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### Creating a Culture of Teamwork and Communication

Ikjae Yang  
iyang@dons.usfca.edu

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**Creating a Culture of Teamwork and Communication: A Quality Improvement  
Project.**

Ikjae Yang, BSN, RN, PHN

N653

University of San Francisco School of Nursing and Health Professions

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## **Creating a Culture of Teamwork and Communication: A Quality Improvement Project.**

### **Abstract**

This paper aims to explain an innovative strategy for integrating research processes and quality improvement in a medical/ surgical telemetry unit (2 North). The project is targeted to improve health care team communication regarding patient safety to improve patient outcomes. The PICO question guiding this project stated: Does the implementation of TeamSTEPPS during orientation improve communication and teamwork? CINAHL database searched terms "TeamSTEPPS", "new graduate nurses", "communication", "healthcare", "teamwork", and TeamSTEPPS effectiveness. In addition to CINAHL, Google Scholar and PubMed databases were used to narrow down database searches. .

The project includes a TeamSTEPPS planning guide that offers the planning organization, developing, and analyzing a restructuring of interprofessional communication among health care teams to enhance patient safety. The restructuring involved developing communication tools to improve communication between the multidisciplinary team and new graduate nurses.

A collective quality enhancement and research project developed using TeamSTEPPS. The implementation is continuing, backed by process evaluation for ongoing process enhancement. A longitudinal examination of the research results will keep on in the future. The study concludes that cohesive research and quality

enhancement processes from evidence-based practice to resolve interprofessional practice issues. The inclusion of research within the project's design allows for evidence-based decisions to update clinical process advancement and documentation of the processes and outcomes of the improvements that can update the duplications in other places.

### **Problem Description**

Patient safety is a priority issue in healthcare. In 1999, the Quality of Health Care in America Committee of the Institute of Medicine (IOM) published, *To Err is Human: Building a Safer Health System*. IOM estimated 44,000 and 98,000 people die annually from inpatient medical errors and is the top ten leading cause of death in the United States (IOM). Moreover, The Joint Commission on Accreditation of Healthcare Organizations (JHACO) attributes 60-70% of medical errors is from a communication error (Inadequate handoff communication, 2017).

Communication among healthcare personnel is the key to excellent patient care, ensuring patient safety and continuity of care. Healthcare workers perform interdependent tasks and individual roles with patient safety (King et al., 2008). New graduate nurses transitioning into a professional role need to feel safe when discussing patient care with the multidisciplinary team, which takes teamwork ("To Err is Human The Next 20 Years", 2019). New graduate nurses transitioning into a professional role are often unprepared to articulate concerns when advocating for patients (Hezaveh et al., 2013). New graduate nurses have trouble expressing concerns about patient safety because of the lack of knowledge and exposure to patient care.

### **Available Knowledge**

New graduate nurses face many obstacles during their transition to a professional role. Researchers have recognized these challenges for decades. New nurses are inadequately prepared for their role as nurses and unsuccessfully oriented to the workplace, indicating increased pressure in the work environment leading to burnout (Bjerknes & Bjørk, 2012). New graduate nurses reported communication barriers and a lack of support from their peers. The barriers made it difficult for new graduate nurses to collaborate effectively with their team members regarding acuity issues, which can lead to medical errors and adverse events due to the inability for a new graduate nurse to communicate a specific item's importance, potentially causing injury and mortality (King et al., 2008).

An essential tool globally recognized in healthcare is teamwork (Babiker et al., 2014). Team effectiveness can be developed using team interventions. Various studies have exhibited the positive impacts of team interventions on patient outcomes (efficiency, patient safety, and effectiveness) within healthcare settings (Manser, 2009). Healthcare organizations are a multigenerational and culturally diverse multidisciplinary team. Teamwork shares a unified goal and requires effective communication to ensure patient safety and a positive work environment (Babiker et al., 2014).

Additionally, a shortage of teamwork is recognized as a significant vulnerability point for safety and quality of care (Donaldson et al., 2000). The enhancement of teamwork, therefore, becomes a priority. With more than 210,000 individuals dying in

the United States per year due to medical errors, minimizing medical errors is the primary concern in every healthcare institution (Makary & Daniel, 2016). Therefore, healthcare events can be eliminated and reduced by changing the culture to self-report patient safety errors.

Conventional accountability systems are based on a culture of punishing individuals for mistakes, limiting the ability to prevent similar occurrences (Morris, 2011). Medical errors can be overcome by working towards a culture of recognizing safety challenges and implementing solutions that focus on system improvement. High-reliability organizations (HROs) build a proactive culture that can generate the ability to come together and think of future improvement processes to deliver safe care. The novice to experienced nurses' proficiency can create information for a team to create predictability and avoid surprises. HROs influence the reliability and persistent mindfulness within an organization to prioritize safety over performance measures (Pronovost et al., 2006).

