CO-LEAD

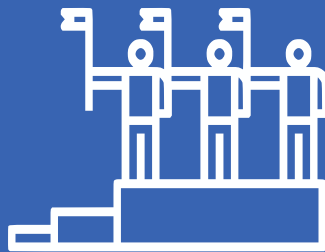**Collective Leadership for Safety Cultures**

CORE TOOLKIT COMPONENTS

TEAM PERFORMANCE

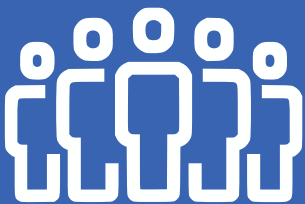**Team values, vision, and mission**
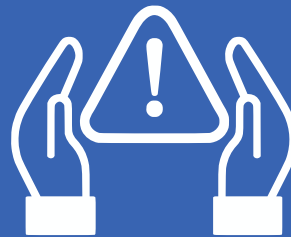

Team goal setting

Role clarity

SAFETY CULTURES

Collective leadership for safety cultures

Risk & safety management at team level

Monitoring & communicating safety performance

OVERVIEW OF THIS CO-LEAD TOOLKIT PACKAGE

Thank you for your interest in the UCD Co-Lead Toolkit. This package contains the six introductory core modules to help multidisciplinary teams discuss and implement collective leadership in 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 undertake the six core modules in the order presented in this package, then collectively decide upon which of the 13 targeted modules are most appropriate for their needs. (The targeted modules are available in a separate package, titled *Co-Lead Targeted 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 can be downloaded at *http://www.ucd.ie/collectiveleadership/resourcehub/toolkit* and the 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.
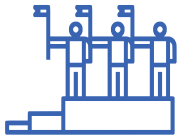
INDEX

TEAM PERFORMANCE

SAFETY CULTURES
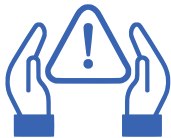
Team values, vision, and mission

ABOUT THIS MODULE

TEAM VALUES, VISION, AND MISSION

Co-Lead

TEAM VALUES, VISION, AND MISSION

What is the goal of this intervention?

To collectively establish and agree: Team values, vision for the team, and mission statement.

What is the collective leadership focus of this intervention?

This intervention will help build shared mental models and shared understanding among team members. It also aims to promote engagement and involvement of all team members.

What areas of team behaviour does this intervention focus on?

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

Who is this intervention for?

As many team members as possible. Engaging in this process as a team will enable individuals to share ownership of the team's vision and mission, and will increase the chances that efforts will be successful.

Useful links for more information about this module

The value of the mission statement for organizational performance in healthcare: Forehand (2000)
https://journals.lww.com/jhmonline/Citation/2000/07000/Mission_and_Organization al_Performance_in_the.12.aspx

How mission statements drive innovation and learning:
Bart et al. (2004)
http://corporatemissionsinc.com/app/webroot/files/13.pdf

Additional detail to guide session(s) if needed can be found at Community Tool Box:
http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/vmosa/main

SESSION OUTLINE

TEAM VALUES, VISION, AND MISSION

SESSION OUTLINE

TEAM VALUES, VISION, AND MISSION

SESSION OVERVIEW

Purpose:	To encourage the team to work collectively to establish and agree team values, vision, and the mission statement. This will build a shared mental model as well as promoting ownership and understanding across the whole group.
Timing:	60 min.
Setup:	Introduction > Discussion > Group work (x2) > Feedback
Outcomes:	The team will establish an agreed set of goals, values, a shared vision, and common mission that they are working towards plus actions that can be taken to achieve them.
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:	**1)** Source the organisation's goals / strategies
	2) Source photo cards
	3) Print OUTCOME TEMPLATE and HANDOUT documents for participants
Equipment:	Flipcharts, markers, pens
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, or they may be asked to pre-submit suggestions that can feed into the values and goal setting process. In such cases, session materials should be shared in advance via email.

