CO-LEAD

Collective Leadership for Safety Cultures

TARGETED TOOLKIT COMPONENTS

TEAM PROCESSES

Effective team meetings

Removing frustrations/ blockers

Building trust

Structured inter-disciplinary rounds

PATIENT SAFETY

Challenging unsafe behaviours

Communicating at safety-critical moments

Talking about safety: PlayDecide Patient Safety

Safety pause huddle

High reliability at team level

WELLBEING

Developing a positive work environment

Emotional support in teams

Enhancing person-centred care

SUSTAINABILITY

Sustaining improvements

OVERVIEW OF THIS CO-LEAD TOOLKIT PACKAGE

Thank you for your interest in the UCD Co-Lead Toolkit. This package contains the 13 targeted modules to help multidisciplinary teams further advance the embedding of collective leadership into their working practice. The toolkit was developed using a co-design process which included multidisciplinary healthcare professionals, patient advocates, and researchers.

USING THE CO-LEAD TOOLKIT COMPONENTS

Teams should collectively decide upon which of these 13 targeted modules are most appropriate for their needs. (Prior to this, teams should have undertaken the six core toolkit modules, available separately in the package titled *Co-Lead Core Toolkit Components*.)

The toolkit modules should be delivered in a workshop format, by one or two facilitators. All members of the team should take a turn facilitating if possible. Each module contains a brief "about this module" introductory section, then provides step-by-step guidance for facilitators on content, format, and timing. Session tools such as outcome templates and handouts are also included and may need to be printed before module delivery.

Occasionally, modules may use online videos or other additional resources not created by the Co-Lead team. These are clearly indicated and the relevant web addresses are included, therefore an internet connection may be required before or during those sessions.

Some modules also make use of PowerPoint presentations, which may be downloaded from http://www.ucd.ie/collectiveleadership/resourcehub/toolkit and individual modules can also be downloaded if needed.

ABOUT CO-LEAD

Collective Leadership and Safety Cultures (Co-Lead) is a 5-year programme in UCD that is researching the impact of an emerging model of leadership (collective leadership) on team performance and healthcare safety. Its overall aim is to support quality and safety cultures through the development of a new model of leadership that is associated with effective team performance.

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WELLBEING

SUSTAINABILITY

Effective team meetings

Co-Lead

ABOUT THIS MODULE

EFFECTIVE TEAM MEETINGS

ABOUT THIS MODULE

EFFECTIVE TEAM MEETINGS

What is the goal of this module?

This module will provide advice and facilitate teams to collectively discuss and agree on the best structure to make the most effective use of meeting times.

What is the collective leadership focus of this module?

- **Cooperation and coordination between members**
- **Recognising and valuing contribution of others**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Coordination and effective team working**
- **Cooperation between team members**
- **Cohesion and coordination**

Who is this module for?

Any individuals who regularly gather in formal or informal teams to discuss issues relevant to their work practice.

What is the patient safety impact of this module?

Team performance and coordination benefit from regular team meetings. Taking the time to come together and reflect on how they do their work enables teams to improve their effectiveness, productivity, and innovation.[1,2]

References

1. Widmer PS, Schippers MC, West MA. Recent developments in reflexivity research: a review. Psychologie des Alltagshandelns. 2009;2(2):2-11.
2. Konradt U, Schippers MC, Garbers Y, Steenfatt C. Effects of guided reflexivity and team feedback on team performance improvement: The role of team regulatory processes and cognitive emergent states, European Journal of Work and Organizational Psychology 2015;24(5):777-795

Co-Lead

SESSION OUTLINE

EFFECTIVE TEAM MEETINGS

SESSION OUTLINE

EFFECTIVE TEAM MEETINGS

SESSION OVERVIEW

Purpose:	This session will give team members advice on how to effectively structure and plan team meetings.
Timing:	60 min.
Setup:	Introduction > Group Exercise > Group Feedback > Group Discussion > Feedback
Outcomes:	Teams will collectively decide on the most appropriate structure for future team meetings to ensure that they run effectively and efficiently.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Materials:	Printed copies of the outcomes template and meeting checklist
Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Room:	Configure for round table discussion or small groups for larger teams
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, the session materials should be shared in advance via email.

SESSION OUTLINE

EFFECTIVE TEAM MEETINGS

START OF SESSION

1) Welcome and introduction (5 min.)

Welcome and re-cap on Co-Lead (aims, sharing of leadership across team, etc.) Introductions if new people in attendance and update the team on progress on goals.

Highlight the relevance of today's topic to practice: Regular team meetings are associated with improved team performance and coordination. Teams that take time to come together and reflect on how they do their work are more effective, productive, and innovative than those that do not meet (Widmer et al. 2009, Konradt et al. 2015).

Note the aim of the session today: This intervention component provides advice and tips on how to effectively structure and plan team meetings. It provides a platform for the team to consider what will work well for their team needs and agree a meeting structure going forward.

During this session the team will collectively decide on the most appropriate structure for future team meetings to ensure they run effectively and efficiently.

2) Icebreaker (5 min.)

Facilitators should ask each team member to come up with one word to describe their experience of team meetings. Go around the room and let each person say their one word.

3) Group exercise (15 min.)

Split the group into smaller groups of 3-5 (mix up groups to include various disciplines if possible), then ask groups to consider:

What can we do to ensure the worst, least productive team and most frustrating team meetings possible?

Ask each group to use the 1-2-4-all (1 minute for reflection, 2 minutes to discuss in pairs and then 4 minutes as a foursome or larger group to discuss and share ideas.) method to come up with initial list on flip chart paper

Each group should then come up with a second list of things from the first list that actually happen or are things we do in our team.

1-2-4-all used again to generate solutions to problems/issues on second list

(Continues on next page)

EFFECTIVE TEAM MEETINGS

4) Group feedback (10 min.)

Feedback to facilitator from all teams feeding back information from all steps to emphasize and highlight where there is overlap/agreement using flip chart paper.

Ensure concrete ideas/solutions are documented:

e.g., *"We will not…", "I will stop…"*

5) Group discussion (20 min.)

Discussion points:

- Do we meet enough as a team? Why/why not?
- Do we have/need a regular meeting where we reflect on how we work as a team?
- What kind of issues/items should be discussed at meetings where we have time to reflect on how we work and how can we ensure this meeting would work for everyone on the team?
- How can we plan and structure (e.g., meeting space, time, frequency and meeting length) this meeting to ensure a productive and efficient meeting? (use solutions from team during from group activity to inform rules/structure for meeting planning; Introduce tool to evaluate meeting mention use of meeting checklist. Can this help us?)

Notes for facilitator:

- Group responses should be discussed among the whole team to reach consensus on priorities for meeting, items for discussion, how meeting should work, when it could take place, how often, etc.
- If there is disagreement on the need for such meetings, suggest a trial period or intermittent meetings (e.g., operational/reflection meetings every 2-3 months ensuring all professions on team feed in/are represented and those that cannot attend can also feed in thoughts.) May require discussion about sharing workload for meeting (assigning rotating roles of minute taker, agenda setter, meeting Chair, etc.) Efforts should be made to get commitment from team and agreement on rules, priorities for meeting, agenda, meeting processes etc.

6) Close of session (5 min.)

Give brief feedback on the session. Notes can be collected and collated by one individual to maintain record of discussion.

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HANDOUTS

EFFECTIVE TEAM MEETINGS

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OUTCOMES TEMPLATE

EFFECTIVE TEAM MEETINGS

QUESTION	TEAM RESPONSE	CAN WE IMPROVE THIS? HOW? WHAT HAS BEEN AGREED?
Do we meet enough / at all as a team? Why / why not?		
Do we have / need a regular meeting where we reflect on how we work as a team?		
What issues/items should be discussed at meetings where we have time to reflect on how we work and how can we ensure this meeting would work for everyone on the team?		
What issues/items should be discussed at meetings where we have time to reflect on how we work and how can we ensure this meeting would work for everyone on the team?		
How can we plan and structure our meeting to ensure it is productive and efficiently run?		

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MEETING EVALUATION CHECKLIST

EFFECTIVE TEAM MEETINGS

1. The meeting was well planned

- ☐ Members were notified in advance
- ☐ There was a pre-arranged agenda
- ☐ Officers and committees were ready to report
- ☐ The meeting room was pre-arranged

2. The meeting was well organized

- ☐ The meeting started on time
- ☐ Guests were introduced and welcomed
- ☐ Agendas were available for all members
- ☐ The purposes for the meeting were made clear
- ☐ There was a transition from the last meeting
- ☐ One topic was discussed at a time
- ☐ One person has the floor at a time
- ☐ Discussion was relevant
- ☐ The chairperson summarized the main points of the discussion
- ☐ The meeting moved along at a workable pace
- ☐ Committee assignments were complete and clear
- ☐ Plans for the next meeting were announced
- ☐ All that was planned for the meeting was covered

3. Participation in the meeting

- ☐ Members participated in discussion and voting
- ☐ The chairperson made good use of questions
- ☐ The pros and cons of all issues were considered
- ☐ Members gave suggestions to committees
- ☐ Responsibilities were evenly distributed
- ☐ Members participated in planning the agenda for the next meeting

4. The value of the meeting

- ☐ Progress was made toward goals
- ☐ Something was learned

5. Attitude of the meeting

- ☐ Attendance was good
- ☐ Everyone present was on time
- ☐ Members knew one another
- ☐ There was a "warm up" period before the meeting
- ☐ There was some humour during the meeting
- ☐ Members and facilitators/chairs helped one another when needed
- ☐ There was an atmosphere of free expression

Adapted from the Holden Leadership Center, University of Oregon
http://leadership.uoregon.edu/resources/exercises_tips/skills/running_effective_meetings

Removing frustrations/ blockers

Co-Lead

ABOUT THIS MODULE

REMOVING FRUSTRATIONS / BLOCKERS

REMOVING FRUSTRATIONS / BLOCKERS

What is the goal of this module?

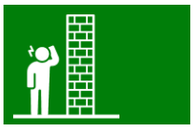
In this module, teams will develop a map of their operational processes and identify areas that could be improved, as well as the barriers and enablers of improvement. They will also decide upon how to incorporate regular check-ups on frustrations and blockers into team meetings and commit to action to resolve them.

What is the collective leadership focus of this module?

- **Engagement of all team members**
- **Recognising and valuing contribution of others**
- **Sharing leadership roles and responsibilities**

What areas of team behaviour does this module focus on?

- **Cooperation between team members**
- **Cohesion and coordination**
- **Cross-monitoring**



Who is this module for?

All team members.

What is the patient safety impact of this module?

Frustrations in our daily job can build up and lead to safety issues. They can sap our energy and make us less efficient in our work. An accumulation of frustrations can create hazardous working conditions and may over time lead to demotivation and burnout.[1] It is important to identify these frustrations early on and act to remove the ones which are within our control. Items from the list of frustrations can be assessed to see if they also need to be included on the organization's 'Hazard / Risk Registry'.

Empowering staff to identify enablers or suggest ways of improving work processes are important to maintain staff motivation and engagement. However, equally important is a process for acting on those suggestions. Building processes for dealing with frustrations and acting on enablers or suggestions for improvement should be built into existing meetings and organisational reporting structures where possible.

References

1. de Lima Garcia C, Bezerra IMP, Ramos JLS, do Valle JETMR, Bezerra de Oliveira ML, Abreu LC. Association between culture of patient safety and burnout in pediatric hospitals. PLoS One. 2019 Jun 24;14(6):e0218756.

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SESSION OUTLINE

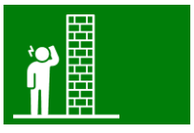
REMOVING FRUSTRATIONS / BLOCKERS

SESSION OUTLINE

REMOVING FRUSTRATIONS / BLOCKERS

SESSION OVERVIEW

Purpose:	To remove anything that frustrates people in their daily role or blocks them from performing their tasks efficiently. Developing a process for acting on frustrations and implementing suggestions for improvement.
Timing:	60 min.
Setup:	Introduction > Group exercise > Facilitated discussion > Action planning > Feedback
Outcomes:	Process map of operational processes (e.g. patient pathways) that could be improved and a list of barriers / enablers to that process. Decision on how to incorporate a regular check on frustrations and suggested enablers into team meetings. Team commitment to address frustrations.
Facilitators:	1-2 team members to facilitate; 1 team member to record ideas, discussion points, and outputs.



ADVANCE PREPARATION

Materials:	Printed outcomes templates for attendees and a large-format sketch of the process map (see below).
Equipment:	Flipcharts, markers, pens, paper, red / green post-it notes.
Room:	Large process map to be displayed and accessible by all.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, session materials should be shared in advance via email.
Facilitators:	Sketch out and prominently display the current operational process. A typical patient pathway through the ward / unit / department could be mapped out for the team to place their frustrations or potential enablers along this path. The names and processes for the current reporting systems in operation for the following issues need to be identified to serve as a reference point for discussion on frustrations / enablers that could be dealt with via one of these channels: • Incident / accident reporting • Hazard identification • Staff abuse or bullying • Staff rights / supports / employee assistance programmes • Health & occupational safety reporting systems for staff injury

SESSION OUTLINE

REMOVING FRUSTRATIONS / BLOCKERS

START OF SESSION

1) Welcome and introduction (5 min.)

For newcomers give a brief introduction to Co-Lead and the aim of introducing Collective Leadership to healthcare teams with the goal of improving patient safety culture. Invite people to share their first names and roles within the organisation if there are any newcomers. Give a short progress to date on status of team goals. Give the introduction and aim of this intervention piece (as set out at beginning of this document) and welcome all.

2) Frustrations and enablers exercise (15 min.)

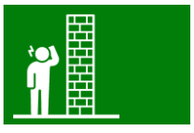
Discuss and expand the process map that was drawn and displayed. Detail who was responsible for drawing the map and state that their different perspectives may help improve or amend the map.

Give each participant a few green and a few red stickies. Invite them to note barriers/blockers/frustrations/pebbles in their shoes to the process on the red stickies – one barrier per sticky.

Invite them to note facilitators/enablers/or suggestions for what might help the process run smoothly/work well on the green stickies – one item per sticky.

Let team members know they can write as many frustrations /enablers as they wish.

Then after people have been given at least 5 minutes to write out barriers and enablers invite them to come forward and place them on the map in the place closest to the where the frustrations/enabler applies to the process.



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SESSION OUTLINE

REMOVING FRUSTRATIONS / BLOCKERS

3) Facilitated discussion on process and frustrations / enablers (20 min.)

The facilitator goes through the map and the frustrations/ enablers, and highlights some of them as examples and checks if there are any 'hot spots' / problem areas in the process map where there are a lot of red stickies and any parts of the process where there are lots of green stickies.

Secondly, the facilitator facilitates a discussion on what the team might do to remove the frustrations or implement enablers in these areas. The team should together agree on the most common or salient frustration and enabler they would like to work on. Then seek a volunteer pair to take on this issue and report back on progress to resolve or implement a solution. If there are issues which the team feel are outside of their control a discussion should take place about which existing reporting processes in the organisation can deal with these types of frustrations or enablers / suggestions for improvement.

4) Course of action (10 min.)

The team should now consider what existing team meeting or forum might be the best place to do a regular brief check on frustrations/enablers and facilitate a volunteer and report back process.

5) Close of session (5 min.)

Give brief feedback on the session. Thank everyone for attending, let people know when the next intervention session is, and what the theme of that will be.

REMOVING FRUSTRATIONS / BLOCKERS

Follow-up after the session

Building resolution of Blockers and acting on Suggestions for Improvement into team's current meeting structures:

- Any frustrations/suggestions raised during the week / month should be discussed at the next team meeting. If a simple solution can be enacted, then it should be (in Lean Six Sigma terms 'just do it').
- If more detail is needed on the problem before coming to a solution then methodologies like the Lean Six Sigma: Define, Measure, Analyse, Implement, Control (DMAIC) can be used to gather more information on the problem. Quality Improvement methods like Plan, Do, Study, Act cycles can be used to implement more complex improvements.