Another study conducted by Hewitt (2010) identified that looking forward to understanding the root causes of medical errors rather than placing blame is crucial to ensuring that nurses are not scared of reporting errors. The study suggested inadequate equipment, lack of sufficient experience, fatigue, time pressures, poor communication, failure to follow standard procedures, insufficient knowledge, incorrect drug prescriptions, and heavy workload as the root causes of medical errors.

Mission (2001) recognized that existing systems should be reviewed to develop safer methods of care. The primary approach to minimizing clinical errors is to encourage high-reliability culture (Mission, 2001). Mission's study recognized three primary aspects that enhance safety by mitigating unidentified errors and developing strategies to avoid errors.

The delivery of high-quality healthcare is dependent on teamwork and all healthcare professional's collaboration. Research by Rosen et al. (2018) examined teams and the quality of teamwork processes associated with patient care delivery. Teamwork ensures patient safety is at the forefront of healthcare by merging observations, expertise, and decision-making responsibilities. New graduate nurses feel overwhelmed in cases where workplace conditions are adversely contributing to burnout. Integrating teamwork has increased job satisfaction, reduced job strain, burnout, and decreased turnover rates (Laschinger et al., 2010). The World Health Organization reported a shortage of 4.3 million healthcare workers globally in 2006, and, within the next 20 years, it will be increased by 20% (Scheffler, 2008). The retention of nurses is a high priority within the healthcare system.

According to the Joint Commission on Accreditation of Healthcare Organizations (JHACO), 'medical errors were the top ten causes of death in the United States. With the rise in medical errors, the centers for Medicare and Medicaid Services (CMS) stopped reimbursing hospitals for preventable medical errors related to poor patient outcomes and dissatisfaction. (Hurting et al., 2018). Medical errors have many variables that influence

these errors. Insufficient staffing levels due to patients' variable volumes and providing care for multiple patients can confuse the nursing staff, which causes miscommunication errors, delayed care, or errors in completing physician orders.

The other causes of medical errors include poor communication, inexperience, unclear orders, and patient care transitions (Farmer, 2016). Research has been done to assess how these errors can be avoided. A descriptive and exploratory qualitative study by Henneman, Blank, Gawlinski, & Henneman (2006) examined a sample of 20 nurse practitioners who worked in an emergency care facility with 20 beds and a yearly tally of 10,000 patients to identify how medical errors were identified and avoided. The results included communication, observation, anticipation, and double-checks among healthcare professionals. Moreover, Henneman et al. research recognized five nurses' methods to prevent errors including verbal disruption, clarification, teamwork, and patient advocacy. The study concludes that teamwork and leadership are necessary for error correction. These subjects are all contained within the TeamSTEPPS model improvement program.

Another retrospective study by Cabilan, Hughes, & Shannon (2017) identified that medication errors in the emergency department could be avoided by taking two steps: fostering physicians' attitudes towards safety and adhering to safety protocols. The data analysis included the utilization of percentages and proportions in the descriptions of emerging themes and errors. About half of the errors concerned high-alert treatments. Most of the errors happened in the administration phase (62.7%), prescription (28.6%), and during both stages (18.5%) (Cabilan et al., 2017). The study concludes that verbal

orders, distractions, interruptions, workload fluctuations, and timeliness are inevitable in emergency centers, which increases the risk of medical errors.

A descriptive study by DiSimone et al. (2018) describes the specific component of nurses' training requirements, behaviors, attitudes, and knowledge to prevent medication errors in an emergency department. A sample of 103 emergency department nurses responded to a questionnaire that consisted of 43 questions about medication preparation and IV treatment administration. The research discovered that 95 percent of the nurses held that ongoing and regular training on medication preparation and administration should happen due to the rising number of medications available for treating patients today. The research also discovered that 89 percent of the nurses believed that awareness of error avoidance, utilization of evidence-based approaches, and nurses' motivation could reduce medical errors. The authors concluded that the utilization of prevention tools, awareness about medical errors, and the promotion of sufficient knowledge could assist in preventing medical errors.

All these activities are provided for in the TeamSTEPPS program. Team STEPPS, developed by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ), integrates a systematic approach of teamwork into practice to improve quality, safety, and efficiency in healthcare (Vermeir et al., 2015). The CUS technique is a tool to express safety concerns and bring awareness of "caution" to a situation (Agency for Healthcare Research and Quality, 2019). According to the Agency of Healthcare Research and Quality (2019),

"If all team members have a shared mental model and are on the same page when these words are spoken, all team members will clearly understand the issue and its magnitude." (AHRQ, 2019).

### **Rationale**

New graduate nurses find it challenging to transition from nursing students to registered nurses due to anxiety about job demands and job requirements. New nurses need to feel that they are on a team and rely on more experienced nurses to collaborate on patient acuity and the next steps for patients' acuity changes. The implementation of TeamSTEPPS in healthcare organizations can enhance the teamwork and communication models in significant ways for healthcare workers while integrating the principles of patient relationship management and human factors. For healthcare organizations that are willing to adopt change and enhance communication and teamwork, the Agency for Healthcare Research and Quality and the Department of Defense provides a powerful tool – TeamSTEPPS. Such a tool can ensure that the healthcare provider's intention is recognized and maintained when care is shifted from one healthcare provider to another.

