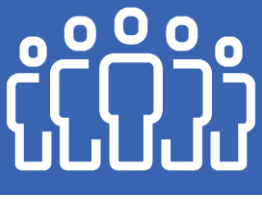
UCD DUBLIN Co-Lead

ABOUT THIS MODULE



COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

Co-Lead

ABOUT THIS MODULE

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

What is the goal of this module?

The focus of this module is to help teams to identify priority areas where they can develop their safety skills, and agree on the actions necessary to achieve this.

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**
- **Sharing leadership roles and responsibilities**
- **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?

- **Cooperation between team members**
- **Cross-monitoring**

Who is this module for?

All team members.

What is the patient safety impact of this module?

Participants will gain better understanding of the levels safety skills present within their team, as well as identifying areas where they can improve. They will also explore how to collectively identify causes of errors and safety incidents, and work to overcome internal biases that could cause core problems to be overlooked.

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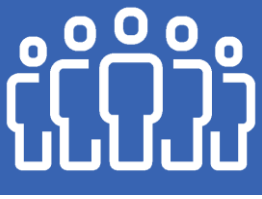
SESSION OUTLINE



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SESSION OUTLINE

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

SESSION OVERVIEW

Purpose:	This session will encourage team members to consider the levels of safety skills in the team and identify areas where they could be improved. Participants will develop a plan for safety skills development in the team.
Timing:	60 min.
Setup:	Introduction > Presentation > Exercise x 2 > Feedback
Outcomes:	Through individual reflection and group discussions, participants will identify priorities for safety skills development and actions to help address them.
Facilitators:	1-2 team members to facilitate; 1 team member to act as a scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Materials:	Please send to participants in advance the H-PEPPS Scale, both Team AND Individual adaptations. Presentation Deck.
Equipment:	Stable internet connection, the capability to share screen during presentation and group discussion.
Room:	Zoom (Premium Account for security) or Skype.
Attendees:	Team members and stakeholders are invited to participate remotely via teleconference. If they can't, share materials in advance via email.

START OF SESSION

1) Welcome and introduction (10 min.)

Start by introducing the session stating that the session will focus on collective leadership and responsibility for safety. The objective is to think about the level of awareness of safety and the safety skills that are strong in the team, as well as those that need to be developed. The desired output is a plan for how to develop better safety skills in all members of the team.

Share Screen. Use the PowerPoint slides to work through the content below:

Slide 1: Title slide

Slide 2: Patient safety is everybody's responsibility. But how do we become collectively responsible for safety in our team? Collective responsibility is the notion that if each individual in a team can affect the team's results, we can attribute the successes and failures of the team to every individual. Collective responsibility asserts that if an error occurs or a patient is harmed, each individual involved—including patients, healthcare professionals and managers—is responsible for that failure. This sense of collective responsibility improves patient safety and helps to build a culture of safety in healthcare systems.

Slide 3: Collectively identifying the causes of errors. Most errors or safety incidents have many causes.

For example: If I bump into the car in front of me, this might be because I was distracted by a phone message coming in, there was black ice on the road, the car in front braked very suddenly and I was too close, my kids were arguing in the back seat and I turned around to tell them stop, I was distracted because I was on my way to visiting my sick mother in the hospital. and I was tired after finishing a long work shift.

Often we only need to fix one or two systemic causes to prevent the same thing occurring again. For example, I could drive more slowly, and I could put my phone away when I am driving. However, immediately following my crash, I'm more likely to blame the driver in front than think about how I might change my behavior.

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Biases in seeing causes

People have cognitive biases that prevent them from seeing causes. For example:

Confirmation bias prefers causes that agree with our initial assumptions.

Ingroup bias prefers causes that implicate people outside our close associates.

Sunk cost bias shuns causes that involve expensive investments.

Recency illusion can prefer causes that have become recently visible but were present and hidden before.

The bandwagon effect prefers causes that other people mention.

2) Exercise: Collectively identifying causes: "5 Whys" (15 min.)

Get the group to think of one error or safety incident that everyone has some knowledge of, perhaps something that occurred recently in the team or the hospital, or in another part of the system.

1. Use a blank Word Document or Notes on a tablet. Share your screen. Write the problem at the centre of the document.
2. Ask someone to name one possible cause of the error/incident.
3. Create a new node or circle for the newly stated cause and draw an arrow from the cause to the problem. The cause now becomes another problem to consider.
4. Ask the next person to name only one new cause for any problem shown on the board, saying "X caused Y". Draw the X node with an arrow to Y.
5. Repeat step 4 until everyone has spoken once. A map should now be starting to emerge. Sometimes something causes multiple problems, in which case that node has many arrows leaving it. Allow everyone to review for a moment.
6. Repeat step 4 and continue until a linear chain of five causes appears somewhere in the graph, or until the team runs out of causes.
7. Then help the team examine the map to find causes that could have been easily prevented. Using those preventable causes, put together a plan to prevent such an error in the future.

This approach can help overcome many sources of cognitive bias. By forcing people to name an unstated cause for a problem, we avoid confirmation and bandwagon bias. By involving people from diverse roles and perspectives, we avoid ingroup bias.

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3) Exercise: Collective responsibility for safety (30 min.)

Slides 4-6:

Use the PowerPoint and handouts to work through this exercise

Collective responsibility motivates the development of broadly skilled colleagues. The concept of T-shaped professionals or T-shaped skills is one where the vertical bar on the T represents the depth of related skills and expertise in a single field or discipline, whereas the horizontal bar is the ability to collaborate across disciplines with experts in other areas and to apply knowledge in areas of expertise other than one's own. T-shaped professionals have well-developed specialty skills and broad capabilities in other areas. Broader skills in a group are important for taking collective responsibility.

Instructions: Refer to the Safety Skills Individual Assessment sheet which you have emailed in advance.

Then take the team assessment handout and project the slides of this onto the screen (**slide 6**). Ask the group to discuss and collectively rate the team on each of the skills they have ranked themselves on. (10 min.)

Now focus on the three or four skills with the lowest team ranking and try to get agreement in the team about which of these skills are most important for the team to develop. Try to identify the top three priorities for development.

Now project the outcome template and split the team into groups of 2-3 to discuss possible actions to develop these skills (5 min.)

4) Close of session (10 min.)

Bring the team back together and ask them to feedback their discussed actions, writing each one into the template (**slide 7**). Finally agree responsible persons, so that the responsibility is shared across the group via email and set dates to review progress on these actions. Give general feedback on the session.