Baby Boomers tend to prefer face-to-face communication and be less comfortable with technology, whereas members of the more tech-savvy Generations X and Y may prefer electronic communication. Also, differing views about working overtime versus guarding a work-life balance, or the reliance on life experience versus reliance on technology, are potential sources of misunderstanding and conflict among team members. These are some of the many factors that may influence team interactions. One key to effective team interactions is respectful recognition of differences to reach mutual understanding (Clark, 2017). In all situations of differences between members, it is important to treat each member of a team as an individual and learn his or her strengths rather than relying on public stereotypes.

Active Learning

Look up characteristics of Baby Boomers, Generation X, and Generation Y.

1. Do the characteristics listed describe your perspectives and values?
2. How do your characteristics differ from the stereotype?
3. Can you think of an example from your experience where generational differences influenced an interaction?
4. How could these differences influence the dynamics of interactions among healthcare team members, patients, and families?

Team members also benefit from awareness of group dynamics and the roles people play within group interactions. For example, assigning silent group members the role of taking minutes increases those members' participation. Another strategy is for a leader to sit next to a member who is reluctant to speak up during meetings. This simple step increases the likelihood that he or she will do so. Other members may take on the role of facilitator and encourage communication both during and between meetings. Being aware of group dynamics, and taking steps to capitalize upon them, contributes to effective team functioning.

Leadership of Healthcare

Teams

Any team member can take on the role of leader depending on the context of the specific patient-care situation. A collaborative leadership style is particularly important in health care. Effective leaders in team-based care value all team members' potential contributions in meeting the needs of patients and communities (IPEC, 2011). Leadership is one of the primary teamwork skills influencing improved team performance (Hjortdahl et al., 2009). Specifically, leadership is defined as the "ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and that team members have the necessary resources" (AHRQ, 2010, p. 5). The following section explores characteristics of leadership and management of healthcare teams.

Leadership Theory

Leadership refers to the ability to influence, motivate, and enable others to contribute. A leader should "inspire, facilitate and direct rather than dictate the way in which work is undertaken" (Ellis & Abbott, 2013, p. 96). Effective team leaders fulfill several important roles as they "organize the team, articulate clear goals, make decisions through collective input of members; empower members to speak up and challenge, when appropriate; actively promote and facilitate good teamwork; are skillful at conflict resolution" (TeamSTEPPS®, AHRQ, 2010, p. 9).

An individual must adapt his or her leadership style to the needs of the team and clinical task. Ezziene (2012a) described the differences in leadership styles among clinical leaders: "Authoritarian leaders like to be in charge, expect people to perform as they are told, and do not like to

be questioned" (p. 265). This style of leadership provides little opportunity for group decisions and may be appropriate in select clinical situations such as managing a cardiac arrest. In contrast, a *shared leadership style* is often preferred for clinical leaders (Ezziene, 2012a). Team members are engaged in decision making with shared responsibility by all members. Effective leaders offer guidance rather than dictating how things will be done. They promote input from team members and rely on follower participation to accomplish teamwork tasks. A collaborative, participative, team-centered leadership style is essential in promoting IPCP. *Transformational leadership* (Ellis & Abbott, 2013) includes the ability to motivate and inspire others by appealing to individual values. Transformational leaders express vision for how the organization operates, providing direction for teams about establishing priorities and goals.

Leadership is more challenging to describe than management, which is often linked to a specific job description and associated responsibilities (Page, 2015). Managers typically have clearly delineated roles within an organization and the authority to carry out specific responsibilities. In contrast, leaders may not have such clearly defined authority, instead relying on teaching or persuasion, rather than controlling, to carry out activities. Leadership roles may shift for different projects in an organization (Ellis & Abbott, 2013; Page, 2015). Sometimes the healthcare team leader will also be a manager, at other times a manager may need to be consulted by the team to get things done. Both management skills and leadership abilities are important elements in health care for smooth, efficient operations and delivery of optimal patient-centered care.

Healthcare Team

Behaviors

Effective leadership contributes to team performance, but equally important is the concept of "followership" (Ezziene, 2012b). Team members who hold a positive attitude toward one another and who avoid "antiteam" behaviors are critical to successful teamwork. The following characteristics of healthcare professionals align well with qualities of effective followership. First, they share a common commitment to the patient and the shared purpose of providing optimal care. Second, healthcare professionals are able to self-manage their specific responsibilities to patients and their sensitive information. Third, most professionals continue to build their competence by improving their knowledge and skills needed for the health service context. Finally, healthcare training includes clearly articulated standards and expectations for honesty and ethical behavior. The characteristics needed for good followership clearly align with development of well-functioning healthcare teams (Ezziene, 2012b).