The literature outlined here is reliable about the significance of integrating the implementation of TeamSTEPPS programs, which align with shared governance implementation. This change is deeply rooted in all stakeholders' direct involvement as part of the process, from training to performance and sustainability, making TeamSTEPPS an excellent option.

Mutual support can help new graduate nurses communicate about the patient's condition during a clinical intervention. Utilizing mutual support, team members identify the risk of error that might occur when another member's workload becomes overwhelming. Based on situation monitoring, the team members shift some responsibilities to others or help each other in executing their duties to balance the workload. Applying TeamSTEPPS competencies can improve patient safety and teamwork to reduce errors caused by human factors.

### **Specific Project Aim**

After researching and understanding the barriers to communication and quality healthcare, we aim to improve communication between healthcare providers and new graduate nurses. The process begins with the training and education of TeamSTEPPS. The process ends with the integration of teamwork skills into daily practice. The project aims to enhance teamwork and communication among new graduate nurses, the management, and providers by training 95 percent of all team members in TeamSTEPPS by April 2021. This will help in ensuring consistency across all departments in relation to the utilization of TeamSTEPPS tools. A toolkit was also advanced to guide future teams about the design, implementation, and sustainability of TeamSTEPPS associated activities.

By working on this process, we expect to: increase patient safety, reduce anxiety, build team collaboration, create an accommodative environment for the new graduate nurses and enhance a healthy relationship between them and their colleagues. It is

essential to work on this now because; additional training and education can improve patient outcomes, reduce patient readmissions and mortalities caused by medical errors, and prevent burnout.

### **Context**

To ensure the intended change, a vast number of stakeholders were recognized and included nurses, support staff, managers, and providers. The study identifies five stakeholders, including opposition, competition, leadership, supporters, and constituents. An individual can belong to one or more categories of stakeholders. Constituents are groups or individuals at the focus of and directly affected by the proposed change or intervention. Ensuring a common goal is crucial for strong participation and engagement from constituents. In the current project, the shared purpose is essential for strong participation and engagement from stakeholders.

In this paper, the common role was to enhance communication and teamwork among the multidisciplinary team and new graduate nurses. The leadership stakeholders include executive stakeholders and other individuals chosen to develop and customize the TeamSTEPPS training program and provide the training to target groups. Supporting stakeholders might not have a direct or distinct interest in the project, but they might, however, benefit indirectly or might be of aid to the project.

The lack of establishing a common goal with the group has the likelihood to cause opposition. Opposing stakeholders usually do not share the same goals or values. Creating a relationship with opposition stakeholders is challenging and might not be

possible, but it is crucial to distinguish their presence and the potential effect on the project. The team members in the leadership positions were enlisted. Communication regarding the project was through surveys and emails using the TeamSTEPPS Team Attitudes Questionnaire (T-TAQ) (Teamwork Attitudes Questionnaire (T-TAQ), 2017). (See Appendix D)

The contextual elements considered necessary at the outset of introducing the intervention were that the best approach to reducing anxiety amongst the new graduate nurses was to provide a healthy working environment. Having supportive colleagues helps the nurses to adapt faster. The assessment discovered that efficient communication positively impacts quality patient care and outcomes. The SWOT analysis was completed and can be seen in Appendix E, which helped discover that healthcare's biggest weakness is communication barriers, which result in threats such as mortalities due to medical errors.

Finally, the operational budget (see Appendix F) for Cost/Benefit Analysis. In the future, we may advocate for additional employee training of TeamSTEPPS.

### **Intervention**

Improve communication between multidisciplinary teams and new graduate nurses by integrating Team STEPPS during orientation to increase patient safety, reduce anxiety, build team collaboration, and reduce medical errors and adverse events. TeamSTEPPS includes four core competencies: mutual support, situational monitoring, communication, and leadership. These competencies help teams embrace a horizontal or

flattened hierarchy, give all team members a voice, and establish a culture of trust and respect. The development of a TeamSTEPPS program includes a four-stage process that consists of assessing needs, planning and design, training and execution, and sustainability.

A toolkit is available to direct teams and leaders on implementing TeamSTEPPS in their specific departments. Ideally, analyzing the intervention's effectiveness depends on the outcome metrics related to improvement in teamwork and communication, including information related to patient errors and harm and nurse engagement information. However, because of various time restrictions and the project's timing, gathering this information was not possible. The study's approach initially used pre- and post-survey using the Teamwork Attitudes Questionnaire (T-TAQ). Additional information included post-training assessment information and training completion information.

### **Measures**

For enhancing improvement, data will be plotted for the measures using charts to determine whether the changes are making improvements to the intended areas. There will be a pre- and post 90-day T-TAQ survey. Leaders in the unit will be designated to coach and actively observe team performance and monitor the project's effectiveness.

