NCPS Medical Team Training Program
Executive Summary
April 2007

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Communication failure is a leading source of adverse events in health care. As of January 2007, 70% to 80% of more than 8,000 Root Cause Analysis reports to the VA National Center for Patient Safety (NCPS) involve communication failure as at least one of the primary factors contributing to adverse events and close calls. In the IOM report, *To Err is Human: Building a Safer Healthcare System*, teamwork training to improve communication is recommended for health care organizations, "…establish team training for personnel in critical care areas … using proven methods such as the Crew Resource Management (CRM) training techniques employed in aviation."

NCPS began developing a Medical Team Training (MTT) program in 2003 designed to introduce communication tools to professionals working in VA facilities with the expectation they will integrate these tools into the clinical work place. Our program is organized into three important components: 1) application, preparation and planning for the Learning Session and MTT project; 2) Learning Session in the VAMC; and 3) follow-up data collection and support of participating VAMCs for one year.

As of March 2007, 40 facilities are enrolled participants in the program involving clinical units, such as the OR, ICU, Emergency Department, Ambulatory Clinics, and Long Term Care Unit. Each Learning Session is held in a VA Medical Center for a full day of interactive dialogue, faculty role play and teaching films of clinical vignettes produced by NCPS demonstrating CRM applications in health care. The *Safety Attitudes Questionnaire (SAQ[1])* provided by the Johns Hopkins Quality and Safety Research Group, is completed anonymously by each participant prior to commencing the session and repeated by the same clinical units one year later. Completing the SAQ is voluntary and individuals participating in the program may choose not to complete the survey. The SAQ measures attitude and behavioral changes expressed in six factors: safety climate, teamwork climate, job satisfaction, working conditions, perceptions of management, and stress recognition. Results of de-identified, aggregate data analysis from all participating VA Medical Centers will contribute to program evaluation.

To participate in the MTT program, each VA facility will make a commitment to an MTT project which is organized by an interdisciplinary Implementation Team of VAMC professionals from the targeted clinical units such as the OR and ICU. Each MTT project must involve briefings and debriefings to be initiated in the clinical unit(s) targeted by leadership within days after the Learning Session. Briefings and debriefings provide the necessary context for the application of CRM. In the clinical context, a briefing is a conversation facilitated by a team leader to establish a shared understanding of the work and management of patient care in the health care environment. A debriefing is a similar conversation to examine perspectives on a recently shared experience.

MTT program faculty will provide follow-up support of each participating VAMC through monthly group conference calls and individual quarterly semi-structured interviews for a minimum of one year. The theory of this program is that implementation of MTT communication principles in health care delivery will improve patient outcomes and staff job satisfaction, which will be tested by a robust program evaluation using a mixed methods approach.

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[1] Sexton JB, Helmreich RL, Neilands TB, Rowan K, Vella K, Boyden J, et al. The Safety Attitudes Questionnaire: Psychometric properties, benchmarking data, and emerging research. *BMC Health Services Research*. 2006; 6: 44. Available at: http://www.biomedcentral.com/1472-6963/6/44/abstract/.