The complexity of healthcare systems requires providers to shift between the roles of leader and follower according to the specific context of patient-care needs. This expectation is articulated in the Core Competency of Teams and Teamwork, where members "apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable" (IPEC, 2016, p. 10). Essential teamwork behaviors include "coordinating one's care with other health professionals so that gaps, redundancies, and errors are avoided; and collaborating with others through shared problem-solving and shared decision-making" (IPEC, 2011, p. 24).

In the busy healthcare environment, providers are sometimes

reluctant to ask for assistance because they want to avoid imposing on others, or are fearful that others may question their competence if they need assistance. Concerns such as these contribute to a perspective of solo responsibility rather than shared responsibility for patient care. Similarly, a provider who lacks a clear understanding of the roles and responsibilities of other team members is less likely to collaborate with others. The concept of cross-monitoring on the healthcare team is one strategy to promote team behaviors. Cross-monitoring entails watching out for one another, rather than placing blame for performance gaps, redundancies, or mistakes. Despite the uncertainties and complexities of the healthcare environment, with rapid changes in knowledge and practice, decisions have to be made and actions have to be taken. An atmosphere of mutual trust and respect promotes cooperation, with a focus on achieving cooperative versus individual goals. Likewise, all team members look out for one another and address errors openly rather than placing blame on others. The key is being willing to admit and learn from mistakes, and to learn from one another through shared problem solving (Edmondson, 2012). Chapter 5 discusses the importance of mutual respect among healthcare professionals.

Organizational, Interpersonal, and Team Interactions

Communication is an essential component of effective teamwork. The Joint Commission Report (2006) indicated that communication failures were the underlying cause of close to 70% of sentinel events. A sentinel event is an unanticipated event resulting in serious injury or death to a patient (The Joint Commission, 2006, 2013). Some communication failures can be attributed to fear related to personal interactions and social risk, which may hamper collaboration. Individuals may be

reluctant to speak up because of fear of embarrassment, rejection, or punishment (Edmondson, 2012). Likewise, team members may not want to “rock the boat” by expressing differences of opinion. A person who perceives risk in speaking up may remain silent, but the failure to speak up can have significant consequences in health care and affect the well-being of patients. Communication is discussed extensively in [Chapters 10 and 11](#).

Leaders must encourage, empower, and support team members' willingness to speak up when they have concerns about care, especially to protect quality and patient safety. (AHRQ, 2010; O'Sullivan, Money Penny, & McKimm, 2015). Simulation training on mannequins provides training opportunities for healthcare professionals to work through patient case scenarios without risk to actual patients. St. Pierre et al. (2012) examined residents' and nursing staff's willingness to challenge physician errors during simulation training. The attending physician was only challenged in 28% of situations because of significant reluctance to speak up during simulation scenarios. In a similar study, medical students were reluctant to speak up when senior colleagues made potentially life-threatening errors during simulation (Money Penny et al., 2013). See the [Research Highlight](#) for a more detailed description of this study. Taken together, these studies emphasize the importance of shifting from leadership based on hierarchies to collaborative leadership (O'Sullivan, Money Penny, & McKimm, 2015).

Research Highlight

Researchers studied medical students' willingness to challenge a senior colleague who made serious, potentially life-threatening errors in care during simulation training (Money Penny et al., 2013). When medical

you do not know something. Leaders can encourage reporting mistakes by team members when they acknowledge their own vulnerability and when they frame failures as learning opportunities (Edmondson, 2012).

Setting Goals and Meeting Objectives in the Context of a Team

One of the key elements of a healthcare team involves clear, shared objectives (West & Lyubovnikova, 2013). This means mutual goal setting so that all team members are working toward the same purpose. The patient and family are essential members of the team and should be active participants in goal setting. The second part of this process is ensuring that mechanisms are in place to assess whether the patient, family, or team goals are being met; this includes measuring outcomes and identifying processes related to patient-centered care. For example, achievement of goals such as “return to home” can be evaluated through direct measures of discharge destination. In these circumstances, the focus is on coordinating care with others to avoid gaps, redundancies, or errors (IPEC, 2011).