Escalation of frustrations/suggestions that cannot be resolved at the local level:

- If blockers/suggestions cannot be resolved at the local level then they must be escalated up the organisation to where they can be resolved.
- A process needs to be established for doing this, ideally building on existing meetings that already happen in the organisation. This is to ensure that improvement work is built into the normal day-to-day management of the organisation.
- A sample escalation process can be found on Co-Lead Website.

Feedback to all staff on the status of frustrations/suggestions:

- The team should strive to resolve all frustrations/suggestions within 30 days and communicate the solution back to the person who raised the frustration/suggestion. If at all possible, this person should be involved in the analysis and resolution of the frustration/suggestion.
- All frustrations/suggestions raised each month, all those in process or being reviewed, and all resolved blockers/suggestions, should be noted on the team noticeboard.
- A traffic light systems of displaying action items and their status could be used for this purpose.

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OUTCOMES TEMPLATE

REMOVING FRUSTRATIONS / BLOCKERS

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OUTCOMES TEMPLATE

REMOVING FRUSTRATIONS / BLOCKERS

1) PROCESS MAP

Please include steps of map or photograph of map

2) LIST OF FRUSTRATIONS AND ENABLERS AND WHERE IN THE PROCESS THEY ARISE

POINT IN THE PROCESS	BARRIERS	ENABLERS	PRIORITY (1, 2, 3 etc)

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OUTCOMES TEMPLATE

REMOVING FRUSTRATIONS / BLOCKERS

3) WAYS OF MOVING FORWARD

A decision on what existing meeting to incorporate regular review of frustrations/enablers. What is the meeting and how frequently will frustrations/enablers feature as an agenda item:

AND

List of team members who have made a commitment to take it in turn to work in pairs to resolve frustrations and implement suggestions.

Building trust

Co-Lead

ABOUT THIS MODULE

BUILDING TRUST

ABOUT THIS MODULE

BUILDING TRUST

What is the goal of this module?

This module will help teams to create an environment where people can share their concerns and trust other team members to support them in their work. They will identify the strong areas of the team and build mechanisms of mutual support. The goal is for team members to feel more supported in times of difficulty, and to foster a climate of trust to facilitate people in being open about errors or mistakes.

What is the collective leadership focus of this module?

- **Cooperation and coordination between members**
- **Engagement of all team members**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Coordination and effective team working**
- **Cooperation between team members**

Who is this module for?

All team members. Every individual can play a role in building a climate of trust within the team.

What is the patient safety impact of this module?

Mutual trust helps teams to work effectively and communicate in an open, respectful manner. This is a cornerstone of high-quality teamworking and supports the delivery of safest possible care.[1]

References

1. Weller J, Boyd M, Cumin D. Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare. Postgrad Med J. 2014 Mar;90(1061):149-54.

Co-Lead

SESSION OUTLINE

BUILDING TRUST

SESSION OUTLINE

BUILDING TRUST

SESSION OVERVIEW

Purpose:	To get to know team members better and create an environment where people can share their concerns and trust other team members to support them in their work.
Timing:	60 min.
Setup:	Information > Group exercise > Facilitated discussion > Feedback
Outcomes:	Getting to know your team members, sharing ambitions and stories. Identifying the strong and weak points of the team and building in mechanisms to support each other and feel supported in difficult times. A climate of openness and trust should facilitate people in admitting errors or mistakes
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed picture cards, one for each team member (see additional materials), list of questions written out on individual pieces of paper. One question per piece, with several copies of each question.
Room:	Configure for round table discussion or small groups for larger teams
Attendees:	If some team members cannot attend due to geographic location, teleconference facilities may be arranged. This should include sharing of the session materials by email.
Discussions:	In advance, facilitators should think about their own strengths that make them good team members and also areas where they are not so good. This will enable them to start the discussion if others are reticent. All members of the team play a role in feeding back from discussion in pairs. All members should contribute to group discussion. Engaging in this process as a team will enable individuals to understand and support each other, identifying individual strengths and how these might be combined to improve the overall functioning of the team.

SESSION OUTLINE

BUILDING TRUST

START OF SESSION

1) Introduction (1 min.)

Outline the aim and goals of the session: To use discussion and exercises to get to know team members better and create an environment where people can share their concerns and trust other team members to support them in their work. After the session, the team will have a better understanding of their combined strengths and the areas that they might develop further for better support.

2) Getting to know each other (20 min.)

Use of questions to stimulate sharing of information.

Scatter the pre-prepared questions on the table and ask each member to pick up 2 questions.

Do not share your questions with the group: Everyone should get up from the table and attempt to mingle and discreetly ask people their questions, noting down the answers as they go (without identifying the person who supplied the answer). The object of the exercise is to get as many people as possible to answer your questions, while providing your answers to other people's questions.

After 10 minutes all the questions and answers are placed in front of the facilitators on the table. The facilitators read out the answers to question 1, one at a time. The team then has to guess which team member supplied each answer. Do this in turn for all 6 questions.

List of questions:

1. If you didn't have to sleep, what would you do with the extra time?
2. What hobby would you get into if time and money weren't an issue?
3. Are you usually early or late?
4. What job would you be terrible at?
5. When was the last time you changed your opinion/belief about something major?
6. Who inspires you to be better?

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3) Team as a combination of individual strengths (30 min.)

Split the group into pairs. Ask each pair to discuss the following 2 questions?

1. What are my strengths when it comes to working in a team?
2. What areas could the team develop further?

Prepare 2 flip charts and label one Team Strengths and the other Team Development Areas. After 10 minutes ask each pair to feedback and note the strengths and Areas for Development on the flipcharts as they are doing so.

In a group ask for ideas on how the team can use its strengths to work better together. Note the ideas on a flip chart.

Then move on to the areas for development, again asking the group to contribute ideas on how these might be addressed. Try to encourage people to build on each other's ideas rather than creating lists.

Conclude the exercise by getting agreement on a priority list of three areas the team needs to work on.

4) Trusting team member instructions (10 min.)

Take the pack of picture cards. Ask each person to discretely pick one from the deck without others seeing what it is and keep it face down. Split the group in pairs, making sure that everyone partners with a new person, and get them to sit back to back in different parts of the room.

In each pair, they should take it in turns to provide instructions for the other person to draw what is on their card, giving as much detail as possible to get an accurate reproduction, but without naming the object. Each person should have no more than 3 minutes to draw. Bring the group back together and lay all cards on the table with the corresponding pictures beside them. Ask people what they have learnt from the exercise.

Debrief: There are some great artists and some great communicators but without the combined efforts of both it is difficult to replicate the picture. In healthcare it is not enough to just be great at what you do. You need to be able to communicate and accept help from others.

(Continues on next page)

5) Close of session (5 min.)

Give general feedback on the session, thank everyone for attending, and let people know when the next intervention session is and what the theme of that will be.

Note: If trust is very low in the team currently, it may be beneficial to run a second session focusing on stories of breaches of trust and how this impacts on individuals. How do you rebuild trust when it has been broken? What would it take for the person whose trust has been broken to regain that trust?

