Teamwork is an essential component of patient safety. Medical education has traditionally lacked the integration of interprofessional teamwork. Interprofessional teamwork promotes adaptive attitudes and shared autonomy. Teams that promote coordination and cooperation create an atmosphere of patient safety awareness. Adverse outcomes often result when teams fail to recognize individual roles, perform coordinated task, fail to adapt, and do not share common goals. Many of these failures result from the lack of communication in the healthcare arena. Approximately 44,000 patients die annually as a result of medical errors. The IOM defined patient safety as “prevention of harm to patients.” 1,2 Communication failures in the medical environment are significantly related to a failure in communication. A root cause analysis performed by the Joint Commission regarding the sentinel events revealed communication failures as the leading cause of sentinel events from 1995 to 2004. The Institute of Medicine reported that up to 98,000 lives are lost annually as a result of error. The IOM defined patient safety as “prevention of harm to patients.” 1,2 When failures result from lack of coordination and communication among hospital teams, the result is higher mortality rates in intensive care units, longer lengths of stay and higher nurse turnover in intensive care units, and greater postoperative pain with lower function levels for patients.2 Communication failures in the operating arena are common and the result is a compromise in the safety of the patient. By assessing the communication abilities of interprofessional teams in the surgical arena, teams are empowered to problem solve and provide more timely and effective interventions.

Many patient safety errors result out of inefficient systems that create barriers to effective communication among team members involved in patient outcomes. The question then arises as to how these errors and sentinel events can be prevented.6

**Methodology**

A literature review conducted using MD Consult was conducted by our team to explore what has been done through interprofessional teamwork to improve patient safety. The results were obvious that communication is the essential component for interprofessional teams in the framework of patient safety. The limitations that arose in our literature search were the correlation with patient safety measures and patient outcomes. This limitation is being considered by investigators as patient outcome data is being more readily available.1,6

**Introduction and Purpose**

Patient safety is an end result of our ability to effectively communicate as a team in the healthcare arena. The incorporation of interprofessional teamwork ideals into educational curricula, preoperative and perioperative protocols has been shown to significantly improve patient safety. Our team recognized that pointing out the problem of communication failures is the first step, but the true epiphany lies in how to address the failure. Traditional healthcare education curricula have relied on the treatment of real patients in actual clinical settings. What we discovered in our literature search is that educational institutions are making tremendous strides to incorporate interprofessional teamwork into medical, nursing, pharmacy, and allied health educational curriculums. Mutual participation is a key to implementing interprofessional collaborative relationships (Figure 1).3 An effective team incorporates commitment, competence, communication, coordination, and agreement on common goals for the patient composed of the five Cs (Figure 1). Team training and medical simulation of surgical operations are cornerstones for this current implementation movement.2,4

**Conceptual Framework**

**The 5 C’s of Interprofessional Teamwork**

1. **Common goal:** Every team member shares the short- and long-term goals of the team/organization. The common goal for clinical teams is patient centered and outcomes directed.

2. **Commitment:** Every team member is committed to attaining the goals that have been mutually set.

3. **Competence:** Every team member has the knowledge, skills, behaviors, and attitudes necessary to perform his or her role.

4. **Communication:** Team members communicate effectively/efficiently with each other, the patient, and other groups or individuals.

5. **Coordination:** Team members work together efficiently and effectively.

**Discussion**

Unfortunately, the modern medical field is embedded in a culture that is deeply rooted, in both custom and training, in autonomous individualized performance. Progress in the past has revolved around research. This culture has created silos for educational curricula that often prevent the fields of healthcare from creating functional interprofessional teams.

When adverse outcomes are associated with errors, it is likely that more than one individual receives the blame and thus there is a “system” allowing these errors to happen. It is evident then curriculums should promote interprofessional teams and simulation exercises that encourage communication skills and practiced interaction. As one researcher has repeatedly observed, “a finger-pointing environment promotes fear and is counterproductive to promoting a collaborative, blame-free systems approach to reducing errors.”4 This is a barrier impeding the incorporation of educational curriculums that promote teamwork into our healthcare institutions. When institutions embrace a system that makes an appropriate use of medical simulation and team training, it is possible that these implementations into the curriculum will factor into a shift in the culture of medical education and promote patient safety. The most essential result of team training and medical simulation is communication. Communication is the key to breaking down the silos in our curriculums, ultimately resulting in improved patient safety.

Evaluating curriculums promote interprofessional teamwork by simulating events with debriefings afterward in a mentored setting to promote effective communication among team members. This provides a safe environment while showing how teamwork can be utilized to prevent real-time adverse events. Team members also perceive the added value of team simulation and debriefing. Preparative and perioperative measures such as the implementation of surgical time outs and preparative briefings have been shown to improve patient safety and prevent errors.1,2 Research has shown that what works in team training and medical simulation is when the participants have the opportunity to practice relevant competencies in a structured, monitored scenario. Afterward, diagnostic feedback on individual and collective performance promotes a framework that embeds active discussion to help facilitate communication among the team players.2,6

**Conclusions**

Teamwork and collaboration among healthcare disciplines is essential for patient safety. Interprofessional teamwork takes place when the time is taken to understand the differences and similarities in cultures, beliefs, and practices that exist among disciplines. When these differences and similarities are explored in a simulated setting, interprofessional education can impact healthcare and change the existing culture to promote patient safety and improve patient outcomes. Interprofessional teamwork has the potential to transform health care into a highly regarded, patient safety centered industry.6

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**Works Cited**