Shared Problem Solving and Decision Making

Two essential components of effective healthcare teams are collaboration and shared decision making processes. This means engaging and integrating the knowledge and experience of other professionals as valuable contributors to patient-centered or population-focused problem solving. The importance of considering multiple perspectives can be understood through the analogy of a puzzle. Each piece is important but only provides a part of the big picture. It takes putting all the pieces

students failed to challenge the medical errors, the leader prompted students by questioning, “That's right, isn't it?” Medical students did not challenge errors of the senior colleague in 16 of 36 opportunities during the study. During debriefing sessions after the simulation, several reasons underlying failure to speak up were identified: assumed hierarchy, fear of being wrong, fear of embarrassment, and deference to more experience of the senior colleague. Errors were not addressed by study participants because of their reluctance to challenge the leader, even when participants recognized that errors were made by the senior colleague. The authors recommended including erroneous decisions as part of simulation training to provide medical students with opportunities to practice speaking up (Money Penny et al., 2013). They also recommended training senior physicians to adopt more receptive attitudes toward discussion of care decisions.

Hierarchy of positions influences team interactions. Those with lower status feel more risk in speaking up. For example, a laboratory technician may be reluctant to question a nurse who is perceived to hold a position of greater status. This hierarchy may decrease the likelihood of some members seeking help, or lead to feeling less able to bring up problems, or feeling that others do not value their contributions. Leaders must recognize the potential influence of hierarchy on interactions and actively provide opportunities for those lower in the hierarchy to offer ideas or ask questions. Edmondson (2012) notes “when people in power speak authoritatively and speak first, it often results in greater self-censorship by others, even if this was not the original intention” (p. 635). As a result, it is the leader's responsibility to actively seek and welcome differences of perspective. When individuals on the team embrace the following behaviors, speaking up is encouraged: communicating respect, acknowledging skills and expertise of all members, and admitting when

together to create the entire seamless picture (Fig. 13.2)



FIG. 13.2 All pieces of the puzzle are needed to create the whole picture. (© ALotOfPeople/iStock/Thinkstock.)

Shared problem solving begins by clearly defining the problem(s), and generating multiple ideas for potential solutions. The team considers the merits of potential options and then comes to a decision about the plan of action (Cooper-Duffy & Eaker, 2017).

Consensus Building and Motivation

Reaching consensus means coming to an agreement about a decision. Establishing consensus is an important step in planning care. Teams start with a range of ideas and concerns, working to refine the plan until it is acceptable to all members. Being able to have productive conversations and creatively resolve differences supports collaboration (Gratton & Erickson, 2007). Having the opportunity to articulate

different perspectives as part of the decision-making process also fosters a greater sense of “buy in” for the team’s purpose, goals, and processes. In turn, this shared commitment translates into greater motivation to follow through with team decisions. When multiple perspectives strengthen team knowledge and understanding, effective teams are able to reach consensus to guide team planning and provision of care. Keeping the focus on providing optimal patient-centered care and valuing the integrated collaborative approach enhances team members’ support of group decisions.

Shared Accountability

We demonstrate the importance of developing consensus-based goals and plans to achieve team goals related to provision of care. To “close the loop,” teams need to foster a sense of shared accountability to one another, to patients and families, and to their communities. This means that all team members are responsible for working interdependently to achieve team goals. In the absence of a strong sense of shared accountability, providers may not share information or coordinate care efforts. This can result in errors or gaps in care and compromise patient safety and wellbeing.

One example of making the concept of shared accountability explicit is the practice of situation monitoring built into the TeamSTEPPS model. Situation monitoring means actively scanning situations and maintaining awareness in order to “support functioning of the team” (AHRQ, 2010, p. 5). This is closely related to the key principle of mutual support, which is the “ability to anticipate and support other team members’ needs through accurate knowledge about their responsibilities and workload” (AHRQ, 2010, p. 5). Implementing these strategies creates an atmosphere of mutual trust where team members offer and seek assistance from others.

2010; Reeves, 2011; Reeves et al., 2009). Long et al. (2006) found that medical professionals unintentionally interacted in dominant roles during team meetings, medical procedures, and case conferences, whereas interactions were more evenly distributed during informal discussions on the floor.

The organizational culture of the healthcare setting may perpetuate hierarchies as well. Physicians are traditionally seen as the key decision makers for patient care in the acute setting, overseeing other healthcare professionals, whereas collaborative decision making is more likely in community settings (Nugus et al., 2010). All team members need to be aware of the potential influences of hierarchical relationships on their interactions. Active listening with an underlying mutual respect for others are key elements of collaborative and collegial team interactions.

The World Health Organization (2011) offers specific strategies to empower team members in their interactions despite hierarchy differences. One strategy to manage differences of opinion in patient-care situations is the “two challenge rule,” which means team members must (1) voice concerns and (2) restate them. Another three-step communication strategy is abbreviated CUS (*I am Concerned, I am Uncomfortable, this is a Safety issue*) (AHRQ, 2013a, p. 30). Use of specific strategies like these during interactions among healthcare professionals notifies all team members to pause and attend to the concerns being raised. Additional communication strategies are covered in more depth in Chapters 10 and 11.