Co-Lead

TEAM VALUES, VISION, AND MISSION (contd.)

START OF SESSION

1) Welcome, introduction, and icebreaker (10 min.)

Welcome participants to the session and start a brief discussion around each individual's own values around vision and mission. Use a photo deck (e.g. EVOKE or similar) to discuss personal values and work / team values.

1. Depending on group size, group people into smaller groups of 3-5 people.
2. Place photo cards on tables and ask individuals to select two photographs: one photo that appeals most/resonates most with them and that represents their personal values and one that represents their team's values.
3. Ask individuals to share this and explain this among their groups.

This values discussion will link closely with how the team will consider what their team values are. Embodying our values in how we work and how we operate as a team are important in ensuring a positive working environment that values all staff contributions.

2) Discussion of values and what are the values we want our team to embody (5 min.)

What is important to us as a team?
What are some of the common values from the table discussions?

How do we want to work?
How can our values be reflected in our daily work?

How do these values translate into behaviours?
How can we work to enact these values in our daily work?

3) Discuss and develop a team vision statement (20 min.)

Give out HANDOUT and give 5 minutes to read it. Then use 1-2-4-all approach: Give 1 minute for quiet reflection, 2 minutes to discuss in pairs and then 4 minutes as a foursome or larger group to discuss and share ideas. Small groups then feed discussions back to facilitator who gets all groups to agree on a common vision statement.

Co-Lead

TEAM VALUES, VISION, AND MISSION (contd.)

(contd.)
By developing a vision statement, your team makes their beliefs and objectives clear within the team itself, to the wider organization, and to patients /community.

There are certain characteristics shared by most vision statements:
- Understood and shared by members of the team
- Encompass a variety of perspectives
- Inspiring and uplifting
- Easy to communicate – short and snappy

For example:
"To be the safest ED team in the country"
"To be a model of good practice for all the primary healthcare teams in the city"

4) Discuss and develop a team mission statement (20 min.)

Give out HANDOUT and give 5 minutes to read it. Then use 1-2-4-all approach: Give 1 minute for quiet reflection, 2 minutes to discuss in pairs and then 4 minutes as a foursome or larger group to discuss and share ideas. Small groups then feed discussions back to facilitator who gets all groups to agree on a common vision statement.

A team's mission statement describes what the group is going to do, and why it is going to do it. They are more concrete and practical than vision statements and are action-oriented.

Principles for mission statements:
- *Should be concise:* Get the point across in one sentence - ideally written in 50 words or less.
- *Should be outcome focused:* Explain the overarching outcomes your team is working towards.
- *Should be inclusive:* Broad statements should be used so that mission statements are not limiting .

(Continues on next page)

TEAM VALUES, VISION, AND MISSION (contd.)

(contd.)

Consider the following Mission Statement structure in designing your own team mission statement:
- **Who?** Define your team
- **What?** What are your team dedicated to/working towards?
- **How?** What will you make it you mission to do?
- **For?** Whom are your efforts targeted at?
- **Why?** Who benefits and how should they benefit from your team's work?

For example, the mission statement of The Mayo Clinic:
"To inspire hope, and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research."

5) Close of session (5 min.)

Facilitators establish participants' agreement and clarity on team goals, vision, mission and team values.

Output: A set of values, vision, and mission statements for the team and short and long terms objectives/goals which the team should agree to review against progress at agreed future date. Ideas for strategies on how to work towards goals. These should be made explicit and posted publicly on ward/unit (teams may need to appoint a volunteer to do this).

Give brief feedback on the session. Thank everyone for contribution, ask people how they found the intervention, give topic and date for next session (Goal setting and role clarity).

HANDOUTS

TEAM VALUES, VISION, AND MISSION

TEAM VALUES, VISION, AND MISSION

Group task 1: Creating vision statement for your team

Your **vision statement** communicates what your team believes are the ideal conditions for how your team work is performed – how things would look if the issues important to the team were perfectly addressed.