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OUTCOMES TEMPLATE

BUILDING TRUST

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OUTCOMES TEMPLATE

BUILDING TRUST

TEAM STRENGTHS	TEAM DEVELOPMENT AREAS	WHAT WE ARE WORKING ON

Co-Lead

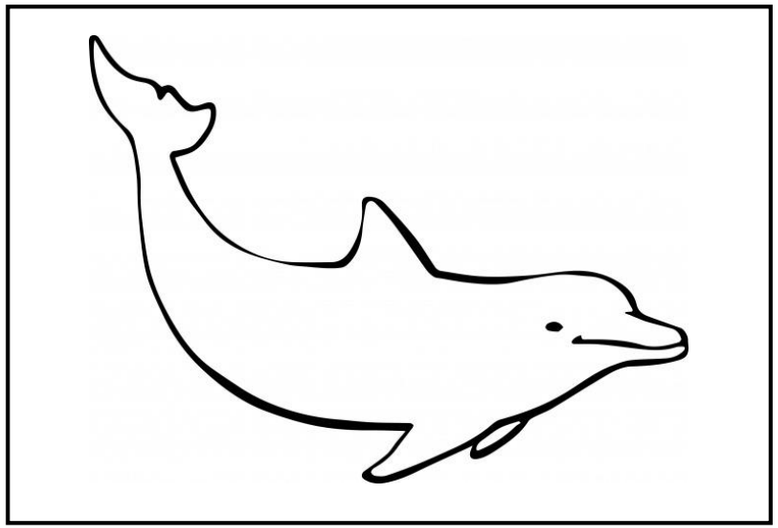
ADDITIONAL MATERIALS

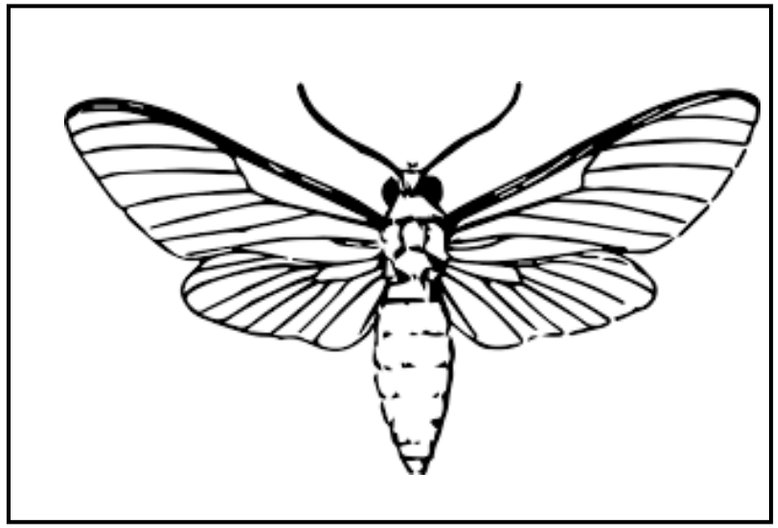
BUILDING TRUST

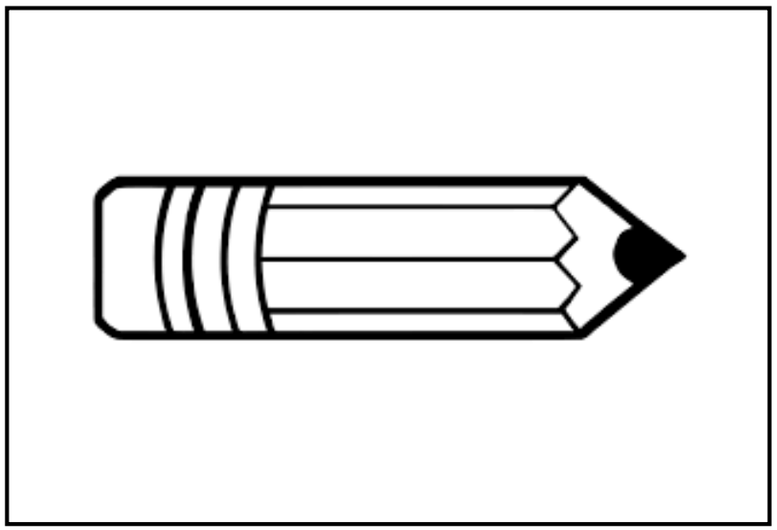
Co-Lead

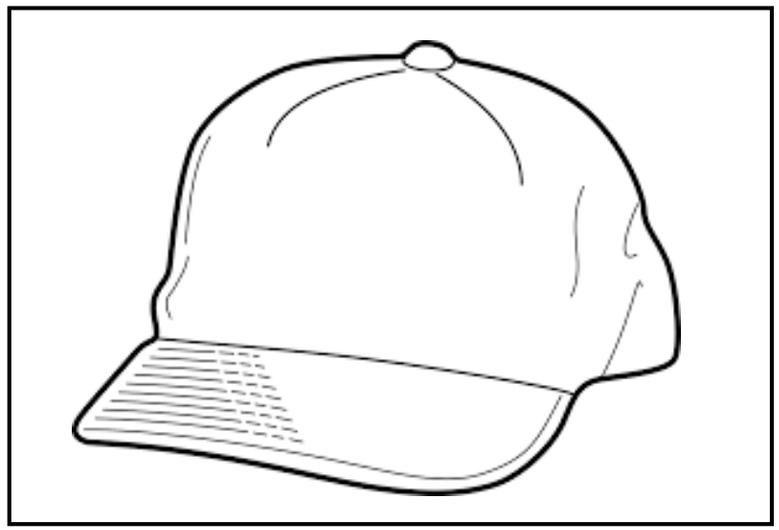
ADDITIONAL MATERIALS

BUILDING TRUST





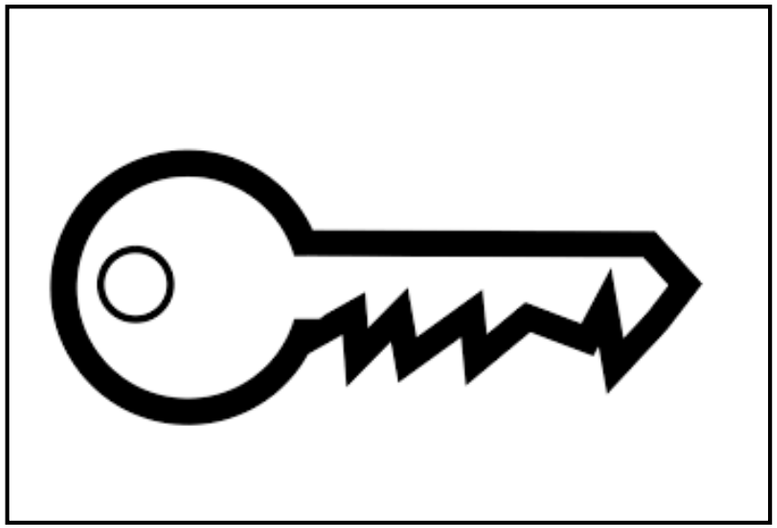


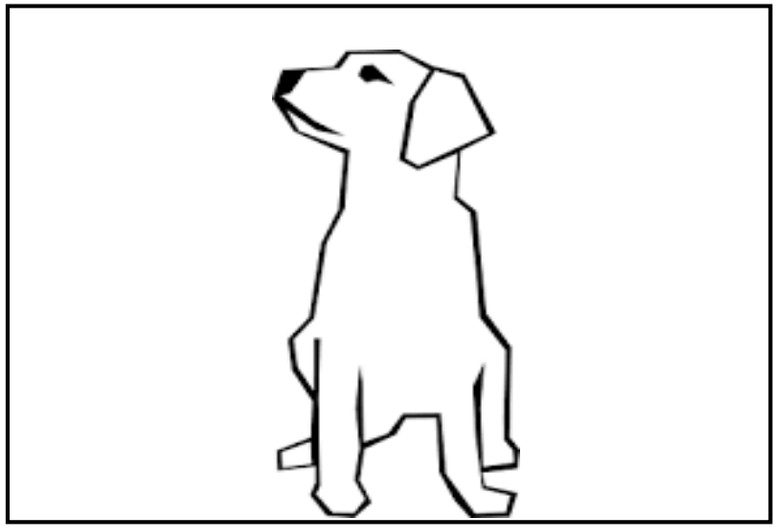


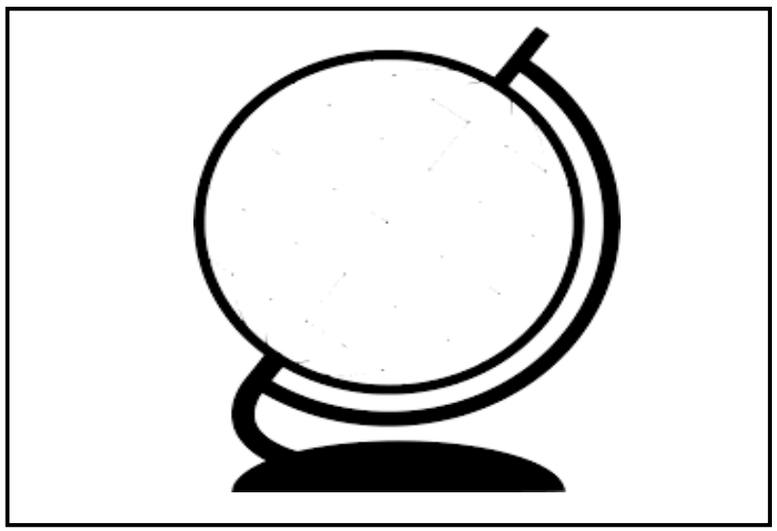
Co-Lead

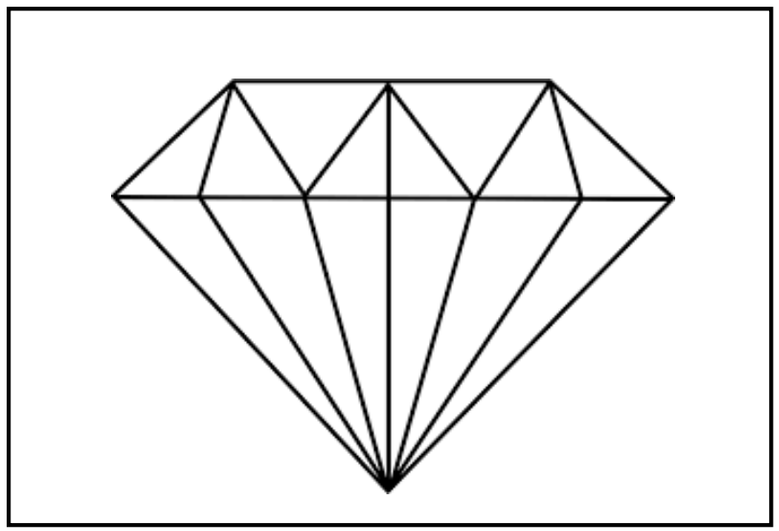
ADDITIONAL MATERIALS

BUILDING TRUST





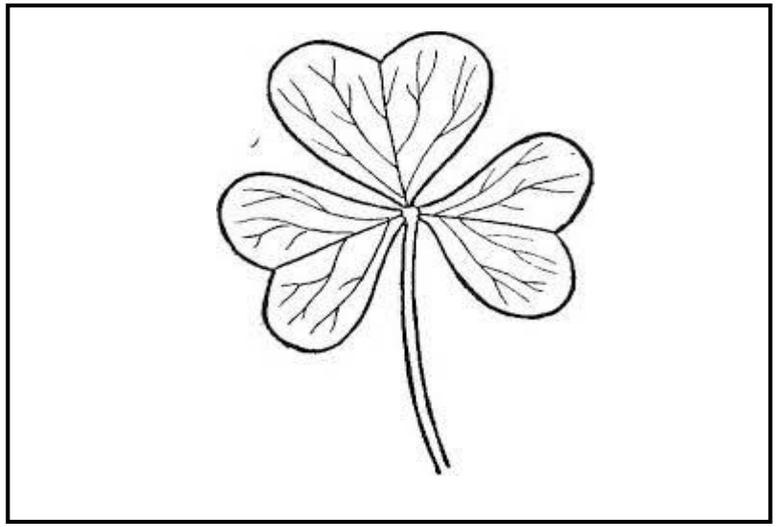


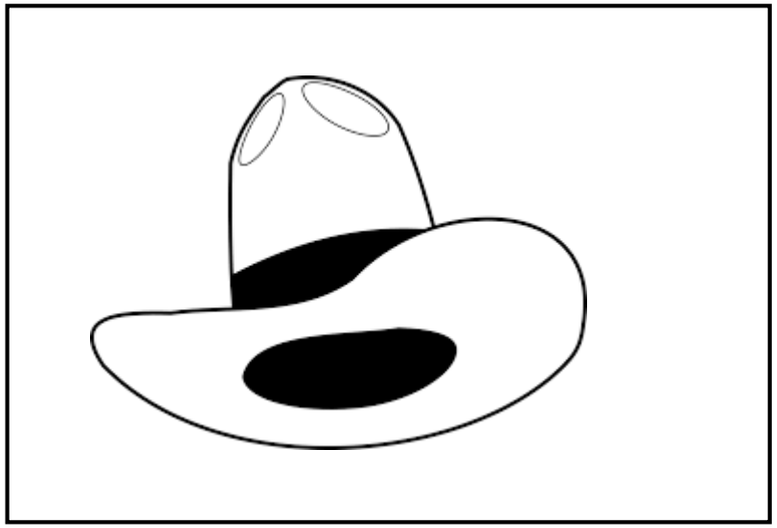


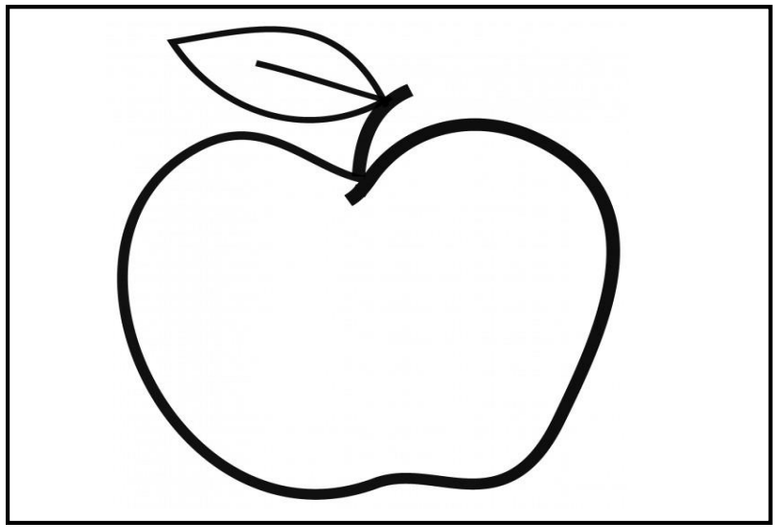
Co-Lead

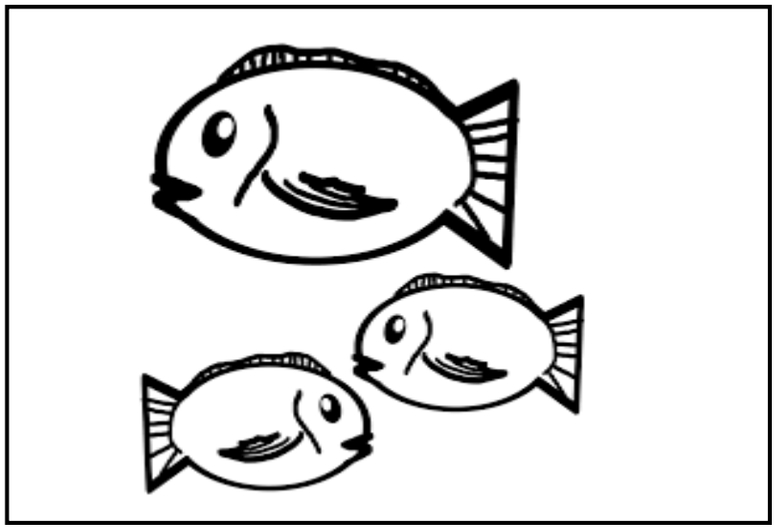
ADDITIONAL MATERIALS

BUILDING TRUST









Structured inter-disciplinary rounds

Co-Lead

ABOUT THIS MODULE

STRUCTURED INTERDISCIPLINARY ROUNDS

STRUCTURED INTERDISCIPLINARY ROUNDS

What is the goal of this module?

This session will create a space for teams to discuss the use of structured interdisciplinary rounds (SIDRs) as a tool for communication, and they will draft a plan for how to best implement structured interdisciplinary rounds in the team's work practices.

What is the collective leadership focus of this module?

- **Cooperation and coordination between members**
- **Engagement of all team members**
- **Recognising and valuing contribution of others**
- **Mix of leadership and followership: People leading on topics where they have expertise and motivation**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Coordination and effective team working**
- **Cooperation between team members**

Who is this module for?

All team members.

What is the patient safety impact of this module?

SIDRs allow for better sharing of information between members of the interdisciplinary team, and give the patient a direct point of contact with all members of the team so they can be involved in their interdisciplinary care goals and decision making. The use of SIDRs can help with communication of patient management plans, increase inputs from the whole team, and improve clarity of tasks.[1]

References

1. Cao V, Tan LD, Horn F, Bland D, Giri P, Maken K, Cho N, Scott L, Dinh VA, Hidalgo D, Nguyen HB. Patient-Centered Structured Interdisciplinary Bedside Rounds in the Medical ICU. Crit Care Med. 2018 Jan;46(1):85-92. doi:10.1097/CCM.0000000000002807.

Co-Lead

SESSION OUTLINE

STRUCTURED INTERDISCIPLINARY ROUNDS

SESSION OUTLINE

STRUCTURED INTERDISCIPLINARY ROUNDS

SESSION OVERVIEW

Purpose:	This session will create a space for teams to discuss the use of structured interdisciplinary rounds as a tool for communication.
Timing:	60 min.
Setup:	Information > Group exercise > Facilitated discussion > Feedback
Outcomes:	The participants will draft a plan for how to best implement structured interdisciplinary rounds in the team.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed discussion questions, handouts, and outcome templates.
Room:	Configure for round table discussion or small groups for larger teams
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, session materials should be shared in advance via email.

SESSION OUTLINE

STRUCTURED INTERDISCIPLINARY ROUNDS

START OF SESSION

1) Welcome and introduction (5 min.)

Introductions if new people are attending the session, recap of the aim of Co-Lead (aim to introduce Collective Leadership to healthcare teams to improve Safety Culture).

Give an update on what progress has been made / is being made on previous sessions (e.g. are any sub-teams working to implement or refine team decisions/outputs from previous sessions?)

Highlight the aim of today's session: To discuss how best to implement structured daily interdisciplinary rounds to facilitate communication between all members of the multidisciplinary team.

2) Icebreaker and discussion (10 min.)

Using the 1-2-4-all method*, have the team reflect on and discuss the following questions:

1. How do our patients benefit from good interdisciplinary work?
2. What barriers can limit good day-to-day interdisciplinary work in our team?

*One minute to reflect individually on the question; two minutes for discussion in pairs, and four minutes for feedback from small groups. If the team size permits, let every individual team member share one central point from their pair's discussion with the whole group.

3) Introduction to structured interdisciplinary rounds (SIDR) (10 min.)

Explain that the team will be trying to introduce SIDR on the ward to reap these benefits and bypass some of the barriers. SIDRs allow for better sharing of information between members of the interdisciplinary team and gives the patient a direct point of contact with all members of the team so they can be involved in their interdisciplinary care goals and decision making.

Show the team the video "Awareness test": https://www.youtube.com/watch?v=Ahg6qcgoay4

(Be careful not to scroll down and reveal the video description, as that will ruin the exercise.) Prior to showing the video, instruct the team members to follow the video's instructions, however give out "secret notes" (notes, post

(Continues on next page)

(contd.)

its or similar) to 2-3 individuals, instructing them to ignore the video's instructions completely and instead look out for what else happens. Pause the video at 23 seconds and ask the team how many passes they counted. After you hear their guesses, ask the one or two of the individuals with the "secret notes" to share what they saw (hopefully they saw a moonwalking bear!). Watch the rest of the video together until 55 seconds – "it's easy to miss something you're not looking for".

Let the team members reflect for a moment on how the exercise relates to interdisciplinary team work.

Give each team member a copy of the handout "Structured Interdisciplinary Rounds (SIDRs) - WHAT, HOW and WHY". Give them 5 minutes to read through the document.

4) Group exercise (15 min.)

Have the team split up in subgroups as appropriate, preferably interdisciplinary groups. Give each group an outcome template and have them discuss and take notes for each of the following questions:

1. How might SIDRs benefit our patient care and daily work?
2. What challenges could we experience in implementing SIDRs in our daily work?
3. When, where and how often will our SIDRs take place?
4. Who will participate in the SIDRs?
5. How will SIDRs run in our team?
6. Choice of structured communication framework (ISDA/ISBAR/other?)
7. How and when will we evaluate the SIDRs?
8. What support/materials would we need to implement the SIDRs? (e.g. pocket cards, posters outlining SIDR goals and/or the communication framework, etc.)

(Continues on next page)

SESSION OUTLINE

STRUCTURED INTERDISCIPLINARY ROUNDS

5) Facilitated discussion (20 min.)

The team will collectively discuss how the SIDRs should be implemented. The subgroups feed back their thoughts on each question, and the team collectively discusses and attempts to reach team consensus on each question.

Facilitator note: If there is team resistance to the SIDR, suggest a trial period. The team will then discuss how, when, how often, etc. the SIDR will take place, and how long the trial period should be. The team should come up with a plan for when and how the trial period is evaluated, and how the decision will be made on whether to implement the SIDR more long term. If there is insurmountable team resistance to trialing the rounds, discuss with the team how else to optimise interdisciplinary team work and -communication and / or how to improve current ward round practice.

Have a team member or co-facilitator write down the discussion points and particularly any decisions made by the team (e.g. by editing into a visible electronic document/power point slide, or by taking notes on a flipchart, whiteboard or similar).

6) Close of session (5 min.)

Please fill in the outcome template using the notes from the team's discussions and decisions for use in future team meetings and in the implementation of the SIDRs. Give brief feedback on the session.

Co-Lead

HANDOUTS

STRUCTURED INTERDISCIPLINARY ROUNDS

UCD DUBLIN Co-Lead

HANDOUT

STRUCTURED INTERDISCIPLINARY ROUNDS

SIDRs: WHAT, WHY, and HOW

WHAT?

- A daily multidisciplinary review of each patient's status and care plan.
- Attended by the patient and all members of the multidisciplinary team as appropriate.
- Typically every morning Monday-Friday.
- Consistent round times result in less waiting time for the patient and makes it easier for patient relatives to attend the rounds.
- Duration depending on the complexity of the patients – up to 3-5 minutes per patient.

WHY?

- Facilitate communication between all members of the multidisciplinary team
- Create situational awareness about the patient and their circumstances
- Enable collaborative decision making between members of the interdisciplinary teams and the patient
- Reduce patient review times (Cornell et.al 2014) facilitating information to be shared among all disciplines
- Reduce adverse events, particularly medication errors (O'Leary et.al 2011)
- Reduce readmission rates (Townsend-Gervis et.al 2014)

Goals of the SIDR

> Exchange information

> Identify patient care plans and goals

> Determine discharge needs

> Generate task-list for interdisciplinary team members

> Problem solve difficult social or discharge issues

> Allow the patient to ask questions to all members of the interdisciplinary team

Co-Lead

HANDOUT

STRUCTURED INTERDISCIPLINARY ROUNDS

HOW?

- The MDT will review and communicate with and about each patient using a structured communication framework (ISDA, ISBAR or similar)
- A facilitator might help facilitating closed loop communication and ensure the rounds are conducted within a reasonable time frame
- Resources to help facilitate the SIDRs can be made, such as facilitator reference sheet and pocket cards (see back of page).
- An Interdisciplinary Documentation Template, following the chosen communication framework, can be developed.
- Can be stationary (e.g. a meeting room) or mobile depending on the ward/team requirement.

ISDA

> **Identify** the patient's name, main diagnosis or reason for admission, anticipated discharge date and disposition

> **Summarise** the goals of care and treatment plan

> **Discuss** and interdisciplinary issues for daily cares and discharge planning

> **Ask** what was missed and what orders need to be placed

Co-Lead

HANDOUT

STRUCTURED INTERDISCIPLINARY ROUNDS

Questions for group discussion

1. How might SIDRs benefit our patient care and daily work?

2. What challenges could we experience in implementing SIDRs in our daily work?

3. When, where and how often will our SIDRs take place?

4. Who will participate in the SIDRs?

5. How will SIDRs be run in our team?
   - Choice of structured communication framework (ISDA/ISBAR/other?)
   - Facilitator role?