Resource Management

One of the most challenging resources to manage in healthcare environments is time. Coordination of optimal care encompasses competing demands for healthcare professionals and for patient availability. Consider the example of an inpatient rehabilitation facility.

Managing Conflict

Interprofessional teams with diverse abilities and areas of expertise provide a more comprehensive plan of care. Inevitably, there will be different perspectives about optimal care for specific patients. Such differences have the potential to lead to conflict among team members. Differences in professional and personal values and perspectives may be a source of potential conflict and difference of approaches to problem solving. For example, medical schools focus more on a scientific approach than humanistic, whereas nursing schools adopt a more holistic, humanistic perspective (McNeil et al., 2013). Yet another potential source of disagreement is differing views about team leadership. Regardless of the source of differences, “staying focused on patient-centered goals and dealing with the conflict openly and constructively through effective interprofessional communication and shared problem-solving strengthen the ability to work together and create a more effective team” (IPEC 2011, p. 24). Team members need to find ways to resolve conflict, yet maintain shared commitment to team goals and mutual respect for differences of perspective.

Conflict, negative emotions, and withholding of information can negatively affect teamwork. A key barrier to effective collaboration is interprofessional conflict associated with threats to professional identity. Specifically, identity threats may result from differential treatment of disciplines, different values between professions, expectations for assimilation, or insults or humiliating actions (Mitchell, Parker, & Giles, 2012). Differential treatment among healthcare professionals is often discussed with examples of dominance of the medical profession. Several authors note the traditional hierarchy of medicine holding a dominant position in the workplace over other professions in areas such as communication, recognition of specialist expertise, economic advantages, and authority over others (Long et al., 2006; Nugus et al.,

All patients must receive at least 3 hours of therapy each day from two or more disciplines. When a patient requires a radiograph or other imaging procedure, staff must communicate and coordinate efforts to reschedule therapy times to ensure patients receive their required therapy hours.

This can be further complicated by limited staffing of one or more disciplines. For example, if there is only one speech therapist to see all clients with a diagnosis of cerebrovascular accident, then the physical and occupational therapists will have to work around the speech language pathologist’s availability to schedule their sessions and achieve the team goal for 3 hours of therapy per day. Ongoing interprofessional collaboration ensures all aspects of the patient’s plan of care are addressed.

Another example is staffing shortages. The census of the hospital can be unpredictable. The number of beds in the hospital or a given unit is a rough guide, but the number of patients admitted can fluctuate over time. On an orthopedic surgical unit, elective surgeries can be scheduled with predictable staffing needs. However, an influx of trauma patients through the emergency department can lead to a shortage of staff to provide patient care. Once again interprofessional collaboration assists in providing coverage of patient-care needs.

Team Effectiveness

A central element of Interprofessional Collaborative Practice is working effectively to plan, deliver, and evaluate optimal patient- or population-centered care (IPEC, 2016). The following sections differentiate characteristics of effective and dysfunctional teams. Strategies to appraise team performance and apply process improvement strategies to healthcare teams are also presented.

Characteristics of Effective Teams

Three essential practices of effective healthcare teams are developing shared objectives, working interdependently to achieve those objectives, and meeting regularly to review team effectiveness (Dawson, Yan, & West, 2007; West & Lyubovinkova, 2012). Of particular importance is having clear team goals with shared commitment to the goals (Reeves et al., 2010). Members of effective teams respect one another's time and expertise and trust each member to do his or her part in achieving mutual goals (Cooper-Duffy & Eaker, 2017). To work closely together, there must be good communication and active engagement among team leaders and team members as necessary elements for collaborative problem solving (Cooper-Duffy & Eaker, 2017; Reeves et al., 2010; Thistlethwaite, 2012) to effectively plan, deliver, and evaluate care. Effective teams embrace collective and individual accountability for achieving their goals and implement explicit plans to evaluate outcomes. High-performing teams collect data, encourage critical appraisal and peer review of their work, and are transparent about their abilities and processes (Ezziane, 2012b; Gawande, 2008).

Characteristics of Dysfunctional Teams

There are a number of challenges to developing and demonstrating the characteristics of an effective team. Lencioni (2002) identified five key characteristics of dysfunctional teams: absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results (Fig. 13.3). At the foundation is an absence of trust that team members will fulfill their roles. For example, if one team member doubts the competency of others, this can lead to a perspective that “the only way things get done is if I do them myself.” This siloed approach can lead to redundancies or gaps in patient care. A lack of trust may stem from

accord and simply refuse to participate in new initiatives or follow established guidelines. A reluctance to change or lack of agreement with the need to do things differently may contribute to a lack of commitment to team goals. A team member may have an underlying belief of “I know best.” Even when based on good intentions, individual or siloed actions can be detrimental to effective team functioning. Lack of commitment to team goals may stem from underlying lack of trust (Lencioni, 2002) or lack of team leadership.