The pre-training data offered significant insights into the required skills for developing the training program and acted as baseline information for the program. The Teamwork Attitudes Questionnaire will be given before the project's launch. The

questionnaires included five constructs teamwork structure, leadership, situation monitoring, mutual support, and communication. The 30 questions utilizing the Likert scale, with comments ranging from **strongly disagree** to **strongly agree**. The questionnaires will be administered using the online Survey Monkey survey tool. There were no personal identifiers in the survey, and the results are offered as aggregate data. The survey data does not include any individual-specific information.

### **Ethical Considerations**

Various ethical concerns were recognized relative to this project—the significance of safeguarding the study participants' privacy and dealing with any issues regarding their psychological safety. Safety measures will be put in place to protect the participants' privacy. In addition, Teamwork Attitudes Questionnaire will be conducted using an anonymous online Survey Monkey tool. No information will be collected that can be utilized to conclude the identity of the participants. Efforts to establish an environment that is psychologically safe for TeamSTEPPS training will include regulations for sharing inside and outside the program. Open participation in the study will be supported and encouraged using non-judgmental control and group reporting instead of individual reporting to minimize any sense of the chain of command influencing the discussions.

### **Results**

Lifelong learning is an expectation in healthcare, staying current in evidence-based practice (EBP) to improve healthcare and redesigning effective, safe care by

responding to up to date EBP (Stevens, 2013). A microsystem can only be as strong as teamwork itself. Teamwork requires effective communication and collaborative care. Team members are valued when their ideas and skills are valued; increasing workplace satisfaction and positive patient care experience (Kalisch, Weaver, & Salas, 2009).

New graduate nurses transitioning into their professional roles are often not prepared to care for complex hospitalized patients. New graduate orientation and residency programs are not funded through federal or state resources. Hospitals pay for new graduate nurse orientation, which estimates around \$50,000 to train one new nurse (Greene, 2010). Research by Nguyen & Christi (2015) examined nursing culture makeover in a 24-bed, medical-surgical unit at a large metropolitan hospital. The medical-surgical department struggled with low employee satisfaction scores, a high turnover rate, and hostile culture involving lack of teamwork, favoritism, and bullying. In 2012, the unit scored poorly with the Press Ganey employee engagement score of 67.7%, an all-time low, and overtime was at an all-time high of 40%.

In 2013, a new nurse manager utilized TeamSTEPPS principles to change the unit culture by encouraging active listening, building team collaboration, and increasing fairness. The establishment of a supportive environment changed the culture to evolve into a positive, engaging team, increasing respect among coworkers, and building teamwork. In the development of trust, staff held each other accountable for behavioral performance issues leading to a more nurturing environment. Through collaboration,

overtime was decreased to 2%, and the Press Ganey employee score increased to 92% (Nguyen & Christi, 2015). TeamSTEPPS is a vital tool to integrate to build teamwork and communication.

Research by Thomas & Galla (2013) implemented TeamSTEPPS to 14 hospitals, two Long Term Care Facilities, and outpatient areas. One hundred fifty healthcare team members trained and piloted TeamSTEPPS at a community hospital within the health system's organizational care delivery model. AHRQ's Hospital Survey on Patient Safety Culture (HSOPSC) was administered before and after the implementation of TeamSTEPPS, comparing the healthcare team's perception of patient safety. Hospital results of HSOPSC showed drastic improvement from 2007 pre-TeamSTEPPS to 2010 and organizational success across the health system (Thomas & Galla, 2013).

Teamwork interventions occur in hospitals but the integration of TeamSTEPPS showed tremendous progress by Affiliates Risk Management Services, Inc. (ARMS), the risk management services organization for an extensive network of reproductive health care organizations in the United States, launched a voluntary 5-year initiative to implement a medical teamwork system TeamSTEPPS model. ARMS described the progress of the first two years and were an important planning and preparation phase to integrate critical components of TeamSTEPPS. ARMS reported the importance of the change team the key stakeholders. By recruiting the key stakeholders, the buy-in is generated (Paul et al., 2017).

Buy-in is considered the importance of the planning phase. Stakeholders do not tell staff what were going to do but sell them on the extent to help them understand the evidence-based practice for TeamSTEPPS by establishing a culture of cooperation and teamwork—the basis of TeamSTEPPS (Natafqi et al., 2017).

### **Summary**

Lifelong learning is an expectation in healthcare, staying current in evidence-based practice (EBP) to improve healthcare and redesigning effective, safe care by responding to up to date EBP (Stevens, 2013). A microsystem can only be as strong as teamwork itself. Teamwork requires effective communication and collaborative care. Team members are valued when their ideas and skills are valued, increasing workplace satisfaction increase positive patient care experience (Kalisch, Weaver, & Salas, 2009).

