

TEAMWORK Toolkit

Teams that communicate effectively and support each other enhance efficiency and reduce the potential for error, improving safety, performance, and clinical outcomes. Creating a team culture that encourages openness and learning builds a foundation on which better decisions are made and improves the well-being of team members.

#1 LEADING TEAMS



1. Foster a culture of constant feedback among staff, not just in yearly or formal evaluations.
2. Start regularly debriefing to get your team in the practice of giving feedback.
3. Role model openness by practicing humble, proactive inquiry.
"How can I help? What are you up against? What am I missing?"
4. Conduct deliberate safety rounding to ask staff what's going well and what could be done better; provide feedback about what you heard and actions you're taking to address concerns.
5. Increase staff participation in decision-making and identifying risks.
6. Reserve fixed hours each week as "open-door office hours" for conversations with your team.
7. Use role activation to elicit the unique expertise of team members.
"Roberto, as a physical therapist, what else should we be thinking about right now?"
8. Look for opportunities to provide real-time teamwork coaching to members of your team.
9. Role model teamwork behaviors in your own practice and team interactions.
10. Small wins are important – identify some easy-to-fix problems and celebrate fixing them.
11. Institute huddles to get everyone on the same page, clarify the plan, and establish role clarity.
12. Don't shy away from tough conversations – address conflict and disruptive behaviors promptly.
13. Play an active role in balancing workloads and promoting task assistance.
14. Be transparent: share what you know, what you don't know, and when you need help.

#2 ENCOURAGE LEARNING & CONTINUOUS IMPROVEMENT



1. Openly discuss errors and work with your team to learn and develop solutions.
2. Routine debriefing – whether things went well or not – is shown to improve team performance.
3. Recognize Good Catches and suggestions for improvement
4. Send staff to Safe Choices training or develop a similar session for your work area
5. Teams that know each other personally are more willing to talk openly about errors and improvement
6. Encourage SRS reporting and follow-up with themes of lessons-learned and solutions generated
7. Talk with other teams to share lessons learned and approaches to similar challenges.
8. Reframe team discussions by asking “what is the right thing for our patients?”
9. Make efforts to learn from the feedback and perspectives of patients and their loved ones.

#3 PROMOTE ROLE CLARITY FOR STAFF, PATIENTS, AND FAMILIES



1. Use simulation to practice teamwork, especially for difficult or rare scenarios.
2. End huddles and meetings by reviewing action items and assigning responsibilities
3. Recognize patients and families as integral team members with valuable information and insights.
4. In the moment, be specific and use names to assign tasks.
“Tonya, get the med cart.”
5. Implement checklists and job aids to ensure appropriate information exchange.
6. Discuss contingency plans and pre-assign roles to create predictability.
7. Help teams get to know each other through interprofessional training and social events.
8. Incorporate patients and families in rounds, handoffs, and times of critical information transfer.

#4 AVOID COMMUNICATION BREAKDOWNS



1. Minimize distractions during critical moments (phone calls, team meetings, etc).
2. Employ SBAR communication to structure phone calls, emails, and other important messages.
3. Teach SBAR-based tools to patients and families for relaying important information.
4. Reinforce readbacks for verbal orders and checkbacks for relaying other critical information.
5. Implement teachbacks with patients and caregivers to ensure understanding.
6. Paging and texting protocols provide consistent terminology and response-time expectations.
7. Hardwire interdisciplinary input into critical decision-making (e.g., rounds, huddles, debriefs)
8. Ensure quality handoffs with scripted language and opportunities to ask clarifying questions; make handoffs face-to-face whenever possible.
9. Strive for consistency in how team members enter and retrieve information in Epic.
10. Use checklists and scripts to help guide team discussions.

#5 SUPPORT SPEAKING UP FOR SAFETY



1. Role model psychological safety by always asking staff to speak up with concerns.
“What are we missing? What have I overlooked?”
2. Implement critical language protocols (e.g., I Need Clarity, CUS, Two Challenge Rule).
3. Thank people immediately and publicly when they raise concerns or speak up.
4. Coach leaders on recognizing and appropriately responding to concerns in the moment.
5. Unprofessional behavior is a safety threat: set expectations for team interactions, report violations, and address concerns promptly.
6. Set the expectation that speaking up is not just encouraged but *expected* for patient safety.
7. Proactively identify and address issues through safety rounding, debriefs, and open discussion.
8. Teams that are used to providing and receiving feedback are more likely to speak up.
9. Establish a practice of introductions during team gatherings – teams are safer when they know the names of fellow team members.
10. Foster a climate of task assistance – teach your staff it is not a weakness to ask for help.
11. Teach patients and families how to speak up for safety (e.g., calling for rapid responses, feedback on handwashing, using callouts/timeouts, CUS).
12. Actively seek to flatten the hierarchy within teams – use role activation, seek input from quieter team members, use “we” instead of “I” language, consider using first names, and support leadership opportunities for junior staff.



COURSES AND RESOURCES

[Duke Team Training Courses](#)

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is an evidence-based set of teamwork tools that improve communication and teamwork among health care professionals. The Master Training Course educates participants on the TeamSTEPPS tools, how to teach them to others, and strategies for implementing and coaching teamwork behaviors.

[Patient Safety Leadership Course](#)

This course is where safety, science, and psychology meet in a comfortable common ground. We cover data, structures, tools, and frameworks for patient safety, quality improvement, evidence-based executive rounding, psychological safety, safety culture, teamwork, dealing with difficult colleagues, second victim of harm, and pacing change in sustainable ways. We also provide tools and strategies for facilitating creativity, mindfulness, and resilience within a given clinical area.

[Patient and Family Advisory Councils \(PFACs\)](#)

PFAC volunteers provide the patient and family perspective on patient care initiatives, projects, programs, and facilities that impact the patient and family experience at Duke University Health System.

[Duke Professional Accountability Program \(PACT\)](#)

As part of Duke's ongoing commitment to professionalism, the health system's Professional Accountability Program (PACT) was developed to improve quality, safety and the patient experience. It is designed to promote the highest standards of professional conduct and ethical behavior and support the delivery of high quality patient-centered care through improved communication and teamwork.

[Duke University Hospital Safe Choices Workshops](#)

Safe Choices is a workshop led by senior leaders and patient safety experts. Small group discussion of national and local safety events is used to identify and analyze risks taken and potential solutions to enhance patient safety. The focus is on individual understanding of the role of human error, at risk and reckless behavior, and the impact of personal choice in preventing patient harm.

[DUHS Safety Reporting System](#)

An online safety reporting system (SRS) has been implemented throughout Duke University Health System (DUHS) as part of Duke Medicine's continuing commitment to advancing patient safety. The SRS module—RL6, developed by RL Solutions—integrates DUHS' patient safety reporting, risk management, and visitor relations systems.