The fourth dysfunction, avoidance of accountability, may lead to the blame game. Individuals hold the perspective that “It's not my job” to make sure “x” happens. Placing blame is more likely from a silo perspective of responsibility versus a team perspective of patient-centered care, where everyone is accountable for optimal patient outcomes. In health care, avoidance of accountability means that patient care suffers. This is in direct contrast to the concept of situation monitoring (AHRQ, 2010), discussed earlier in the chapter. Implementing specific strategies to counter avoidance of responsibility can enhance team performance and outcomes. For an example, see the [Research Highlight](#).

Research Highlight

A study of 4863 cases in the operating room (OR) examined performance after team training using TeamSTEPPS tools of briefings and debriefings. After training, the OR team (surgeons, anesthesia professionals, and perioperative personnel) implemented preoperative briefings in the OR. To encourage input by all team members, surgeons asked for concerns from everyone. This promoted communication and teamwork before and throughout the procedure, rather than reinforcing the strict hierarchy of

prior experiences (Lencioni, 2002) or stereotypes about other healthcare professions.



FIG. 13.3 Five dysfunctions of teams. (From Lencioni, P. [2002]. *The five dysfunctions of a team*. San Francisco, CA: Jossey-Bass.)

The second dysfunction, fear of conflict, leads to avoidance behaviors. This can mean not raising valid concerns about patient care because of fears that you are “stepping on the toes” of another team member, which might anger the other individual. A culture where varied perspectives are encouraged and valued will help reduce this. Although uncomfortable, speaking up and learning to constructively manage conflict are essential skills for healthcare professionals.

Third, lack of commitment to group decisions or administrative directives means that team members may continue to act of their own

the surgeon “in charge.” Postoperative debriefings were conducted to review team performance, identify any missteps or problems, and thank team members for positive contributions.

Six months after implementation, there was a 95% compliance rate for the new procedures. Participants surveyed reported that the program improved patient safety and collegiality, with better resolution of emerging issues. Evidence from medical records revealed fewer delayed start times (32%–19%), fewer delays for equipment (24%–6.8%), and fewer issues requiring follow-up (44%–0%) (Wolf, Way, & Steward, 2010).

Finally, inattention to results can happen if each person has tunnel vision of his or her silo perspective, instead of appreciating responsibilities for the big picture outcome of providing optimal patient-centered care. This dysfunction is closely linked to avoidance of accountability. Healthcare providers may report being “too busy” to evaluate the results or the process in achieving patient outcomes. Adopting this perspective can lead to gaps or redundancies in patient care.

Impact on Optimal Patient Outcomes

One of the criticisms of discipline-specific care delivered with a “siloed” approach has been episodic and fragmented delivery of services with resulting gaps in care for ongoing patient needs. The Triple Aim describes an approach to optimizing health system performance by (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care (IHI, 2017). These concepts were applied at one organization. Significant gaps in care were observed in the management of children with chronic conditions, with patients receiving

only half of their recommended care ([Mangione-Smith et al., 2007](#)). Cincinnati Children's Hospital Medical Center implemented the Condition Outcomes Improvement Initiative (COI) to improve clinical outcomes for children with chronic conditions through enhanced coordination of care by the healthcare team, population management, improvements of the delivery system, and application of evidence-based care ([Lail et al., 2017](#)). For specific details, see the [Research Highlight](#).

Collectively, COI improved outcomes for 13,601 children over the 3-year initiative. Eighteen chronic condition teams participated in the initiative; eleven achieved the goal of 20% improvement in their selected clinical outcome over the 3-year initiative ([Lail et al., 2017](#)). Two additional teams showed smaller improvements. Successful COI teams shared several characteristics. Team leaders were motivated to change and committed to standardization and shared accountability. The teams had prior quality improvement (QI) training or experience, a physician champion, and prior experience working together. The successful teams showed commitment to application of evidence-based care through consistent implementation of identified processes and accountability for data collection. Successful teams used provider- or team-specific feedback and actively sought family perspectives through team meetings, focus groups, and development of patient education materials. Broad representation of providers and parent or family involvement fostered selection of meaningful goals and outcome measures and improved clinic processes and communication strategies.