### **Conclusions**

According to the American Association of Colleges of Nursing (2020), report the United States is projected to experience a shortage of Registered Nurses as Baby Boomers age and the need for healthcare grows. Healthcare is a hierarchical environment and diverse environment that needs a cultural change from an individual's culture to a collaborative team environment. Teamwork is a critical health intervention with the aging populations and the increase of chronic diseases. Patient-centered care is essential to take a multidisciplinary approach to healthcare to manage patients suffering from multiple

health problems (Babiker et al., 2014). TeamSTEPPS influences and integrates a comfortable environment to speak up with observations, questions, and concerns that may critically influence team outcomes. Cultural change can help teams learn by communicating a motivating rationale for change and minimizing problems about power and status differences to promote speaking up in the service of learning.

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**Appendix A**

CNL Project: Statement of Non-Research Determination Form

**Student Name: Ikjae Yang****Title of Project:** Creating a Culture of Teamwork and Communication**Brief Description of Project:**

**A) Aim Statement:** To improve communication between healthcare providers and new graduate nurses.

**B) Description of Intervention:** The process begins with the training and education of TeamSTEPPS. The process ends with the integration of teamwork skills into daily practice.

**C) How will this intervention change practice?** By working on this process, we expect (1) increase patient safety, (2) reduce anxiety, and (3) build team collaboration. It is essential to work on this now because (1) additional training and education can improve patient outcomes, (2) reduce patient readmissions, and (3) prevent stress and burnout.

**D) Outcome measurements:** Pre- and post 90-day T-TAQ survey. Leaders in the unit will be designated to coach and actively observe team performance and monitor the project's effectiveness.

**CNL Project: Statement**

**CNL Project: Statement of Non-Research Determination Form**

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

(<http://answers.hhs.gov/ohrp/categories/1569>)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

**EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST \***

**Instructions: Answer YES or NO to each of the following statements:**

<b>Project Title:</b>	<b>YES</b>	<b>NO</b>
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	<b>x</b>	
The specific aim is to improve performance on a specific service or program and is <b>a part of usual care</b> . ALL participants will receive standard of care.	<b>x</b>	
The project is <b>NOT</b> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <b>NOT</b> follow a protocol that overrides clinical decision-making.	<b>x</b>	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <b>NOT</b> develop paradigms or untested methods or new untested standards.	<b>x</b>	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <b>NOT</b> seek to test an intervention that is beyond current science and experience.	<b>x</b>	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	<b>x</b>	

The project has <b>NO</b> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	<b>x</b>	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <b>not</b> a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	<b>x</b>	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	<b>x</b>	

**ANSWER KEY:** If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

\*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

**STUDENT NAME: Ikjae Yang, MSN, RN, PHN DATE 09/28/2020**

**SUPERVISING FACULTY MEMBER Robin Jackson, MSN, RN, CNL**

## Appendix B

### Literature Review

**Hezaveh, M., Rafii, F., & Seyedfatemi, N. (2013). Novice Nurses' Experiences of Unpreparedness at the Beginning of the Work. *Global Journal Of Health Science*, 6(1). <https://doi.org/10.5539/gjhs.v6n1p215>**

The research study was conducted qualitatively by using conventional content analysis. Participants were 21 persons, including 17 novice nurses, two supervisors, and two experienced nurses. The author's research identified three common themes new nurses encountered during their transition into a professional role. The three themes included functional disability, communication issues, and managerial challenges, leading to the inability to apply learned knowledge in practice.

**Hurtig, R., Alper, R., & Berkowitz, B. (2018). The Cost of Not Addressing the Communication Barriers Faced by Hospitalized Patients. *Perspectives Of The ASHA Special Interest Groups*, 3(12), 99-112. <https://doi.org/10.1044/persp3.sig12.99>**

The article describes communication barriers leading to adverse events, poorer patient outcomes, and patient suffering and dissatisfaction. Therefore, by eliminating communication barriers, adverse events are preventable increasing patient satisfaction and decrease healthcare spending.

**King, H. B., Battles, J., Baker, D. P., Alonso, A., Salas, E., Webster, J., ... Salisbury, M. (2008, August). *TeamSTEPPS™: Team Strategies and Tools to Enhance* ... <https://www.ncbi.nlm.nih.gov/books/NBK43686/>.**

The authors describe a comprehensive review of the evidence-based relationship between teamwork and patient safety by incorporating strategies of TeamSTEPPS. Patient safety is the number one priority in healthcare, and working cohesively with clear communication, coordination, and cooperation will lead to optimal outcomes for all patients.

**Laschinger, H. K. S., Grau, A. L., Finegan, J., & Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing*, 66(12), 2732–2742. <https://doi.org/10.1111/j.1365-2648.2010.05420.x>**

The research model consisted of 415 new graduate nurses with less than three years of experience in acute care hospitals. The longitudinal study suggests new graduate nurses working in an empowering environment were less likely exposed to bullying and burnout.