6. How and when will we evaluate the SIDRs?

7. What support/materials would we need to implement the SIDRs? (e.g. pocket cards, posters outlining SIDR goals and/or the communication framework, etc.)

Co-Lead

HANDOUT

STRUCTURED INTERDISCIPLINARY ROUNDS

7E/7W Interdisciplinary Rounds

VA Quality Scholars

The most valuable 15 minutes of your day

When: M-F, 11:30am-12:15pm (Blue, Red, then White Team)

Where: Interdisciplinary Care Room, 7W07

Who: Interdisciplinary care team members -- Resident Physician, Charge Nurse, Nurse Manager, Social Work, Palliative Care, Utilization Review, Respiratory Therapist, Pharmacist, Dietician, Physical Therapist, Occupational Therapist, Diabetic Nurse Educator, and anyone else involved in care coordination and discharge planning.

Why: Exchange information, identify patient daily care plan and goals, determine discharge needs, get assistance in accessing resources for patient, generate task list for interdisciplinary team members, and problem solve difficult social or discharge issues.

What is the physician role?

1. **Identify:** patient name, PCP, hospital day, main diagnosis or medical issue, anticipated discharge date and discharge disposition. (*"Mr. Smith is a 67 yo followed by Dr. Iverson in the White team admitted 2 days ago for community acquired pneumonia. We anticipate he will be able to discharge to home on Wednesday."*)
2. **Summarize:** the goals of care and treatment plan. If this is not clear to the medical team, enlist the interdisciplinary care team to help identify goals. (*"His goals of care are to return to his baseline functional status and go home."*)
3. **Discuss:** the main interdisciplinary issues in daily care and discharge planning (See over). (*"The main issue for him today is to continue IV antibiotics until stable for discharge. He is weak and needs PT evaluation to determine whether he will need outpatient physical therapy. He is on O2 now, but was not prior to admission and we do not anticipate he will need home O2.)*
4. **Ask:** what was missed and orders to place? (e.g., home health, travel needs, home O2, medical supplies) (*"What other interdisciplinary issues have I missed?"*)

How long should it take?

Discussions of daily care plan and discharge needs can take anywhere from a few seconds to 3-5 minutes per Veteran, depending on how complex the issues are. By focusing on the main interdisciplinary care issues, asking for input from team members, and being on time, you can make these minutes *the most valuable 15 minutes of your day*.

ICVA Hospitalist Service:
Hilary Mosher, MD

Common Interdisciplinary Issues

Early Hospitalization

- Physical Function
- Mental Function
- Nutrition and Swallowing
- Palliative Care/ Advanced Care Planning

Daily Care & Preparing for Discharge

- Lines and Tubes
- Medication reconciliation
- Poly-Pharmacy
- Non-Formulary Medications

Planning for On Time Departure

- Transportation (DAV, ambulance, etc)
- Placement
- Medical Supplies
- Home Infusion (e.g. antibiotics)
- Home Support (homemaker, skilled nursing)
- Home Oxygen
- Outpatient Appointments

Example of a facilitator reference sheet and pocket card for use in Structured Interdisciplinary Rounds – from VA Quality Scholars (VAQS), available at https://www.cadre.research.va.gov/forms/IDRToolkit.pdf

Patient communication boards can assist the SIDRs: The patient and family can record questions for all or any members of the MDT ahead of the SIDRs, and the team can record collaborative goals and plans on the board.

UCD DUBLIN Co-Lead

OUTCOMES TEMPLATE

STRUCTURED INTERDISCIPLINARY ROUNDS

	SUGGESTED AT THE INTERVENTION SESSION	SUBSEQUENT FOLLOW UP ON THE TEAM'S SUGGESTIONS
How might SIDRs benefit our patient care and daily work?		
What challenges could we experience in implementing SIDRs in our daily work?		
When, where and how often will the SIDRs take place?		
Who will participate in the SIDRs?		
How will SIDRs run in our team? e.g. choice of structured communication framework (ISDA / ISBAR / other?)		
How and when will we evaluate the SIDRs?		
What resources / materials would we need to implement the SIDRs? (e.g. pocket cards, facilitator reference cards)		

Challenging unsafe behaviours

Co-Lead

ABOUT THIS MODULE

CHALLENGING UNSAFE BEHAVIOURS

CHALLENGING UNSAFE BEHAVIOURS

What is the goal of this module?

This module aims to introduce team members to a new graded assertiveness method for raising safety concerns with colleagues, with the goal of adopting this method for use in their everyday work.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Cooperation and coordination between members**
- **Engagement of all team members**

What areas of team behaviour does this module focus on?

- **Coordination and effective team working**
- **Cohesion and coordination**
- **Cross-monitoring**

Who is this module for?

All team members. This module provides a standardised means of communicating about safety, which will be most effective when the entire team is familiar with its use.

What is the patient safety impact of this module?

Good communication around safety between team members is a critical step in creating and ensuring an environment of good patient safety.[1] Having a standardised tool with graded steps to communicate concerns about unsafe behaviours will aid in this process.

References

1. O'Donovan R, Ward M, De Brún A, McAuliffe E. Safety culture in health care teams: A narrative review of the literature. J Nurs Manag. 2019 Jul;27(5):871-883. doi: 10.1111/jonm.12740.

Co-Lead

SESSION OUTLINE

CHALLENGING UNSAFE BEHAVIOURS

SESSION OUTLINE

CHALLENGING UNSAFE BEHAVIOURS

SESSION OVERVIEW

Purpose:	This session will introduce team members to a technique that may be useful in situations where they have concerns about safety of a procedure or intervention being put in place.
Timing:	60 min.
Setup:	Information > Video x2 > Facilitated discussion > Feedback
Outcomes:	The team will have a graded assertiveness method for communicating safety concerns with colleagues.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed outcome template.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. Preparation for this will include sharing of the materials in advance via email.

SESSION OUTLINE

CHALLENGING UNSAFE BEHAVIOURS

START OF SESSION

1) Introduction (5 min.)

Welcome and re-cap on Co-Lead (aims, sharing of leadership across team, etc.), give introductions if new people in attendance and update team on goal progress.

Highlight the relevance of this topic to practice: Following this intervention, if any team member is concerned with a process or intervention being put in place, they will have a technique to raise concerns with colleagues, getting more assertive if their concerns are not listened to.

The aim of this session is to agree a standard method of raising concerns within the team, after which they will have a graded assertiveness method for communicating safety concerns with colleagues.

2) Icebreaker (5 min.)

Take a minute of personal reflection and ask each member of the team to outline in one word/sentence how they felt the last time they were not listened to? Facilitator then asks each member of the team to feedback their thoughts to the larger group.

3) YouTube video and discussion (15 min.)

As a team watch the YouTube video of Captain Martin Bromiley talking about his wife Elaine's death in surgery:

https://www.youtube.com/watch?v=JzlvgtPIof4 *(Watch until time 10.10)

Facilitators should ask the team to reflect on the video and share their thoughts. Emphasise how this video highlights what can happen when staff are unable to speak up.

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CHALLENGING UNSAFE BEHAVIOURS

4) Learning about the good "CUSS" words (5 min.)

Facilitators should go through the S.A.F.E. programme PowerPoint slides on a structured way to communicate about safety concerns (CUSS). Following the presentation, watch the video on how these words might be used in practice:

https://www.ahrq.gov/teamstepps/instructor/videos/ts_CUS_LandD/CUS_LandD.html

5) Facilitated discussion (25 min.)

Facilitators should lead a group discussion and gain consensus from participants on the following questions:

1. Are the "CUSS" words (concern, uncomfortable, unsafe, stop) something we can use as a team?
2. How will we ensure all team members are aware of the "CUSS" words?
3. What will happen when we use the "CUSS" words?
4. How will we encourage our team to use these "CUSS" words?

*Note one facilitator should record the team's answers using the template provided.

6) Close of session (5 min.)

Give brief feedback on the session. Notes can be collected and collated by one individual to maintain record of discussion.

Co-Lead

OUTCOMES TEMPLATE

CHALLENGING UNSAFE BEHAVIOURS

Co-Lead

OUTCOMES TEMPLATE

CHALLENGING UNSAFE BEHAVIOURS

QUESTION	AGREED BY THE TEAM
Are the "CUSS" words (concern, uncomfortable, unsafe, stop) something we can use as a team?	
How will we ensure all team members are aware of the "CUSS" words?	
What will happen when we use the "CUSS" words?	
How will we encourage our team to use these "CUSS" words?	

Communicating at safety-critical moments using ISBAR

Co-Lead

ABOUT THIS MODULE

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

What is the goal of this module?

This module will familiarise teams with ISBAR and ISBAR$_3$, which enable the communication of information at safety-critical moments in a focused and structured way.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Cooperation and coordination between members**
- **Engagement of all team members**

What areas of team behaviour does this module focus on?

- **Coordination and effective team working**
- **Cooperation between team members**
- **Cross-monitoring**

Who is this module for?

This module is for team members providing care to patients where there may be changeovers of staff or where responsibilities are transferred from one team member to another, e.g. between shifts.

What is the patient safety impact of this module?

Poor communication at safety-critical moments can undermine team performance.[1] ISBAR and ISBAR$_3$ are nationally-recommended tools[2] that provide a structure for teams to communicate important safety information at times when timely and correct information transfer is vital, such as during clinical handover.[3]

References

1. Lingard L. Productive Complications: Emergent Ideas in Team Communication and Patient Safety. 2012. Healthcare Quarterly 15 (Special Issue):18-23.doi:10.12927/hcq.2012.22846
2. National Clinical Effectiveness Committee. National Clinical Guideline No. 11: Clinical Handover in Acute and Children's Hospital Services. 2015. Department of Health.
3. Marshall S, Harrison J, Flanagan B. The teaching of a structured tool improves the clarity and content of interprofessional clinical communication. Qual Saf Health Care. 2009 Apr;18(2):137-40. doi: 10.1136/qshc.2007.025247.

Co-Lead

SESSION OUTLINE

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

SESSION OUTLINE

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

SESSION OVERVIEW

Purpose:	This session will introduce a tool to help optimise patient care by improving communication and teamwork skills at safety critical moments (e.g. patient deterioration and clinical handover).
Timing:	60 min.
Setup:	Information > Group exercise > Video > Familiarisation > Facilitated discussion > Feedback
Outcomes:	The team will be familiar with using tools that facilitate more focused communication between team members to deliver information in a structured and effective way.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed outcome template and handouts of the HSE ISBAR Communication Tool and $ISBAR_3$ (**note:** ISBAR3 is reproduced from the HSE's *Resource Manual & Facilitator Guide For Clinical Handover: An Inter-disciplinary Education Programme (2017)*)
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In this case, materials should be shared in advance via email.

SESSION OUTLINE

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

START OF SESSION

1) Introduction (5 min.)

Welcome and re-cap on Co-Lead (aims, sharing of leadership across team, etc.) and give introductions if new people in attendance, and update the team on goal progress.

Highlight the relevance of today's topic to practice: "Without effective communication, competent individuals form an incompetent team" (Lingard 2012). The ISBAR tool has been associated with improved transfer of information and overall clarity and organisation of communication (Marshall et al. 2009). ISBAR is the nationally recommended communication tool in all cases of escalation of patient care while $ISBAR_3$ is nationally recommended for conducting effective clinical handover (National Clinical Guideline No. 1 and No.11, National Clinical Effectiveness Committee, Department of Health, 2013 and 2015).

Note that the aim of this session is to provide a tool to help optimise patient care by improving communication and teamwork skills at safety critical moments (e.g. patient deterioration and clinical handover).

2) Icebreaker (5 min.)

Everyone should sit/stand in a semicircle, close enough that whispering is possible. One facilitator begins the game by whispering the phrase: A dog named Teddy ran through the spruce forest. He was chasing 3 geese that were also being followed by a skulk of red foxes. Each person whispers the phrase to their neighbour until it reaches the end. The last person says the phrase out loud for everyone to hear. Note how much the phrase changed from the beginning of the circle.

3) Group exercise (10 min.)

Ask the team to split into pairs. Ask all team members to take one minute of personal reflection to choose a patient they are caring for. With the colleague sitting next to them ask team members to take on the role of either providing handover or receiving the information. Team members should not use any handover sheets to aid the process. (*Note ask team members to anonymise the patients' names by using the pseudonyms Joe Bloggs/Jane Doe).

When the individual providing the handover is finished, they should reflect on what was difficult about giving the information and both individuals should discuss possible aspects of care missed. The pairs should then swap roles and repeat the exercise.

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COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

4) Video (5 min.)

As a team watch the following video: **Video – ISBAR patient safety**

https://www.youtube.com/watch?v=h0Ol6CiJAZw

5) Learning about ISBAR, ISBAR$_3$ and the Safety Pause (20 min.)

Distribute the handouts on ISBAR and ISBAR$_3$. First go through each of the letters of ISBAR stating what they stand for and highlight how this tool is used in all cases of escalation of patient care in conjunction with the Early Warning Score systems. Facilitators can demonstrate the use of ISBAR by working through an example for the team

Next discuss the ISBAR$_3$ tool by going through each letter again and stating its purpose (conducting effective clinical handover). This tool slightly differs from ISBAR as it emphasises a two-way process of communication with inclusion of additional components: Read-back and Risk.

Ask all team members to split into pairs again and repeat the earlier group exercise using the ISBAR$_3$ tool with the same patient handover.

6) Facilitated discussion (15 min.)

Facilitators should lead a group discussion and ask the team for feedback about their experience repeating the exercise with a more structured format (did communication improve? were there any benefits to using the tools?). Facilitators can use the additional prompts below to help generate further discussion. One facilitator should summarise the discussion using the template provided.

Some questions for the team:

- Do we use ISBAR and ISBAR$_3$ within the team? If not, should we?
- When will we incorporate its use; face-to-face, telephone, written communication?
- National Clinical Guideline No.11 suggests that teams tailor the ISBAR$_3$ to the needs of the department. Can we add to the framework to better suit our team's needs (e.g. include infection status, social circumstances, Waterlow score)?
- National Clinical Guideline No.11 encourages healthcare organisations to implement interdisciplinary clinical handover where possible? Would this be beneficial/feasible to implement within our team?
- How can we promote/improve the use of ISBAR, and ISBAR$_3$ in communicating clinical handover?

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COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

7) Close of session (5 min.)

Facilitators should give brief feedback on the session if time allows. Facilitator summary notes should be retained by one individual to maintain record of discussion.

Co-Lead

HANDOUTS

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

Co-Lead

OUTCOMES TEMPLATE

COMMUNICATING AT SAFETY-CRITICAL MOMENTS USING ISBAR

QUESTION	SUGGESTED AT THE INTERVENTION SESSION
Do we use these communication tools (ISBAR, ISBAR3,) as a team? > Should we?	
When should we use each communication tool (face-to-face, telephone, written communication)?	
Can we adapt/alter the ISBAR3 framework to suit our needs as a team?	
Is it feasible to have interdisciplinary clinical handover? > If so, how can this be structured > If not, why is this not achievable?	
How can we improve the use of ISBAR in communicating safety critical information?	

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Tús Áite do Shábháilteacht Othar
Patient Safety First

ACUTE MEDICINE

National Early Warning Score and associated Education Programme

ISBAR
Communication Tool

I **Identify**	**Identify: You, Doctor, Patient** Is this Dr. _____? This is _____ *(e.g Mary, I am team leader on 7A)* I am calling about _____ *(e.g Mr David Jones)*
S **Situation**	**Situation: Why are you calling?** I am calling because _____ *(e.g Total EWS of 6 or 3 in a single parameter)* Resp Rate _____ Sats _____ O_2 Delivery _____ Temp _____ Heart Rate _____ BP _____ Urinary Output _____ LOC _____ *(only use abnormal reading initially)*
B **Background**	**Background: What is relevant background?** They are _____ years old Admitted for _____ Recent surgery or procedures _____ Relevant past medical/surgical history _____ They currently have _____ *(e.g. IV fluids, Urinary Catheter, PCA)*
A **Assessment**	**Assessment: What do you think is the problem?** I think _____ *(e.g they are hypovolaemic)* *(you can skip this if they don't know what is wrong)*
R **Recommendation**	**Recommendation: What do you want them to do?** I would like you to _____ *(e.g come and review him please)* Is there anything you would like me to do before you get here?