COI teams that were unable to demonstrate or sustain improvement had inconsistent implementation of changes in care delivery processes and inconsistent data collection. Changes in leadership or staffing challenged some teams. They also identified implementation barriers of time for QI work, staff turnover, and competing clinical priorities. In summary, the outcomes of this initiative highlight the essential role of

population management strategies for groups of children / youths with a specific chronic condition, while identifying and addressing the family's self-management needs" ([Lail et al., 2017](#), pp.108–109). They analyzed baseline data to identify processes to reduce variation and enhance consistency of care, using evidence-based interventions. The quality improvement efforts led to establishing previsit planning as part of enhanced care coordination. As a result, teams were able to identify and prioritize care needs before, during, and after office visits, including laboratory work, imaging studies, and referrals (both prior and for follow-up care).

Performance Appraisal (Individual and Team)

Most healthcare professions require some form of performance appraisal to ensure that an individual is able to carry out his or her designated roles and responsibilities. In addition to discipline-specific abilities, healthcare providers are expected to be effective team members. For this reason, performance appraisals also need to include assessment of, and feedback regarding, an individual's ability to function as a team member. This assessment may include skills and behaviors such as willingness to speak up, ability to constructively manage conflict, engaging in shared planning and decision making, and shared accountability for patient care. Individual performance and each individual's interactions within the team directly influence healthcare team performance.

Providing explicit feedback on team performance, in addition to patient outcomes, reinforces team goals, expectations, and performance. In one example, the clinicians and staff of a large healthcare organization received training specifically dedicated to team-oriented care. This orientation emphasized the organization's commitment to developing

effective teamwork in transforming care delivery to provide optimal patient-centered and population-centered care.

Research Highlight

The Condition Outcomes Improvement Initiative's (COI) goals were "the delivery and measurement of the right care to each patient, data feedback to clinical teams, and planned, deliberate population management strategies for groups of children/youth with a specific chronic conditions, while identifying and addressing the family's self-management needs" ([Lail et al., 2017](#), pp. 108–109). Optimal management of children with chronic and complex conditions required explicit training and support for teams providing care for children with conditions such as asthma, epilepsy, juvenile idiopathic arthritis, sickle cell disease, and torticollis.

Specific elements of COI that addressed teamwork were practice redesign and deliberate planning and coordination of care that bridged the outpatient clinic and inpatient and acute care settings. Leaders worked with teams to clarify roles and responsibilities to optimize care and streamlined processes by reducing duplication of services while identifying the most appropriate team member for specific care. Improvement required dedicated time with team leaders, who were committed to accountability and standardization of processes and data collection. COI teams included physicians, nurses, care managers, family members, mental health providers, and social workers. Families participated on clinical teams, in team meetings, on conference calls, and in focus groups and completed electronic surveys.

COI also embraced the importance of improving population health through development of clinical registries and "planned, deliberate

effective interprofessional teams for delivering patient care. After implementation, each team within the healthcare system received regular feedback on team functioning and staff satisfaction, in addition to patient care outcomes ([Grumbach & Bodenheimer, 2004](#)). Establishing expectations and explicit mechanisms for feedback on performance as part of the planning and implementation process helped build shared accountability for outcomes without damaging trust among team members. Teams were informed ahead of time regarding who would provide feedback and the type of performance measures.

Process Improvement Strategies

The expectation for engaging in process improvement to promote effective team-based care is explicitly addressed in the Teams and Teamwork Sub-competencies ([IPEC, 2011, 2016](#)). However, few clinical care providers receive formal training in quality-improvement strategies, or the management of healthcare organizations, as part of their professional training. Several approaches have been used to improve quality and performance in healthcare organizations, including Six Sigma, Lean/Toyota Production System, or Studer's Hardwiring Excellence ([Koning et al., 2006; Vest & Gamm, 2009](#)). A systematic review of implementing various quality-improvement strategies to address common clinical issues revealed improved processes and outcomes in areas such as clinic appointment access, hand hygiene compliance, incidence of urinary tract infections, patient falls, and patient satisfaction ([Vest & Gamm, 2009](#)). Quality-improvement activities yielded changes in both practices and organizational culture, which in turn led to better health care.

Training healthcare team members in quality-improvement strategies equips them with the tools to actively engage in continuous improvement of patient care and interprofessional team performance. Workshops and

coaching for healthcare organizations can move participants from discipline-specific perspectives within individual silos, to a sense of shared ownership for process improvement (Studer, 2003). Engaging front-line providers in quality-assurance activities through collaborative problem solving to generate creative solutions, rather than recommending “top down” solutions, yields greater “buy in” when strategies to enhance overall patient care experiences are implemented. Fostering a collaborative problem-solving approach to quality improvement improves satisfaction of patients, employees, and physicians (Studer, 2003) while creating a shared commitment to a culture of excellence in healthcare organizations.