***Leading the Way to Zero | The Joint Commission. Joint Commission.***  
**<https://www.jointcommission.org/>**

The Joint Commission safety practices concentrate on aligning safety practices to an organization's priorities and goals to achieve zero harm by implementing a standardized process to empower staff to report potential unsafe situations.

**Pronovost, P., Berenholtz, S., Goeschel, C., Needham, D., Sexton, J., & Thompson, D. et al. (2006). Creating High Reliability in Health Care Organizations. *Health Services Research, 41*(4p2), 1599-1617. <https://doi.org/10.1111/j.1475-6773.2006.00567.x>**

The article describes the use of high-reliability interventions to improve patient safety by using CUSP, a component of TeamSTEPPS. The interventions focused on evidence-based interventions to improve outcomes by selecting interventions that impact outcomes and converting behaviors by developing measures to evaluate reliability to ensure patients receive evidence-based interventions.

**Riesenberg, L. A., Leisch, J., & Cunningham, J. M. (2010). Nursing Handoffs: A Systematic Review of the Literature. *AJN, American Journal of Nursing, 110*(4), 24–34. <https://doi.org/10.1097/01.naj.0000370154.79857.09>**

The research conducted a systematic review that focused on nursing handoffs. The authors identify barriers to effective handoffs, such as poor communication and variable procedures resulting in inadequate handoffs.

**Rosen, M. A., Diazgranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *American Psychologist*, 73(4), 433–450. <https://doi.org/10.1037/amp0000298>**

The authors of the study examined teamwork and communication challenges in health care. With healthcare complexity, no one individual can ensure the patient receives the highest standard of care. Healthcare has many components involving teams and individuals who are interdependent and communication at the forefront of delivering safe patient care.

***TeamSTEPPS Fundamentals Course: Module 6. Mutual Support ... Agency for Healthcare Research and Quality. (2019, March). <https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html>.***

This research study examined the participant's attitudes before and after a TeamSTEPPS training session. The training enhanced mutual support among health care professionals and increased mutual support in ensuring patient safety.

**Wangensteen, S., Johansson, I. S., & Nordström, G. (2008). The first year as a graduate nurse – an experience of growth and development. *Journal of Clinical Nursing (Wiley-Blackwell)*, 17(14), 1877–1885. <https://doi.org/10.1111/j.1365-2702.2007.02229.x>**

The research study investigated novice nurses' experiences in their first year in a professional role on a longitudinal basis. The study revealed novice nurses found it challenging to relate with seasoned nurses, and positive feedback from colleagues was a challenge in decreasing morale.

**Appendix C**

Project Charter

**Creating a Culture of Teamwork and Communication: A Quality Improvement  
Project.**

Ikjae Yang, BSN, RN, PHN

N653

University of San Francisco School of Nursing and Health Professions

November 15, 2020

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## Project Charter

### **Title**

Creating a Culture of Teamwork and Communication

### **Global Aim**

Improve teamwork and communication between healthcare providers and new graduate nurses.

### **Specific Aim:**

To integrate TeamSTEPPS during orientation for new graduate nurses. A systemic teamwork approach to improve communication, quality, safety, and efficiency in healthcare.

### **Background:**

New graduate nurses face many obstacles during their transition to a professional role (Bjerknes & Bjørk, 2012). Communication barriers and lack of support from peers make it difficult for a new graduate nurse to collaborate effectively with team members with acuity issues. Such barriers result in medical errors due to the inability to communicate a specific item's importance, potentially causing injury and mortality (Reisenberg et al., 2010).

### **Goals**

We aim to improve communication between healthcare providers and new graduate nurses. The process begins with the training and education of TeamSTEPPS. The process

ends with the integration of teamwork skills into daily practice. By working on this process, we expect (1) increase patient safety, (2) reduce anxiety, and (3) build team collaboration. It is essential to work on this now because (1) additional training and education can improve patient outcomes, (2) reduce patient readmissions, and (3) prevent stress and burnout.

**(Appendix D)****Measures/ Tools:****Population Criteria:** New graduate nurses

- TeamSTEPPS Teamwork Attitudes Questionnaire (T-TAQ).
- T-TAQ is a validated 30 item survey measuring 5 core components of teamwork.
- Questionnaire will be distributed pre- and post TeamSTEPPS training.

**Data Collection Method:** Data will be collected pre and post TeamSTEPPS training.**\*\* Positive Change = (T-TAQ Score before – T-TAQ Score after) >/ =1**

**TeamSTEPPS<sup>®</sup> 2.0** Measurement

## TeamSTEPPS Teamwork Attitudes Questionnaire (T-TAQ)

- Level II Learning
- Found in Tab F
- 30-item self-report tool
- Respondents rate their agreement with items on a 5-point Likert scale
- Measures attitudes toward:
  - Team Structure
  - Leadership
  - Situation Monitoring
  - Mutual Support
  - Communication

**TeamSTEPPS Materials and Tools**

*Team Strategies & Tools to Enhance Performance & Patient Safety*

(Teamwork Attitudes Questionnaire (T-TAQ), 2015)