Appendix 6 ISBAR$_3$ Template (Inter-departmental Handover)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NATIONAL CLINICAL EFFECTIVENESS COMMITTEE

ISBAR$_3$ Communication (clinical handover) Tool SAMPLE Inter-departmental Handover	
I Identify	**Identify:** You Recipient of handover information Patient
S Situation	**Situation:** Location of patient as appropriate Brief summary of patient's current status Is there a problem?
B Background	**Background:** Concise summary of reason for interdepartmental handover Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S_pO_2, (F_iO_2), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)
A Assessment	**Assessment:** What is your clinical assessment of the patient at present?
R_3 Recommendation Read-Back Risk	**Recommendation:** Specify your recommendations Read-Back: Recipient(s) to confirm handover information and responsibility Risk: Include the safety pause to identify possible risks

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Appendix 7 ISBAR$_3$ Template (Shift Clinical Handover)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NATIONAL CLINICAL EFFECTIVENESS COMMITTEE

ISBAR$_3$ Communication (clinical handover) Tool SAMPLE Shift Handover	
I Identify	**Identify:** Lead handover person Individuals/Team receiving handover Patient(s)
S Situation	**Situation:** Location of patient(s) Brief summary of current status Is there a problem?
B Background	**Background:** Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S_pO_2, (F_iO_2), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)
A Assessment	**Assessment:** What is your clinical assessment of the patient at present?
R_3 Recommendation Read-Back Risk	**Recommendation:** Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Talking about safety: PlayDecide Patient Safety

Co-Lead

ABOUT THIS MODULE

TALKING ABOUT SAFETY USING PLAYDECIDE: PATIENT SAFETY

TALKING ABOUT PATIENT SAFETY - PLAYDECIDE: PATIENT SAFETY

What is the goal of this module?

This module will give participants a broader understanding of barriers and enablers of error reporting, by discussing complex scenarios based on real-world patient safety events and sharing their own lived experiences. After taking part in the session, team members will have a strengthened awareness of the importance of error reporting, and they will have built a shared consensus position on the responsibility of team members to report errors.

What is the collective leadership focus of this module?

- **Cooperation and coordination between members**
- **Engagement of all team members**
- **Recognising and valuing contribution of others**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Cohesion and coordination**
- **Cross-monitoring**

Who is this module for?

All team members. Patient safety and good error reporting can be supported by improving understanding among the whole team.

What is the patient safety impact of this module?

Error reporting and speaking up about safety are important components of medical professionalism and patient safety culture.[1] However, there are numerous challenges to good error reporting practice, such as fear of retribution, thinking that someone else is dealing with the problem, and a belief that reporting problems would be futile.[2] By encouraging discussion and building consensus around the benefits of error reporting, teams and institutions can improve patient safety culture.

References

1. Health Information and Quality Authority. National Standards for Safer Better Healthcare. Dublin: Health Information and Quality Authority, 2012.
2. Rafter N, Hickey A, Conroy RM, et al. The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals-a retrospective record review study. BMJ Qual Saf 2017;26:111–9.doi:10.1136/bmjqs-2015-004828

Co-Lead

SESSION OUTLINE

TALKING ABOUT SAFETY USING PLAYDECIDE: PATIENT SAFETY

TALKING ABOUT PATIENT SAFETY - PLAYDECIDE: PATIENT SAFETY

SESSION OVERVIEW

Purpose:	This session will introduce a tool to help teams discuss patient safety issues using case studies and guided discussion.
Timing:	60 min.
Setup:	Information > Video > Group exercise
Outcomes:	The team will gain greater awareness of the ways in which all staff can help ensure patient safety, and agree on a consensus position around error reporting to strengthen daily practice.
Facilitators:	1 facilitator is required for each group of 4 – 8 participants.

ADVANCE PREPARATION

Equipment:	Pens, Computer with online access and screen to show the PlayDecide: Patient Safety informational video.
Materials:	Printed copies of the PlayDecide: Patient Safety Game (1 set per 4 – 8 participants). This must be downloaded beforehand from **www.patientsafetydiscussions.ie** and then printed in colour if possible.
Room:	Configure for round table discussion in groups of 4 – 8 participants. Place one set of the PlayDecide: Patient Safety Game at each table, making sure that there are enough placemats and position statement voting sheets for all the participants.
Facilitators:	Before conducting the session, facilitators should read through the PlayDecide: Patient Safety game instructions, or conduct a trial session. This will help them become familiarised with the game flow and allow them to conduct the session with good timing.
Attendees:	Attendance should be in-person to facilitate rapid but deep discussions.

SESSION OUTLINE

TALKING ABOUT PATIENT SAFETY - PLAYDECIDE: PATIENT SAFETY

START OF SESSION

1) Introduction (5 min.)

Welcome and introductions if new members are attending.

Introduce the aim of the session: To engage in discussion about the importance of speaking up about safety and having a collective vision of how reporting of patient safety errors should be done. Note the background of the PlayDecide: Patient Safety game, which was developed out of a research project aimed at teaching junior doctors the importance of speaking up and reporting safety concerns. It contains real-world scenarios and was co-developed in close partnership with clinicians and patients.

2) Video (5 min.)

Show participants the introductory video at the PlayDecide: Patient Safety website, **www.patientsafetydiscussions.ie**

This will help familiarise them with the concepts of the game, and the basic flow of the session.

3) PlayDecide: Patient Safety game (50 min.)

Note to facilitators: It is important to ensure that the game is completed within the session time, therefore facilitators may need to prompt the participants to move on to the next phase of the game at the right time.

Give the participants a few minutes to read the game instructions which are included in the PlayDecide: Patient Safety game kit, then guide them through the PlayDecide: Patient Safety game session phases of **Information gathering > Discussion > Group response formulation.**

3) Close of session (5 min.)

Ask participants or groups to briefly feed back any observations made, what policy positions they agreed on, and whether there were any disagreements, and how they were resolved. Note any differences or similarities among groups' position statements. Restate the aim of the session: to engage team members in discussion around patient safety and error reporting. Encourage team members to try using the PlayDecide: Patient Safety game with other teams that they might be a part of, and to visit the website www.patientsafetydiscussions.ie and share it with other colleagues or teams that may be interested in using it.

Safety pause huddle

Co-Lead

ABOUT THIS MODULE

SAFETY PAUSE HUDDLE

SAFETY PAUSE HUDDLE

What is the goal of this module?

This module will familiarise team members with the safety pause, which aims to improve safety following clinical handovers, with the goal of adopting it for use in everyday practice.

What is the collective leadership focus of this module?

- **Cooperation and coordination between members**
- **Engagement of all team members**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Coordination and effective team working**
- **Cross-monitoring**

Who is this module for?

This module is suitable for all team members whose everyday practice involves clinical handovers.

What is the patient safety impact of this module?

The Safety Pause is a nationally-recommended tool to improve clinical handover that provides space for staff to highlight any current safety issues.[1] This allows them to be proactive in addressing any safety challenges that might occur in everyday practice.

References

1. National Clinical Effectiveness Committee, National Clinical Guideline No. 11: Clinical Handover in Acute and Children's Hospital Services. 2015. Department of Health.

UCD DUBLIN Co-Lead

SESSION OUTLINE

SAFETY PAUSE HUDDLE

SESSION OUTLINE

SAFETY PAUSE HUDDLE

SESSION OVERVIEW

Purpose:	To familiarize team members with the Safety Pause - a nationally recommended tool to improve clinical handover.
Timing:	60 min.
Setup:	Information > Group exercise > Group Feedback > Feedback
Outcomes:	The team will decide on important safety issues to include, how they will use the Safety Pause in everyday practice, and allocate individuals to be responsible for implementing the Safety Pause.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed copies of the safety pause tool and outcomes template.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, session materials should be shared in advance via email.

SESSION OUTLINE

SAFETY PAUSE HUDDLE

START OF SESSION

1) Introduction (5 min.)

Welcome and re-cap on Co-Lead (aims, sharing of leadership across team, etc.), giving introductions if new people in attendance, and update the team on goal progress.

Highlight the relevance of today's topic - the Safety Pause is a nationally recommended tool to improve clinical handover. It provides an opportunity for staff to pause and highlight safety issues which may assist them in being proactive about the challenges they face in providing safe high-quality care for patients (National Clinical Effectiveness Committee, Department of Health, 2013). By using the Safety Pause tool during a multidisciplinary huddle it can enhance open communication among team members highlighting the current situation on the ward.

Note the aim of the session - by using a more structured approach to identify safety concerns the team can proactively anticipate any risks to the quality of patient care, and prioritise and plan actions based on patient need and available resources.

The team will decide how they will use the safety pause huddle in everyday practice.

2) Icebreaker (5 min.)

Facilitators should ask each team member to come up with one word to describe communication on the team. Go around the room and let each person say their one word.

Note: The same word cannot be used twice.

3) Learning about the safety pause (10 min.)

Distribute the handout on the Safety Pause.

Facilitators should discuss how the Safety Pause is associated with the Risk element of $ISBAR_3$ (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk). If the team requires further information, see the COMMUNICATING AT SAFETY-CRITICAL MOMENTS module. Discuss with the team how this tool provides staff with a method of highlighting safety issues by asking the question; "what patient safety issues do we need to be aware of today?" Outline the four "P"s that staff should be aware of (patients, professionals, processes, patterns).

(Continues on next page)

SAFETY PAUSE HUDDLE

4) Group exercise (10 min.)

Ask team members to take a minute of personal reflection and using the 4 "P"s outlined above, compile a list of patient safety issues that they have to be aware of day to day (e.g. 2 patients with similar names in the same room, shortage of staff/ agency staff on duty).

Following personal reflection, if possible, create sub-groups that are multi-disciplinary. Ask team members to compare their lists of safety related concerns.

5) Group feedback (25 min.)

Facilitators should lead a group discussion and ask each subgroup to feedback what they have discussed (any similarities/differences acknowledged?).

Facilitators should use the additional prompts below to help generate further discussion about the Safety Pause and the development of a multidisciplinary Safety Pause Huddle:

- Is the Safety Pause tool something we can use as a team?
- Who will be involved in and who will be responsible for the Safety Pause huddle?
- When and where will the Safety Pause huddle take place?
- How will we ensure all team members are aware of the Safety Pause huddle?
- How can we evaluate the Safety Pause huddle?

Note: One facilitator should record the team's answers using the template provided.

6) Close of session (5 min.)

Give brief feedback on the session. Notes can be collected and collated by one individual to maintain record of discussion.

Co-Lead

HANDOUTS

SAFETY PAUSE HUDDLE

Co-Lead

OUTCOMES TEMPLATE

SAFETY PAUSE HUDDLE

QUESTION	AGREED BY THE TEAM
What patient safety issues do we need to be aware of day-to-day?	
Is the Safety Pause tool something we can use as a team?	
Who will be involved in and who will be responsible for the Safety Pause huddle?	
When and where will the Safety Pause huddle take place?	
How will we ensure all team members are aware of the Safety Pause huddle?	
How can we evaluate the Safety Pause huddle?	

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality and Patient Safety Directorate

We are all responsible…and together
we are creating a safer healthcare system

An Roinn Sláinte
DEPARTMENT OF HEALTH

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

Why	Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.
Who	Team lead and available multidisciplinary team members.
When	Any time (aim for a maximum of five minutes).
How	Focus on things everyone needs to know to maintain safety. Based on one question *'what patient safety issues do we need to be aware of today'* - resulting in immediate actions. The four P's below provide examples to prompt the discussion (any prolonged discussion on specific issues can be deferred until after the safety pause).

THE SAFETY PAUSE

QUESTION:

WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY?

Examples

- **Patients:** are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients?
- **Professionals:** are there agency, locum or new staff who may not be familiar with environment/procedures?
- **Processes:** do we have: new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections?
- **Patterns:** are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

Heads-up for today

- Challenges e.g. illness related leave, staffing levels, skill mix, demand surges.
- Meetings/training sessions staff need to attend e.g. mandatory training.
- New initiatives/information e.g. new protocols; feedback from external groups.
- Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/ patient status at a glance (PSAG) board/ other communication system etc.

Patient Feedback

- Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today?

Follow-ups	Issues raised previously (confirm included on existing risk register if appropriate), solutions introduced or being developed. For those involved in the 'productive ward' initiative this is an opportunity to review the 'safety cross' data and any improvements.
Team morale	Recent achievements, compliments from patients and what works well.

Acknowledgements:
The HSE Clinical Governance Development initiative wishes to thank the National Emergency Medicine Programme for assisting in the development of this information sheet. It has been adapted with permission from Clinical Microsystems "The Place Where Patients, Families and Clinical Teams Meet Assessing, Diagnosing and Treating Your Emergency Department" ©2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden and the IHI Safety Briefing tool Copyright © 2004 Institute for Healthcare Improvement.

An initiative of the Quality and Patient Safety Directorate, May 2013

For further informaton see www.hse.ie/go/clinicalgovernance

Tús Áite do Shábháilteacht Othar
Patient Safety First

High reliability at team level

Co-Lead

ABOUT THIS MODULE

HIGH RELIABILITY AT TEAM LEVEL

HIGH RELIABILITY AT TEAM LEVEL

What is the goal of this module?

In this session, participants will discuss what they can to do as a team to achieve higher collective safety awareness, and become a high reliability team. The goal is to create an agreed set of actions to help the team achieve high reliability, and assign persons responsible and dates for follow-up.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Cooperation and coordination between members**
- **Engagement of all team members**
- **Mix of leadership and followership: People leading on topics where they have expertise and motivation**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Cohesion and coordination**
- **Cross-monitoring**

Who is this module for?

All team members.

What is the patient safety impact of this module?

A reliable and supportive team is necessary for staff to perform at their best in their everyday work – particularly in healthcare where the day to day working environment is dynamic and complex.[1] High-reliability teams aim to navigate such environments successfully to deliver at a high capacity whilst simultaneously minimising errors.[2]

References

1. Sutcliffe KM. High reliability organizations (HROs). Best Pract Res Clin Anaesthesiol. 2011 Jun;25(2):133-44. doi: 10.1016/j.bpa.2011.03.001.
2. The Health Foundation. Evidence scan: High-reliability organisations. 2011. The Health Foundation, London, UK.

Co-Lead

SESSION OUTLINE

HIGH RELIABILITY AT TEAM LEVEL

SESSION OUTLINE

HIGH RELIABILITY AT TEAM LEVEL

SESSION OVERVIEW

Purpose:	The aim of the session is for participants to discuss what they can to do as a team to achieve higher collective safety awareness, and become a high reliability team.
Timing:	60 min.
Setup:	Introduction > Learning > Group discussion > Team discussion > Feedback
Outcomes:	An agreed set of actions to help the team achieve high reliability using a predetermined set of criteria, along with persons responsible and dates for follow-up.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed handouts and outcomes template.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, session materials should be shared in advance via email.

SESSION OUTLINE

HIGH RELIABILITY AT TEAM LEVEL

START OF SESSION

1) Introduction (5 min.)

Introductions if new people are attending the session, followed by recap of the aim of Co-Lead (aim to introduce Collective Leadership to healthcare teams to improve Safety Culture) and update on what progress has been made/is being made on previous sessions (e.g. are sub-teams team working to implement or refine team decisions/outputs from previous sessions?)

Facilitators will outline the aim of today's session: for participants to discuss what they can to do as a team to achieve higher collective safety awareness and become a high reliability team. Include a brief definition of high reliability: "the ability to deliver consistent quality care and reduce errors despite a complex and changing work environment."