Improvement in provision of services requires planning, action, and evaluation. Another process improvement strategy is the Plan-Do-Study-Act (PDSA) cycle to identify and analyze a problem, followed by planning actions for improvement (Institute for Healthcare Improvement, 2009) (Fig. 13.4). In essence, this cycle adapted the scientific method for action-oriented learning. The PDSA cycle describes a deliberate process for testing change in the work setting by planning it, trying out the change, observing the results, and then evaluating and acting on what was learned. Teams collect enough data to describe and understand an existing process, and then identify aspects of that process to begin to address. The cyclical process of testing change on a small scale, and subsequently refining changes, continues through repeated PDSA cycles. Teams can then decide to implement change in a more widespread manner. PDSA cycles offer a structured improvement process for multidisciplinary teams to identify and solve complex problems that can be applied to health care (Simons et al., 2014). More information can be found in the [Additional Resources](#) section at the end of the chapter.

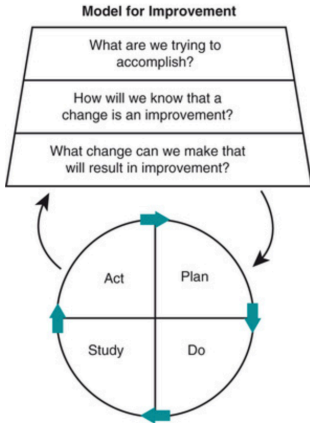


FIG. 13.4 Model for improvement: Plan-Do-Study-Act cycle for quality improvement. (Developed by Associates in Process Improvement. [2009]. In G. L. Langley, R. Moen, K. M. Nolan, T. W. Nolan, C. L. Norman, & L. P. Provost. *The improvement guide: a practical approach to enhancing organizational performance* [2nd ed.]. San Francisco, CA: Jossey-Bass.)

There are several examples of applying this process improvement strategy in health care. Simons et al. (2014) used a structured problem-solving process based on a Plan-Do-Check-Act (PDCA) cycle (an earlier version of the PDSA cycle, Deming, 2000) to improve patient safety in operating rooms. They determined that one factor in the development of surgical site infections was traffic flow and door movement in the

operating room (OR). First, they tracked the high number of OR door movements to develop a clear description of the problem. The team identified three actions to reduce OR door movement. The team also determined a feasible target outcome. During the implementation phase, they reduced the number of door movements, including a 78% reduction during orthopedic surgeries (Simons et al., 2014). The authors concluded that the PDCA process was a feasible and relevant mechanism for quality improvement.

Additional Resources

The following resources are provided to assist you in identifying tools and techniques to facilitate effective teamwork as the foundation for interprofessional collaboration.

TeamSTEPPS®

This resource is an evidence-based teamwork system developed by Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality. The TeamSTEPPS system is designed to improve communication and teamwork skills among healthcare professionals and provides ready-to-use materials and a training curriculum that can be used to integrate teamwork principles into all areas of the healthcare system. The training curriculum materials also include an updated pocket guide (AHRQ, 2013b) and an application that can be ordered online (TeamSTEPPS® Pocket Guide App).

For more information, access <https://www.ahrq.gov/teamstepps/about-teamstepps/index.html>. Curriculum materials available at

<https://www.ahrq.gov/teamstepps/curriculum-materials.html>
TeamSTEPPS Pocket Guide 2.0 Strategies and Tools to Enhance Performance and Patient Safety. AHRQ Pub. No. 14-0001-2. (2013a). Available at <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.pdf>
TeamSTEPPS® Pocket Guide App provides a quick-reference tool for the TeamSTEPPS® communication framework. Information about obtaining this app is available at <https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguideapp.html>

Distinguishing Teams From Groups*

The following table is a useful guide to distinguish characteristics of working groups from teams.

Working Group	Team
Strong, clearly focused leader	Shared leadership roles
Individual accountability	Individual and mutual accountability
The group's purpose is the same as the broader organizational mission	Specific team purpose that the team itself delivers
Individual work-products	Collective work-products
Runs efficient meetings	Encourages open-ended discussion and active problem-solving meetings
Measures its effectiveness indirectly by its influence on others (e.g., financial performance of the business)	Measures performance directly by assessing collective work-products
Discusses, decides, and delegates	Discusses, decides, and does real work together

Canadian Interprofessional Health Collaborative (CIHC)

Three of the Domains from the Canadian Interprofessional Health Collaborative (CIHC) have relevance for the Sub-competencies of Teams and Teamwork. The CIHC Domain and Competency Statements are provided below. Readers are encouraged to explore this resource further for additional information.