**Swot Analysis (Appendix E)**



**Cost Benefits Analysis**

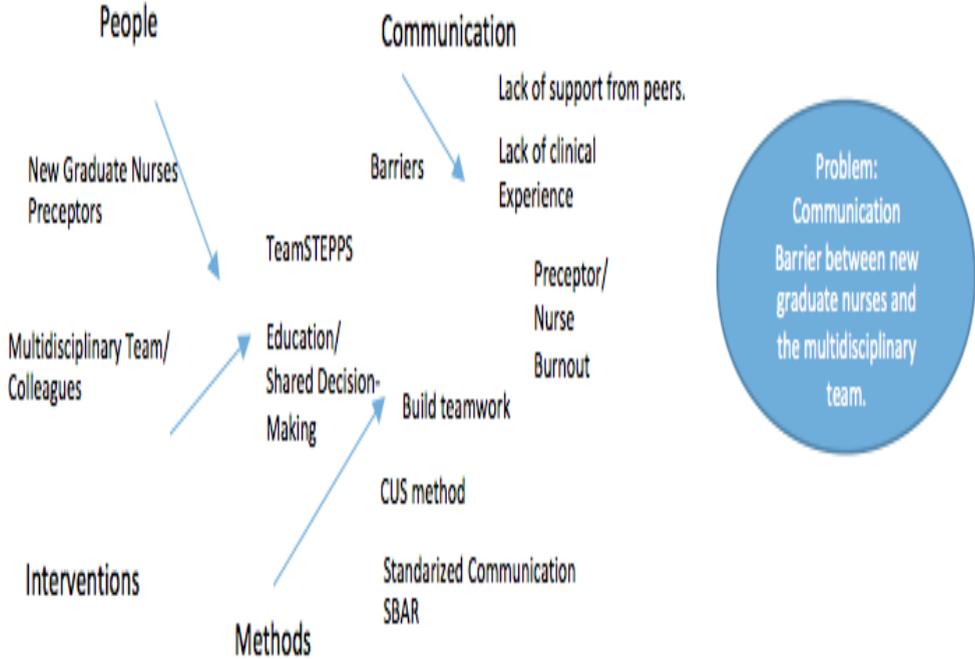
This project's benefits will improve new graduate nurses' transitional experiences with a focus on communication, organization, critical thinking, and stress management, leading to improved job satisfaction, nurse retention, and patient safety. The goal of this project is to reduce medical errors and preventable adverse events. There are two significant omission errors and no action taken and errors of commission resulting in the wrong action taken. On average, the cost per medical error was \$11,000, and 1.5 million were avoidable errors (Andel et al., 2012).

(Appendix F)

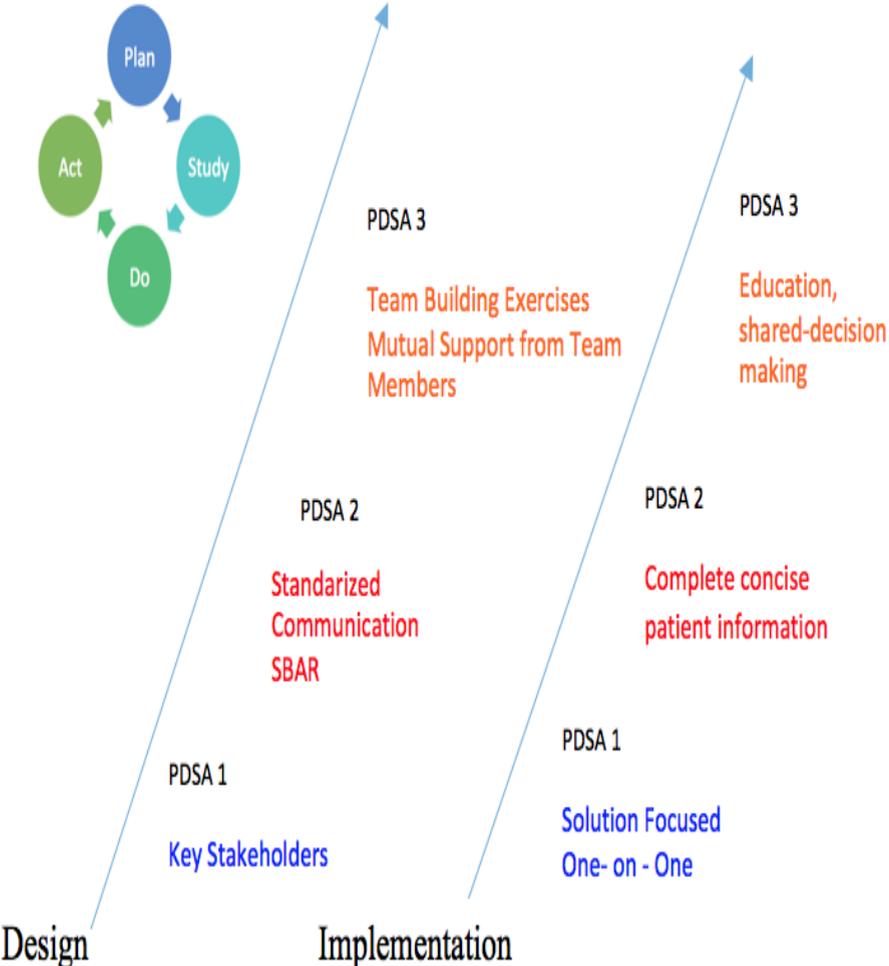
<b>Project Budget</b>		
<b>FTE Expense</b>		<b>2021</b>
Nurse Educator \$60/ hour, 3 hours per every 3 months		\$720.00
Team Education for 6 new grad nurses \$60/ hour, 3 hours		\$1,080.00
CNL yearly Salary		\$120,000.00
<b>Total</b>		<b>\$121,100.00</b>
<b>Non-FTE Expenses</b>		
IT Support		\$150.00
Nursing Education Printing		\$200.00
Meeting/ Computer Rooms \$75/ hour		\$900.00
<b>Total</b>		<b>\$1,250.00</b>