2) Icebreaker (5 min.)

Let the team members reflect individually for one minute on the following question: "What factors (at individual, team, and organisational level) are most important for me to perform my best at work?"

Go around the room and have each team member share (in one no more than a sentence) just one thing at either individual, team or organisational level that is important for them to perform their best at work.

3. Introduction to high reliability/collective safety awareness (10 min.)

Introduce the team to the terms "high reliability" and "collective safety awareness", using the session slides and notes. The slides contain a 5-minute reflection/discussion task. For this task, have everyone reflect quietly on the question for 2 minutes, and then share/discuss their thoughts in pairs or small groups for 3 minutes

(Continues on next page)

HIGH RELIABILITY AT TEAM LEVEL

4. Group discussion (10 min.)

Split the team into five groups. Assign each group one of the five key processes required for achieving high reliability and give them their respective handout to read.

- **Preoccupation with failure**
- **Reluctance to simplify interpretations**
- **Sensitivity to operations**
- **Commitment to resilience**
- **Deference to expertise**

(There must be at least two people in each group – if not, reduce number of groups and give some groups two processes to discuss)

Each group should read the handout about their specific process and discuss the following questions:

- What do we do well as a team in relation to this process?
- What can we improve on in relation to this process?

Suggest that the groups take notes, as they will need to explain their process and feed back their key discussion points to the whole group.

5. Team discussion (30 min.)

Each subgroup explains their process (what it is/how to achieve it) to the whole team and feeds back their main discussion points.

The whole team discusses the following questions: **How do we improve in relation to this process? What actions can we take? Who will be responsible?**

Facilitators should ensure strict time keeping (~5 minutes for each process) to allow the team to get around all of the key processes

If any time is left, try to rank the five key processes 1-5, starting with the one the team needs to focus on/work on the most. See if the team can reach a consensus on which processes to prioritise.

6. Close of session (5 min.)

Give brief feedback on the session. Keep record of the notes from the team discussion for future use by the team.

Co-Lead

FACILITATOR NOTES FOR PRESENTATION

HIGH RELIABILITY AT TEAM LEVEL

HIGH RELIABILITY AT TEAM LEVEL

1) Title slide
2) A general definition of high reliability is "The unusual capacity to produce collective outcomes of a certain minimum quality repeatedly". In relation to healthcare this could be interpreted as "the ability to deliver consistent quality care and reduce errors despite a complex and changing work environment". At an organisational level this can be achieved through highly standardised routines to minimise fluctuations in team performance.
3) A team's collective safety awareness is essential to achieve high reliability, as it provides a collective focus on optimising safety. Collective safety awareness can be defined as "a shared team focus on achieving high safety through an on-going effort to update and optimise routines, procedures and actions based on experience and anticipation". A safety aware team is willing to scrutinise perceptions and expectations to make sense of and learn from new events.
4) The 'high reliability organization' (HRO) paradigm was developed by a group of researchers at the University of California, Berkeley, based on observations of teams in aviation, nuclear energy and aerospace. These settings are the default reference when describing the processes found in the most effective HROs. The HROs strive to deliver at maximum capacity and operate in a nearly error-free fashion. Serious errors in these three reference settings are very rare (but often catastrophic when they do happen – e.g. Tenerife Airport Disaster 1977, 583 fatalities – a runway collision caused by pilot error, communication errors and other factors).
5) Give team members a brief moment to consider the numbers for each question (number of aviation fatalities in 2017 and annual number of patient deaths in US related to preventable harm) before continuing with the slides and revealing the numbers.
6) Sutcliffe (2011) identified similarities between the settings in which the most effective HROs are found, and applied the HRO principles to anaesthesia – which shares some of the same characteristics:
    - It's a potential high risk environment
    - It works in an unforgiving social and political environment
    - The scale of consequences of errors precludes learning through experimentation
    - and the work involves complex processes and procedures
7) Reflection and discussion exercise (see slides/session outline
    - Team members should reflect individually on the question presented for 2 minutes, followed by 3 minutes of discussion in pairs or small groups)

(Continues on next page)

HIGH RELIABILITY AT TEAM LEVEL

6) Sutcliffe (2011) identified similarities between the settings in which the most effective HROs are found, and applied the HRO principles to anaesthesia – which shares some of the same characteristics:

- It's a potential high risk environment
- It works in an unforgiving social and political environment
- The scale of consequences of errors precludes learning through experimentation
- and the work involves complex processes and procedures

7) Reflection and discussion exercise (see slides/session outline

- Team members should reflect individually on the question presented for 2 minutes, followed by 3 minutes of discussion in pairs or small groups)

8) High reliability organisations share some common characteristics.

- They strive to do zero-harm and operate entirely error free.
- There are systems and routines in place to minimise the risk and/or consequences of inevitable human error.
- Authority patterns are based on functional skill and expertise, rather than formal hierarchical rank – especially in times of high-tempo. In emergencies, the authority patterns are based on pre-determined, pre-programmed allocation of duties, which requires simulation and practise.
- And they encourage the reporting of errors, as well as the discussion of near-misses and potential errors, as these provide insight into potential system weaknesses. Any error reported is discussed in order to learn as much as possible to avoid future more serious errors. This requires an environment with a no-blame culture where staff feel safe reporting or bringing attention to any and all incidents.

9) Five key processes have been identified that underlie high collective safety awareness and high reliability in teams. These are:

- Preoccupation with failure, which means that all team members are consistently aware of, thinking about, and preparing for the potential for failure
- Reluctance to simplify interpretations, which means that team members avoid simplifying their understanding of how and why things succeed or fail in their environment, but seek to discover the underlying mechanisms and challenge assumptions.
- Sensitivity to operations, which essentially means "situational awareness" – awareness of context and how that may impact on safety.
- Commitment to resilience, which means coping with, containing, and bouncing back from mistakes.
- And deference to local and situational expertise rather than formal rank, especially in high-tempo or emergency situations.

10-11) Group and team discussion – see session outline

Co-Lead

HANDOUTS

HIGH RELIABILITY AT TEAM LEVEL

Co-Lead

HANDOUT

HIGH RELIABILITY AT TEAM LEVEL

1: PREOCCUPATION WITH FAILURE

What it is:

Everyone is constantly aware of and preparing for unexpected events that may jeopardise safety by engaging in proactive analysis and discussion and after-action reviews (AARs). The absence of errors does not reduce the vigilance for any potential future errors, and every team member is alert to small signs of problems that may indicate a system weakness.

How to achieve it:

The team proactively spends time identifying and discussing activities that may go wrong, for example using safety pauses. Structures are in place to ensure that identified safety risks are communicated at important points, e.g. shift turnovers. Mistakes and near misses are seen as opportunities to learn about and improve on system weaknesses.

2: RELUCTANCE TO SIMPLIFY INTERPRETATIONS

What it is:

Team members avoid simplifying explanations of why things succeed and fail in their environment. They understand that processes are complex and seek underlying rather than surface explanations. They deliberately question assumptions to create a more complete and nuanced picture of situations.

How to achieve it:

Team members seek alternative perspectives and are encouraged to express, discuss and consider different opinions. Team members feel free to bring up problems and tough issues.

3: SENSITIVITY TO OPERATIONS

What it is:

The team engages in on-going interaction and information sharing about current human and organisational factors to create situational awareness of on-going situations – i.e. "what is going on around us, and how might that impact on safety" - so that adjustments can be made to prevent errors from accumulating.

How to achieve it:

Systems or processes are in place to ensure that team members interact often enough to build a clear picture of what is happening here and now, in order for all team members to develop an understanding of the importance of the context of their work.

4: COMMITMENT TO RESILIENCE

What it is:

The team has capabilities to cope with, contain, and bounce back from mishaps that have already occurred, before they worsen and cause more serious harm. Team members feel safe to report and discuss incidents in a no-blame environment, as errors and adverse events are considered to be system weaknesses.

How to achieve it:

The team continually report and talk about mistakes and near-misses, their prevention, and what can be learned from them. The team consistently work to conduct quick assessments of and responses to challenging situations.

5: DEFERENCE TO EXPERTISE

What it is:

During high-tempo times (i.e., when attempting to resolve a problem or crisis), decision-making migrates to the person or people with the most expertise with the problem at hand, regardless of authority or rank.

How to achieve it:

The team members are aware of each other's roles, unique skills and knowledge. When problems arise, they take advantage of the unique skills of their colleagues. When a patient crisis occurs, people rapidly pool their collective expertise to attempt to resolve it.

Co-Lead

OUTCOMES TEMPLATE

HIGH RELIABILITY AT TEAM LEVEL

KEY PROCESS	AGREED ACTIONS TO DEVELOP THIS PROCESS IN OUR TEAM	RESPONSIBLE PERSON	DATE TO REVIEW PROGRESS	PRIORITY (1-5)
PREOCCUPATION WITH FAILURE				
RELUCTANCE TO SIMPLIFY INTERPRETATIONS				
SENSITIVITY TO OPERATIONS				
COMMITMENT TO RESILIENCE				
DEFERENCE TO EXPERTISE				

Developing a positive work environment

Co-Lead

ABOUT THIS MODULE

DEVELOPING A POSITIVE WORK ENVIRONMENT

ABOUT THIS MODULE

DEVELOPING A POSITIVE WORK ENVIRONMENT

What is the goal of this module?

This module will enable teams to discuss possible steps to create a more positive environment where members feel more engaged and valued. The goal is to agree on three key initiatives to implement, and concrete actions to make them happen, so that team members sense of meaning and fulfilment in work can be improved.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Engagement of all team members**
- **Recognising and valuing contribution of others**

What areas of team behaviour does this module focus on?

- **Motivation towards goals**
- **Cooperation between team members**
- **Cohesion and coordination**

Who is this module for?

All team members. The creation of a positive work environment is something that every team member has the potential to contribute towards.

What is the patient safety impact of this module?

Burnout and reduced job satisfaction can arise in challenging work environments, undermining performance, safety, and teamwork[1,2] Fostering a positive work environment can improve individual staff experiences as well as having a positive impact on patient safety.

References

1. Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry. 2016;15(2):103–111. doi:10.1002/wps.20311
2. Olds DM, Aiken LH, Cimiotti JP, Lake ET. Association of nurse work environment and safety climate on patient mortality: A cross-sectional study. Int J Nurs Stud. 2017;74:155–161. doi:10.1016/j.ijnurstu.2017.06.004

Co-Lead

SESSION OUTLINE

DEVELOPING A POSITIVE WORK ENVIRONMENT

SESSION OUTLINE

DEVELOPING A POSITIVE WORK ENVIRONMENT

SESSION OVERVIEW

Purpose:	The aim of the session is for the team to discuss what the team can do to create a more positive work environment where team members feel engaged and valued in order to increase job satisfaction and reduce burnout.
Timing:	60 min.
Setup:	Introduction > Group discussion > Group exercise > Feedback
Outcomes:	At the end of the session the team will have generated three key initiatives to increase joy and meaning in the team, along with concrete actions to make them happen.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed cases handout and outcomes template.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In this case the session materials should be shared in advance via email.

SESSION OUTLINE

DEVELOPING A POSITIVE WORK ENVIRONMENT

START OF SESSION

1) Introduction (5 min.)

Introductions if new people attend, and brief explanation of Co-Lead (aim – to introduce Collective Leadership to healthcare teams to improve Safety Culture) and 'ground rules' – use first names, value all voices, encourage all to bring skills and talents to the table etc.

Give an update on what the project has achieved so far and what progress is being made.

Highlight the aim of today's session – to discuss what the team can do to create a more positive work environment where team members feel engaged and valued in order to increase job satisfaction and reduce burnout.

2) Icebreaker and discussion (15 min.)

For this discussion exercise, facilitator should draw a line numbered 0-10 on a large piece of paper, whiteboard, blackboard or similar. Present the "work environment rating scale" to the team. 10 means that the work environment is extremely positive and could not possibly be any better. 0 means that the work environment is extremely negative and could not possibly be any worse.

Read out the two cases in the document "A Positive Work Environment CASES" and give team members a moment to consider where they would place these two cases on the rating scale.

Hand out post-its or pieces of paper to the team members. Ask each team member to anonymously rate the work environment in their own team (the team gathered) by writing down a number from 0-10. Nobody is required to share their number with others, but the facilitator can collect all post its to get an indication of the work environment in the team. (The exercise can also involve team members mentally rating the work environment if appropriate or if no paper is available).

Ask the team to split into small groups (2-4 people) to discuss the following questions:

- *Why did you not rate the work environment in the team any lower than you did?*
- *What currently prevents you from rating the work environment 0?*

This question will help participants to identify what the team is already

(Continues on next page)

(contd.)

doing well in relation to ensuring a positive work environment. Allow a couple of minutes for the small group discussion, then have the small groups feed back to the whole team all their reasons for not rating any lower. A team member or co-facilitator should take notes on a whiteboard, into a power point or similar. All reasons mentioned should be noted. Notes should be visible to all, as the team will need them later in the session.

Ask the team to split into small groups again. This time have the team discuss the following questions:

- *What would have made you rate the work environment in the team higher than you did?*
- *What would it take for you to rate it 10?*

This will similarly help the team identify where there is room for improvement. Once again allow a couple of minutes for the small group discussion, then have the groups feed back all their reasons to the whole team. Once again all reasons should be noted down by a team member or co-facilitator.

Explain to the team that this exercise is meant to help them identify initiatives to create a more positive work environment, and that they will return to the exercise later in the session.

3) Group talk about burnout (5 min.)

Burnout is a serious occupational hazard for people working in healthcare jobs. Briefly share with the team the definition and key dimensions of burnout:

"Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment." (Maslach and Leiter, 2016)

Allow each team member to reflect individually on burnout, focusing on how burnout affects people and their work, and how to identify signs of burnout in themselves or their colleagues. Let people share their thoughts in pairs or groups of three for a couple of minutes.

Explain to the group that some elements of a positive work environment, such as perceived strong support from co-workers and supervisors, can act as a protective factor against burnout.

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DEVELOPING A POSITIVE WORK ENVIRONMENT

4) Group exercise (10 min.)

The notes from the initial discussion exercise should be visible to the team during this exercise, as they represent both what the team currently does well and what the team could do better.

Have the team split into smaller groups once more (4-6 people in each group). With the previously generated notes in mind, each group should come up with one or two initiatives that they believe would help generating a more positive work environment within the team.

The groups should bear in mind that this could be both new initiatives, strengthening of initiatives that are already happening, or getting rid of things that are currently negatively impacting the work environment. The initiatives need to be within the team's own influence – not at an overall organisational or political level (e.g. the organisation's sick leave policy, or a 30-hour work week).

5) Team discussion (20 min.)

Have each group feed back their initiatives to the whole team. Discuss the suggestions as a team, and identify three key initiatives you will work on to create or improve a positive work environment within the team. **This should take no more than 10 minutes.**

Once the 3 key initiatives have been identified, the team should find concrete actions to carry out each suggested initiative, as well as identify individuals who will take ownership for facilitating/carrying out the identified action items. A team member or co-facilitator should take notes/fill in the Co-Lead outcome template to record the decisions made by the team.

If any of the team's identified initiatives are related to stronger social support, consider following this session up with the Co-Lead session "Emotional Support in Teams".

6) Close of session (5 min.)

Give general feedback on the session. Notes can be collected and collated by one individual to maintain record of discussion.

Co-Lead

HANDOUTS

DEVELOPING A POSITIVE WORK ENVIRONMENT

CASE 1 – ANXIETY AND LACK OF SUPPORT

The worst thing about my work? I feel very on my own. If I am on call at night, even if something goes wrong and a patient gets unwell, I feel like I can not just call the consultant. I feel like people expect me to just get on with it on my own, that I should be independent, that I am not allowed to ask for help. But I am not in this field for long, and sometimes I feel anxious of making a mistake and could use an opportunity to spar with someone more senior. There are many things that bother me. I work insane hours, our internal communication is not very good, and I feel like if I bring up any of these issues, it might harm my career because I rely on these people for references or maybe a job down the line. So I want them to see me as competent and reliable. I have gone to work with the flu because I was afraid of calling in sick, even though I know that it is a big risk to my patients. I have talked to some of my peers about all of this. Most of them agree with me, but nobody is really sticking up for each other. There is this feeling that because the specialty is so popular, I should just be glad I got the chance and grin and bear it. But it wears me down, and I honestly do not know how long I can stay here. I always wanted to be a doctor, but some days I think about quitting the medical profession entirely.