Domain: Team Functioning (CIHC, 2010, p. 14).

Competency Statement: Learners/practitioners understand the principles of teamwork dynamics and group/team processes to enable effective interprofessional collaboration.

Domain: Collaborative Leadership (CIHC, 2010, p. 15).

Competency Statement: Learners/practitioners understand and can apply leadership principles that support a collaborative practice model.

Domain: Interprofessional Conflict Resolution (CIHC, 2010, p. 17).

Competency Statement: Learners/practitioners actively engage self and others, including the client/patient/family, in positively and constructively addressing disagreements as they arise.

The Teamwork Assessment Scale

This tool was developed to train and to assess undergraduate medical students' ability to work in teams. The tool can be accessed free in the website of the National Center for Interprofessional Education and Practice.

Kiesewetter, J., & Fischer, M. R. (2015). The teamwork assessment scale: A novel instrument to assess quality of undergraduate medical students' teamwork using the example of simulation-based ward-rounds. *GMS Zeitschrift für Medizinische Ausbildung*, 32(2), 1-9.

<https://nexusipe.org/advancing/assessment-evaluation/teamwork-assessment-scale-tas>

Four Habits of High Performance Teams

Using a person-centered perspective, this course explores four habits of high performance teams and teamwork. This online course is provided free by the Center for Advancing Interprofessional Practice, Education and Research from Arizona State University.

Saewert, K. J. (2017, May). Four habits of high performance teams & teamwork from a person-centered perspective (Y. Price, Designer.) [Interactive video module]. Center for Advancing Interprofessional Practice, Education & Research, Arizona State University, Phoenix. <https://ipe.asu.edu/curriculum/elearning-module-four-habits-high-performance-teams-teamwork-person-centered-perspective>

Healthcare Quality Improvement Processes

Readers interested in the [Institute for Healthcare Improvement Model for Improvement \(2009\)](#) are encouraged to explore this website further. These resources provide practical strategies for improving individual and team performance. A wide variety of resources, tools, white papers, and audios/videos are provided. Individuals can learn the fundamentals of quality improvement (QI) through online courses that are free with registration. Resources include Plan-Do-Study-Act (PDSA) Worksheets and Project planning forms. Registered users can access and download the Quality Improvement Essentials Toolkit.

*From Katzenbach J. R., & Smith D. K. (1993). The discipline of teams. *Harvard Business Review*, 71(2),111-120. <https://hbr.org/1993/03/the-discipline-of-teams-2>

Key Points

- Effective teamwork is essential when healthcare professionals interact to provide care to achieve optimal patient outcomes.
- Essential team characteristics include (1) clear, shared objectives; (2) working closely and interdependently; and (3) shared accountability and reflection on team processes and outcomes.
- A key difference between a team and a group of providers delivering care is intentional collaboration.
- Coordination of patient care through effective interprofessional teamwork reduces gaps in care, redundancies, and errors.
- Shared problem solving includes building consensus to integrate multiple perspectives among team members and constructively managing differences of perspectives.
- Effective leadership influences team performance.
- A collaborative, shared leadership style is often preferred for clinical teams.

- Ongoing assessment and improvement of individual performance and team performance improves quality and coordination of care.

References

- AHRQ. *Advances in patient safety: New directions and alternative approaches*. Agency for Healthcare Research and Quality: Rockville, MD; 2008.
- AHRQ. *TeamSTEPPS Pocket Guide: Strategies and Tools to Enhance Performance and Patient Safety*. [AHRQ Pub. No. 14-0001-1; Retrieved from] www.ahrq.gov/teamstepps/pocketguide.pdf; 2010.
- AHRQ. *TeamSTEPPS Pocket Guide 2.0 Strategies and Tools to Enhance Performance and Patient Safety*. [AHRQ Pub. No. 14-0001-2; Retrieved from] www.ahrq.gov/teamstepps/pocketguide.pdf; 2013.
- AHRQ. *Curriculum Materials*. [Agency for Healthcare Research and Quality. Rockville, MD Content reviewed November 2017; Retrieved from] <https://www.ahrq.gov/teamstepps/curriculum-materials.html>; 2013.
- Canadian Interprofessional Health Collaborative (CIHC). *A National interprofessional competency framework*. [Vancouver, Canada; Retrieved from] https://www.cihc.ca/files/CIHC_IPCompetencies_Feb210.pdf; 2010.
- Clancy CM, Tornberg DN. TeamSTEPPS: Assuring