**Fishbone Diagram**

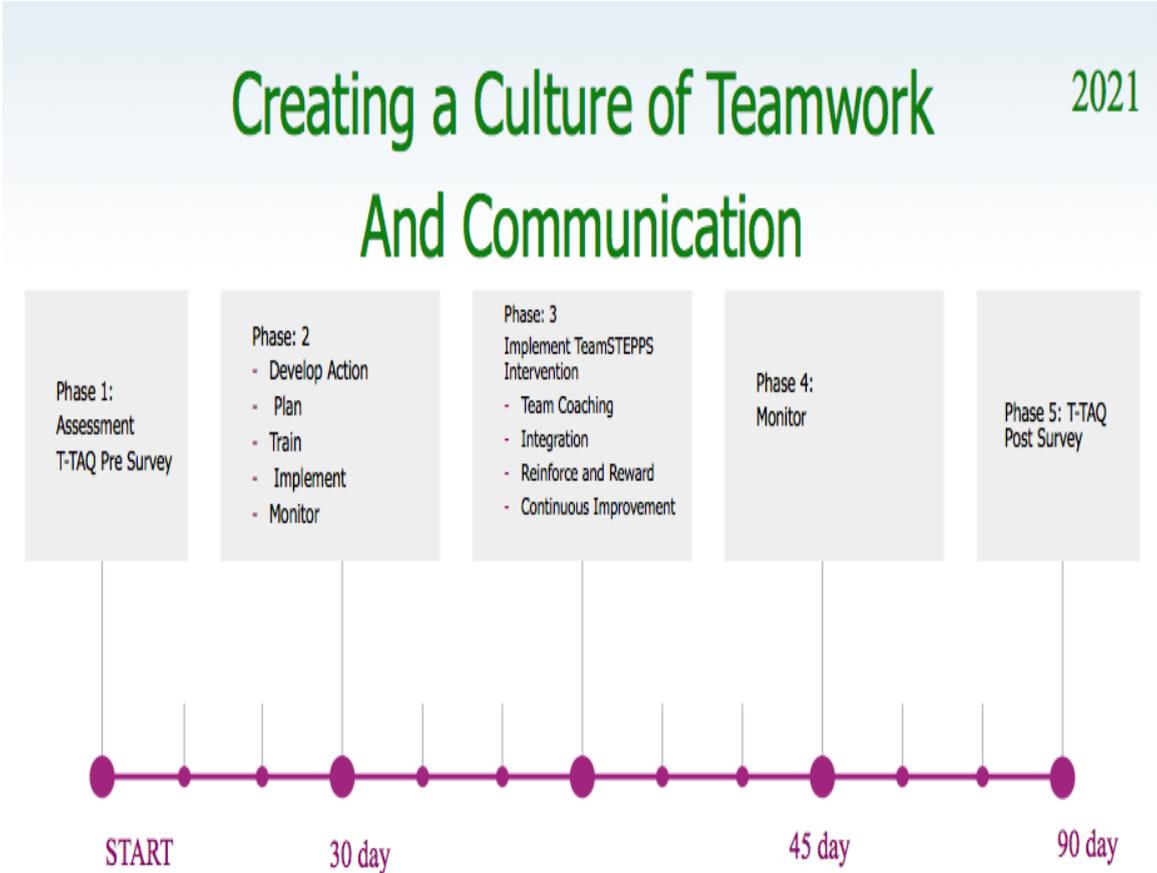
### Fishbone Diagram:



**PDSA Testing and Adaptation**



**Timeline**



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<https://doi.org/10.1097/01.NAJ.0000370154.79857.09>
- Teamwork Attitudes Questionnaire (T-TAQ)*. AHRQ. (2017).  
<https://www.ahrq.gov/teamstepps/instructor/reference/teamattitude.html>.