CASE 2 – CAMERADERIE AND FEELING VALUED

I know it sounds like a cliché, but I love coming to work every day. I feel like I can influence my own work day, and I feel that my ideas and suggestions are being listened to. I feel I am valued by my colleagues, patients and management, and I take pride in the work we do and the service we deliver. We are occasionally a bit under-staffed, I think we all feel that sometimes, and we have to run really fast, but when things get busy, everyone shares the workload. There is a great feeling of camaraderie, that we are in it together, and I feel that if I ever have an off-day, my colleagues will have my back. If we make a mistake or if I have a bad experience with a patient, I feel comfortable talking to my colleagues and managers, because I know they will be supportive and constructive. There is also a good atmosphere in the team, and we do social events outside of work once or twice a year. It is good to see everyone out of their day-to-day roles, I think it brings us closer together.

Co-Lead

OUTCOMES TEMPLATE

DEVELOPING A POSITIVE WORK ENVIRONMENT

PRIORITY RANKING	KEY INITIATIVE TO IMPROVE THE WORK ENVIRONMENT	AGREED ACTION(S) TO ACHIEVE THIS IMPROVEMENT	RESPONSIBLE PERSON(S)	DATE TO REVIEW PROGRESS
1				
2				
3				
4				
5				

Emotional support in teams

Co-Lead

ABOUT THIS MODULE

EMOTIONAL SUPPORT IN TEAMS

ABOUT THIS MODULE

EMOTIONAL SUPPORT IN TEAMS

What is the goal of this module?

The aim of the session is for the team to reflect on, learn about, and discuss emotional support for staff following traumatic or adverse events. After the session, team members should feel more equipped to support each other when needed and have generated ideas for increasing and sustaining awareness of second victims within the team.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Engagement of all team members**
- **Recognising and valuing contribution of others**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Motivation towards goals**
- **Cohesion and coordination**

Who is this module for?

All team members. Every member of the team can provide support to colleagues in times of difficulty, and the tools in this module can enhance this process.

What is the patient safety impact of this module?

Adverse events during work may have an emotional toll that impacts on staff's professional and personal lives, reducing their ability to provide excellent care.[1] Ensuring that adequate emotional support is given to team members following traumatic or adverse events will enable them to recover quickly and use the experience to strengthen their working practice in future.

References

1. Serou N, Sahota L, Husband AK, et al. Systematic review of psychological, emotional and behavioural impacts of surgical incidents on operating theatre staff. BJS Open. 2017;1(4):106–113. Published 2017 Oct 26. doi:10.1002/bjs5.21

Co-Lead

SESSION OUTLINE

EMOTIONAL SUPPORT IN TEAMS

SESSION OUTLINE

EMOTIONAL SUPPORT IN TEAMS

SESSION OVERVIEW

Purpose:	This session will highlight the importance of emotional support in teams to enhance trust and enable open communication.
Timing:	60 min.
Setup:	Introduction > Video > Reflection > Learning > Group exercise > Discussion
Outcomes:	Participants will gain improved awareness of situations where emotional support can be beneficial, and establish goals and activities to help make the work environment more emotionally supportive.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Printed handouts, story cards, poster example, and poster template.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, the session materials should be shared in advance via email.

SESSION OUTLINE

EMOTIONAL SUPPORT IN TEAMS

START OF SESSION

1) Introduction (5 min.)

Welcome should include introductions for new members, a brief explanation of Co-Lead, and 'ground rules' - use first names, value all voices, encourage all to bring skills and talents to the table etc. Facilitators should note the aim of the session – to emphasise the importance of emotional support in teams, enhance members' abilities to support each other, and generate ideas to build / sustain awareness of emotional support.

Facilitator note: The slides showcase a timer bar below the heading to keep track of time. Please click only once to activate (in case you double click you can always go back to previous slide and click again to reset the timer). Once the timer is done click to activate next slide and timer. The timer on each slide corresponds to the timing given in this session outline

2) Video and reflection (5 min.)

Watch the following video from the HSE about a nurse administering adrenaline to an infant through the wrong line.

https://www.hse.ie/eng/about/qavd/incident-management/patient-safety-voices.html

(The video is embedded in the first slide of the power point presentation. If accessing via the link, click on the 3rd story – "Barry").

After watching the video, ask team members to reflect individually on what colleagues and managers could have done to support the nurse following the event, and how his experience might have been different with adequate support. Team members are not required to share at this point.

3) Learning about emotional support (10 min.)

Introduce the team to important concepts and models for providing support for the second victim, using the session slides 3-9.

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4) Group exercise (20 min.)

Ask the team to form groups of three for this communication exercise. Each group should have three different story cards and the ASSIST-ME handout for support. The exercise is described in slide 10.

The team chooses one of the story cards to start with, and each team member will take on one of the following roles:

1) The second victim

- One person takes the perspective of the affected staff member as described in the story card (if there are multiple affected staff members in the story, the individual decides which staff member).
- The "second victim" attempts to put themselves in the shoes of the affected staff member in the story.

2) The colleague

- The second person takes on the role of a colleague of the affected staff member.
- The "colleague" attempts to support them, using the ASSIST-ME model and general empathy

3) The observer

- The third person takes on the role of observer.
- The observer observes without interfering, potentially taking notes, noticing what works and does not work.

Team members will carry out a supportive conversation between the second victim and the colleague, using the ASSIST ME handout and general empathy. After a couple of minutes of supportive communication, the observer prompts the "second victim" and the "colleague" to reflect on the experience and certain aspects of the conversation by asking questions, for example "how would you encourage your colleague to seek further support?", "could you have asked *x* differently?", or "how did you feel when asked *y*?". The observer does not give feedback or advice. His/her role is to ask questions to prompt reflection. After five minutes, the exercise is repeated with new story cards/new roles.

Facilitator note: All group members do not need to try all roles. The exercise should be repeated at least twice. If time allows, suggest that groups do a short debrief after the exercise, collectively reflecting on and discussing how the two different stories called for different needs for support.

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EMOTIONAL SUPPORT IN TEAMS

5) Team discussion on how to improve the emotional support within the team (20 min.)

Hand out the Emotional Support in Teams poster example and template. Explain to the team that today's outcomes (i.e., team agreement on how we can best support each other) will be added into a poster to increase team awareness and as a prompt to encourage provision of emotional support.

Facilitator note: Call for a volunteer or a small group who will take responsibility for taking notes and adding the team notes into the digital poster template and distribute the final product to the whole team (by e-mail and/or display of the poster, or whichever way is appropriate for the team).

The team should discuss the following questions to generate content for the poster:

- Which resources/support systems are currently available in the team/hospital to provide support for second victims?
- What should we say to/what questions should we ask our colleagues who have been involved in adverse/traumatic events?
- What else can we do to improve the emotional support within the team?
- Are there any factors impeding support for second victims in our team? If so, how can we improve it?
- **Agreement on poster content (questions/prompts)**

5) Close of session (5 min.)

Volunteer team members collate notes. It is their responsibility to add them into the poster template and distribute the final result to the team. The poster can be modified in any way the team sees fit (both content and layout).

Co-Lead

HANDOUTS

EMOTIONAL SUPPORT IN TEAMS

Co-Lead

HANDOUT

EMOTIONAL SUPPORT IN TEAMS

The "ASSIST ME" model

The ASSIST ME model has been adapted by the HSE from the Medical Protection Society's A.S.S.I.S.T model. It is developed to assist line managers, colleagues and peers in providing support for staff following adverse or traumatic events.

A	**ACKNOWLEDGE** with empathy the event and the impact on the member of staff. **ASSESS** the impact of the event on the member of staff and on their ability to continue normal duties.	"I came to see you as soon as I heard what happened. This must be very difficult for you. How are you doing?"
S	**SORRY** - express regret for their experience	"I am so sorry that this has happened" "Sometimes despite our best efforts things can go wrong/errors can occur"
S	**STORY** – allow time and space for them to recount what happened using active listening skills. SHARE personal experience	"Can I tell you about an experience of my own, how I felt and what I found helped me at that time?" "You may find it helpful to talk about what happened. Would you like to talk about what has happened?"
I	**INQUIRE** – encourage questions **INFORMATION** – provide answers/information	"Do you have any questions?" "Is there anything I can help you with at this time?"
S	**SUPPORTS** and **SOLUTIONS** - Formal emotional support - Informal emotional support - Practical support	Provide information on debriefing and the benefits of the same. Organise, with the consent of the staff member, one to one or team debriefing. Provide information on the other formal supports available, e.g. counselling. "My door is open for you at all times. I will be checking in with you regularly to see how you are doing. In the meantime if you do wish to talk about this or discuss anything with me please come and see me or give me a call at any time. Can I arrange for someone to collect you from work?"

(Continues on next page)

Co-Lead

HANDOUT

EMOTIONAL SUPPORT IN TEAMS

T	**TRAVEL** – providing continued support and reassurance going forward and throughout the investigation/review process and open disclosure process.	"I am here to support you going forward" "I will be with you every step of the way and I will assist you in any way I can"
M	**MAINTAIN** contact **MONITOR** progress **MOVING** forward	Ensure that there is continued contact with the staff member to prevent feelings of isolation. Continually monitor and assess the staff member's response to the event and their response to any interventions. Provide guidance and support on their return to normal duties.
E	**END** – reaching a stage of closure from the event. **EVALUATE**	Establish when the staff member has reached a stage of closure from the event as it is important at this stage not to keep re-opening the event with them. Leave your door open to them if they should require any further assistance going forward. Review the support provided with the staff member involved. Consider feedback and establish any learning which may benefit other staff.

Source: HSE - Supporting Staff following an adverse event. For details, see https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/opendiscfiles/bookletsuppstaffadverseevent.pdf

Co-Lead

STORY CARDS

EMOTIONAL SUPPORT IN TEAMS

Story Card 6

Air in an intravenous line

Thomas is a 15 year old boy with rare disease requiring frequent hospital admission.

I was prescribed 2 litres of intravenous normal saline. The first bag of saline finished during the night, and when the pump alarm went off, the nurse came in with the second bag. I asked if she wanted to turn on the light, but she didn't, and changed the bag. After she left I switched the light on and saw that the line was full of air. I knew that was dangerous, so I turned off the pump and called the nurse. She then primed the line properly and restarted the pump. She looked shocked, but she didn't say anything about it.

Story Card 8

Ignored patient

John is an intern in a large hospital on surgical rotation.

On a Registrar-led ward round with my team we came to Tom's bed. It was obvious he needed intervention. Tom was lethargic, and had not taken oral fluids or eaten in the previous 24 hours, on a background of chronic diarrhoea. His skin was dark purple and his face was bloated. The Registrar said that Tom was no longer our patient, his care had been transferred to the medical team, so we moved to the next patient. I wanted to intervene, but was afraid what the Registrar might say. Tom died that night.

Story Card 1

Communication/ Cover-up

Megan is a staff nurse in the Emergency Department.

A patient presented to the Emergency Department with a dislocated shoulder and underwent a reduction procedure to relocate the shoulder. The patient was administered an incorrect drug, stopped breathing and required resuscitation. The Registrar approached me and advised me that he was going to make an entry on the chart that it was a drug allergy because documenting it as a medication error would put both our jobs at risk.

Source: PlayDecide: Patient Safety – A "serious game" learning tool to help health professionals to discuss patient safety and error reporting.
http://www.patientsafetydiscussions.ie

UCD DUBLIN Co-Lead

POSTER EXAMPLE

EMOTIONAL SUPPORT IN TEAMS

Emotional Support in Our Team

On May 1st we participated in a Co-Lead meeting with the aim to increase our ability to support our colleagues following adverse or traumatic events. This poster contains our most important suggestions to improve the emotional support in Our Team.

We have identified the following resources currently in place in Our Team/Hospital for staff seeking emotional support following adverse or traumatic events:

Open door policy

Occupational Health Psychologist

Chaplain

Peer counselling programme

We will support our colleagues who have experienced adverse or traumatic events by asking questions like:

"Would you like to talk about what happened?"

"Do you want to go for a coffee with me and chat?"

"This must be difficult for you. How are you feeling?"

"Can I arrange for someone to take you home?"

"Would you like me to be there when you speak to … (e.g. the manager)?"

"You seem to be having a hard time. I just want to check that you are aware of the support options available (e.g. occupational health psychologist). Will I find their phone number for you?"

We will furthermore support our colleagues by:

Attempting to organise a bi-weekly walk around hospital campus during lunch break – all can join, and each walk will be led by a volunteer willing to have an informal chat (To join the volunteer rota, contact Mary O'Leary). Times/starting points TBD – announced on board.

Adding this poster to the team induction pack.

If we need further information or resources, we will find them at:

https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/opendiscfiles/bookletsuppstaffadverseevent.pdf

Any other resources identified by the team (e.g. hospital policies, resources)

Co-Lead

POSTER TEMPLATE

EMOTIONAL SUPPORT IN TEAMS

Emotional Support in [Team Name]

On [date] we participated in a Co-Lead meeting with the aim to increase our ability to support our colleagues following adverse or traumatic events. This poster contains our most important suggestions to improve the emotional support in [Team Name].

We have identified the following resources currently in place in [Our Team/Hospital] for staff seeking emotional support following adverse or traumatic events:

We will support our colleagues who have experienced adverse or traumatic events by asking questions like:

We will furthermore support our colleagues by:

If we need further information or resources, we will find them at:

https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/opendiscfiles/bookletsuppstaffadverseevent.pdf

And…

Enhancing person-centred care

Co-Lead

ABOUT THIS MODULE

ENHANCING PERSON-CENTRED CARE

ABOUT THIS MODULE

ENHANCING PERSON-CENTRED CARE

What is the goal of this module?

This module introduces basic concepts of including the patient as a partner in their care, fostering empathy and ensuring that their voices are heard, and their experience is valued. Participants will explore the strategies and tools that can be used to create a culture of person-centred care as a team.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Recognising and valuing contribution of others**
- **Mix of leadership and followership: People leading on topics where they have expertise and motivation**

What areas of team behaviour does this module focus on?

- **Coordination and effective team working**
- **Motivation towards goals**

Who is this module for?

All team members.

What is the patient safety impact of this module?

The person-centred approach is a key component in health systems improvement, enabling the creation of programmes and care pathways that are appropriate for all patients, thereby enabling the highest-quality and safest possible care.[1,2] Providing a space for team members to explore their understanding of person-centred care will ensure a shared person-centric focus in their everyday practice.

References

1. World Health Organization. 2015. WHO global strategy on people-centred and integrated health services. Geneva, Switzerland: World Health Organization
2. Santana MJ, Manalili K, Jolley RJ, Zelinsky S, Quan H, Lu M. How to practice person-centred care: A conceptual framework. Health Expect. 2018;21(2):429–440. doi:10.1111/hex.12640

Co-Lead

SESSION OUTLINE

ENHANCING PERSON-CENTRED CARE

SESSION OUTLINE

ENHANCING PERSON-CENTRED CARE

SESSION OVERVIEW

Purpose:	This session will introduce the basic concepts of including the patient as a partner in their care, fostering empathy and ensuring that their voices are heard, and their experience is valued.
Timing:	60 min.
Setup:	Introduction > Learning > Discussion > Group exercise > Discussion and Feedback
Outcomes:	Participants will explore the strategies and tools that can be used to create a culture of person-centred care as a team.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Facilitator presentation, internet connection to be able to show online video.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, the session materials should be shared in advance via email.
Facilitators:	Before the session, facilitators should gather relevant information from the patient safety survey relevant to their organisation to identify positive and negative aspects of patients' experience of care in the organisation.

SESSION OUTLINE

ENHANCING PERSON-CENTRED CARE

START OF SESSION

1) Introduction (5 min.)

Welcome the participants to the session and provide a brief review of the Co-Lead project. If new people are attending, provide a brief introduction and an update on progress so far.

Highlight the relevance of today's session topic to practice: Person centred care is the healthcare of the future. The healthcare staff are most knowledgeable about the diseases and conditions, however it is the person who knows best about their own experiences. Patients have critical information and therefore should be treated as partners in their care. To achieve this, it is important to be empathetic to them, provide them with a safe space where their voices are heard, and their experiences are valued.

Note the aims of this session: To introduce the basic concepts of how to value the patient as a person and explore the strategies and tools that we can use to create a culture of person-centred care as a team.

2) Empathy in healthcare video (8 min.)

[Slide 3] Play the video and engage in a discussion with the team and ask them what person-centred care means to them. Write the responses down so the participants can refer to these during the session.

3) Learning person-centredness (15 min.)

[Slide 4] Definition: Go through the definition of person-centred care

[Slide 5] HSE Person centred principles: Slide on principles of person centredness by the HSE. Shows factors that play a role in achieving a person-centred mindset.

[Slide 6] The ladder of engagement and participation: The ladder of engagement and participation was developed by NHS England. This framework acknowledges that depending on the person's interest and personal circumstances, they can be involved in the healthcare delivery process on different levels. The lowest level of involvement on the ladder is "informing". Engagement increases at each step of the ladder.

- Ask the team where they would place themselves on the ladder. Why?

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(contd.)

[Slide 7] Patient Engagement Continuum: There are different levels of engagement however we will be focusing on the level of "direct care" as we are working directly with patients.

As a team, we want to build a partnership and practice shared leadership with while delivering direct care to the patients. An important part of this is to base treatment decisions on a combination of patient preferences, medical evidence and clinical judgement.

4) Irish context: Patient experience survey (7 min.)

[Slide 8] A nation-wide patient experience survey was conducted in Ireland in 2017 which revealed what factors were important from a patient's experience in their healthcare delivery process.

The slide shows the areas that were lowest rated by the patients. Although some of the factors may be outside the control of the team, there are a few that we as healthcare staff can work on improving such as ensuring the patient understands the treatment and encouraging them to ask questions. Educating patients about the side effects of the medication they have been prescribed can also help us in becoming more person-centred.

[Slide 9-10] Discussion: In groups of 3-4, discuss the lowest rated areas in patient experience for your facility. Discuss ideas for improving these areas. Share with wider group.

5) Encouraging person-centred thinking (5 min.)

[Slide 11] In this discussion activity, ask the participants the following questions:

- What are the top 3 questions I should ask myself to be more person centred?
- What are the top 3 questions I should encourage the patient to ask me to become more person centred?

Some useful guiding questions for the facilitator might be:

- Am I fully aware what is important to the person and their communication?
- Am I the best person to support this decision-making?
- Do I have all the information the person requires to make this decision?

(Continues on next page)

(contd.)

- Am I providing all the relevant information?
- Am I presenting it in a way that the person can understand?
- I am giving the information in the right place and time?
- Have I given the person the best chance to make the decision themselves?
- How would you like to get the information?
- How can we help you understand?

[Slide 12] This slide lists some ideas that can be used to help the team become more patient centric. The facilitator can ask the participants what they can implement in their team.

6) Emotional journey map (15 min.)

The aim of this activity is to encourage the team to walk in the patient's shoes. Slide 14 contains a possible patient experience flow. The participants can come up with their own steps as well.

Once they decide on the steps, hand out post it notes and ask them to list down all possible factors that could cause stress to the patient.

Ask them to list down all possible factors that the team could contribute to help the patient overcome these stressful situations

7) Discuss session outcomes (5 min.)

Briefly discuss all the possible benefits of being more person centric. The facilitator can use the following themes as an aid:

- Transparent and clear processes
- Family engagement
- Respecting privacy
- Differences recognised and respected
- Individuals make informed choices and accept related risks
- Patients viewed as equal and active partners

Give brief feedback on the session.

Sustaining improvements

Co-Lead

ABOUT THIS MODULE

SUSTAINING IMPROVEMENTS

ABOUT THIS MODULE

SUSTAINING IMPROVEMENTS

What is the goal of this module?

This module aims to provide space for reflection on what the Co-Lead intervention has meant for each person individually, for the team and for the organisation. Through this, the team will reach a shared agreement on how to plan for, and ensure, sustainability, and if an existing framework will be adopted to inform strategies to sustain changes that have arisen due to Co-Lead.

What is the collective leadership focus of this module?

- **Shared mental models and shared understanding**
- **Cooperation and coordination between members**
- **Engagement of all team members**

What areas of team behaviour does this module focus on?

- **Enhanced collaboration**
- **Coordination and effective team working**
- **Motivation towards goals**

Who is this module for?

All team members.

What is the patient safety impact of this module?

The adoption of new practices and tools from the Co-Lead toolkit will help reinforce teams' patient safety behaviours and help them to deliver the safest possible care. However, planning and structures are needed to ensure that positive changes are maintained in the long term.

Co-Lead

SESSION OUTLINE

SUSTAINING IMPROVEMENTS

SESSION OUTLINE

SUSTAINING IMPROVEMENTS

SESSION OVERVIEW

Purpose:	The team needs to take time to reflect on what the Co-Lead intervention has meant for each person individually, for the team and for the organisation. This reflection process needs to be supported by the sessions and interventions already selected and completed by the team, as well as the team's priorities and progress to date on team goals.
Timing:	60 min.
Setup:	Presentation > Group discussion > Session evaluation
Outcomes:	The team will agree on how to plan for, and ensure, sustainability and if an existing framework will be adopted to inform strategies to sustain Co-Lead changes.
Facilitators:	1-2 team members to facilitate; 1 team member to act as flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Equipment:	Flipcharts, markers, pens, paper, post-it notes.
Materials:	Facilitator presentation.
Room:	Configure for round table discussion or small groups for larger teams.
Attendees:	If some team members cannot attend due to geographic location, they may participate remotely via teleconference. In such cases, session materials should be shared in advance via email.

SESSION OUTLINE

SUSTAINING IMPROVEMENTS

START OF SESSION

1) Introduction (10 min.)

Facilitators will guide participants through the presentation on sustainability.

2) Group discussion (45 min.)

Reflect on each of the seven Co-Lead intervention components completed by the team to date:

- Team Values, Vision and Mission
- Team Goal setting
- Role Clarity
- Collective Leadership for Safety Skills
- Risk and Safety Management at Team Level
- Monitoring and Communicating Safety Performance at Team Level
- Targeted intervention selected by Team

Facilitators should ask the group to reflect during this session on what has the Co-Lead intervention meant in terms of:

- **Introducing the principles of Collective Leadership:** Does each person's voice count on the team? Does each person have a say? Are each person's skills and talents being recognised and nurtured? Are we sharing leadership roles and responsibilities where appropriate?
- **Improving team performance:** Are we working better as a team? Why? Have relationship among team members improved? Do we understand and communicate better with each other?
- **Improving safety culture:** Are we more aware of safety in the moment, do we realise the harm that has happened in the past and understand how to make our team prepared for any risks or safety threats that might arise, do we have greater shared situational awareness?

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SUSTAINING IMPROVEMENTS

(contd.)

Questions for the team to work through

(Adapted from Lennox, Maher & Reed (2018). Navigating the sustainability landscape: a systematic review of sustainability approaches in healthcare. Implementation Science, 13:27.)

1. What is it that you wish to sustain?

For example: the principles of Collective Leadership, continuing improvement in team performance, continuing improvement in safety culture, the regular team meetings, doing interventions together, the LIT meetings, continually improving as a team, sharing and monitoring of performance data, and/or individual Co-Lead intervention components (e.g. removing blockers, using CUSS words, using S.A.F.E. Huddles, ISBAR, monitoring safety/KPIs, etc.).

2. How do you wish to view sustainability – as a process or an outcome?

For example: continuing with some or all elements of the Co-Lead programme (as a process) achieving an increase in collective leadership, team performance or safety culture (as an end goal). Can we monitor and measure this over time to ensure sustainability? How?

3. What would sustainability mean to the team?

What would it look like to say that Co-Lead had been sustained? Would this mean continuation of the programme, continuation of the benefits to staff, continuation of the benefits to patients and patient safety, having educated staff and built capacity in terms of collective leader/team performance/safety culture, would it mean further development of aspects of the programme, would it mean cost savings?

4. If you adapt an approach/framework to sustainability where would you use this approach/framework and who would use it?

For example, at the level of the team where the Co-Lead programme was implemented, the ward or across the organisation? Who will use the approach/framework? (researcher, practitioner, managers etc.)

5. Does an existing approach meet your needs? If not, what needs to change or be adapted and why?

Please see the HANDOUT for examples of approaches to sustainability below. The team needs to decide on what you want to sustain and then take an approach and amend as necessary to your local needs and implement this approach. Ideally sustainability needs to be thought about from the beginning of the intervention.

(Continues on next page)

SUSTAINING IMPROVEMENTS

3) Facilitator wrap-up (5 min.)

Facilitators will give a summary of what the team have agreed, about what they would like to sustain. Also highlight the shared sense of how sustaining these aspects would benefit the team, patients, staff and / or the organisation.

Participants should have reached agreement on how to plan for, and ensure, sustainability and if an existing framework will be adopted to inform strategies to sustain Co-Lead changes.

Give brief feedback on the session.

Co-Lead

HANDOUTS

SUSTAINING IMPROVEMENTS

SAMPLE APPROACHES/FRAMEWORKS TO SUSTAINABILITY

(A) Peoples' Needs Defining Change, Health Services Change Guide (2018)

Available at: https://www.hse.ie/eng/staff/resources/changeguide/

Figure 59: Sustain Improvement

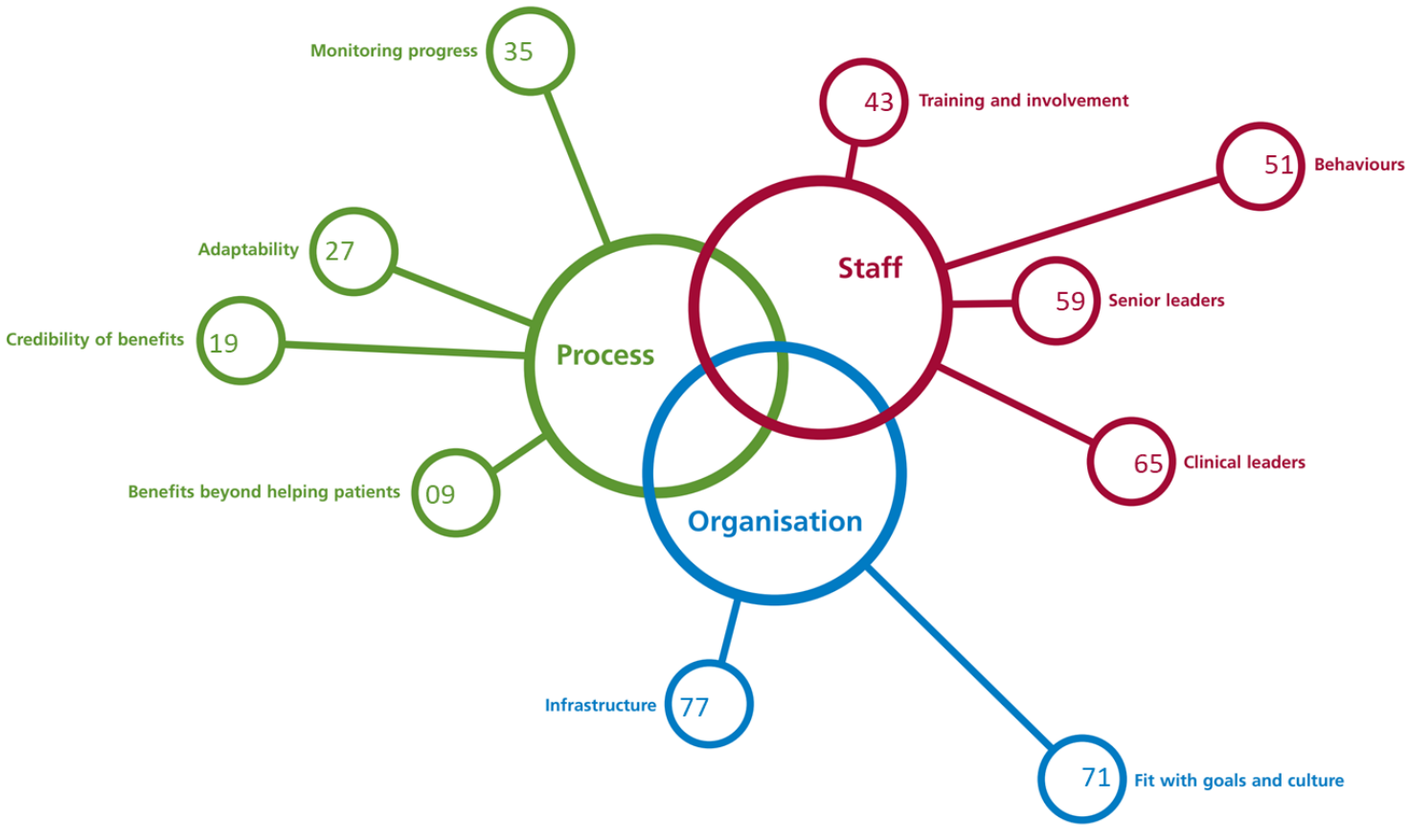
- Explicitly **reinforce responsibility** for ongoing leadership, monitoring and reporting.
- Remain alert to **changing contexts** and emerging data that require you to agree 'course correction' to keep the change on track. Remain connected to frontline service delivery to be in tune with implementation challenges and new drivers for change.
- Build in **'review/learning points'** during implementation or when scaling-up, where key partners can review the roles and resources needed at different phases, and consider changes.
- Monitor how well the changes have been **integrated and embedded** into the broader continuum of services or practices within the service. Are key leaders reinforcing this alignment – if not, what action is needed?
- Clear and consistent means of **monitoring** need to be incorporated into the delivery process, with agreed outcome measures and indicators.
- Support the use of **new skills and practices** into everyday activities to enable real behaviour change.
- Use **feedback loops** to inform what is needed (e.g. people, infrastructure) for sustainability, and proactively address these factors.
- Consider if improvements are dependent on individuals or groups, on technology or finance. Could it keep going if these were removed? **Succession planning** may need to be reviewed so that the change is not dependent on any one individual or group of individuals.
- Scan for any remaining dual systems and **decommission** appropriately.
- Attend to the **end stage of projects**. When a dedicated change project is finished, steering groups or other governance arrangements may need to be 'stood down', contracts ended, etc. Where project leads are in place, these posts may need to be discontinued or redesigned to integrate into existing services. Documentation may need to be archived or stored, learning documented and organisational 'intelligence' shared.

People's Needs Defining Change – Health Services Change Guide

SAMPLE APPROACHES/FRAMEWORKS TO SUSTAINABILITY

(B) NHS Institute for Innovation and Improvement Sustainability Model and Guide

This model presents 10 factors that are important for sustainability and a way of scoring how your intervention would do on each of the factors. The model and scoring sheet are available at: http://webarchive.nationalarchives.gov.uk/20160805122935/http://www.nhsiq.nhs.uk/media/2757778/nhs_sustainability_model_-_february_2010_1_.pdf



The model helps teams:

- Plan for sustainability of improvement efforts
- Recognise and understand key barriers for sustainability, relating to their specific local context
- Self-assess against a number of key criteria for sustaining change
- Identify strengths in sustaining improvement
- Monitor progress over time.

CO-LEAD | Collective Leadership for Safety Cultures

Feidhmeannacht na Seirbhíse Sláinte
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