By developing a vision statement, your team makes its beliefs and objectives clear - within the team itself, to the wider organization, and to patients / community.

There are certain characteristics shared by most vision statements:
- Understood and shared by members of the team
- Encompass a variety of perspectives
- Inspiring and uplifting
- Easy to communicate – short and snappy

e.g. The Mayo Clinic's vision statement: "Mayo Clinic will provide an unparalleled experience as the most trusted partner for health care."

Group task 2: Creating mission statement for your team

Mission statements describe what the team will do, and why. They are more concrete and practical than vision statements and are action-oriented.

Principles for effective mission statements:
- *Should be concise:* Ideally one sentence, written in 50 words or less.
- *Should be outcome focused:* Explain the outcomes your team is working towards.
- *Should be inclusive:* Broad statements so that mission statements are not limiting.

Consider this structure in designing your team mission statement:
- **Who?** Define your team
- **What?** What are your team dedicated to/working towards?
- **How?** What will you make it you mission to do?
- **For?** Whom are your efforts targeted at?
- **Why?** Who benefits and how should they benefit from your team's work?

e.g. The Mayo Clinic's Mission statement: *"To inspire hope, and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research."*

TEAM VALUES, VISION, AND MISSION

Example vision, mission, and goals

Anytown Primary Healthcare Team

Vision

We will improve the quality of life for those we serve by ensuring their health care is leading-edge and humane.

Mission

Our mission is to promote the health, growth, and wellbeing of all those in our community, including patients, relatives, community members, and practice members, by respecting the individual, encouraging co-operation and collaboration, and emphasising excellence in all we do.

Team Goals

- To put as much resource (people, time, money) into health promotion as into illness treatment – measured by resource allocation.

- To involve all team members in setting goals and improve our functioning of a team continuously – measured by improvements in team functioning.

- To promote the control and quality of life of those with long-term conditions (such as diabetes and asthma) – measured by their ratings of care quality and symptom control.

- To improve health outcomes in the community by seeing decreases in heart disease, cancer, obesity, and drug and alcohol misuse.

- To improve the quality of relationships we have with other organisations and teams we work with (hospital, other primary health care teams, social services) – measured by their annual ratings of our cooperativeness.

From West et al., 2017 – Sample case study on how teams can derive goals from vision and mission statement

OUTCOMES TEMPLATE

	TEAM VALUES, VISION, AND MISSION

OUTCOMES TEMPLATE

Co-Lead

TEAM VALUES, VISION, AND MISSION

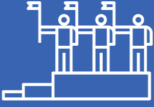| TEAM NAME		
	SUGGESTED AT THE INTERVENTION SESSION	**FINALISED BY THE LOCAL IMPLEMENTATION TEAM**
Values we would like the team to embody		
Vision Statement		
Mission Statement		

Team goal setting

ABOUT THIS MODULE
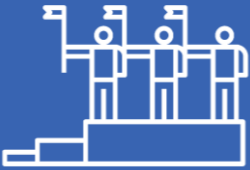
TEAM GOAL SETTING

TEAM GOAL SETTING

What is the goal of this intervention?

This intervention aims to enhance participants' understanding of the overall vision and desired goals of the team.

What is the collective leadership focus of this intervention?

- **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 intervention focus on?

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

Who is this intervention for?

All team members. Collaborative and explicit goal setting will ensure clarity among team members in their role in helping the team achieve its goals; ensures a shared mental model/vision for the team's work.

What is the patient safety impact of this intervention?

Collaborative and explicit goal setting will ensure clarity among team members in their role in helping the team achieve its goals. This will help ensure a shared mental model/ vision for the team's work.

Clarity of team goals is the single most important predictor of success in healthcare teams.[1,2] However, many teams still do not have clear goals.

Large scale reviews of the literature have found that goal-setting has a large positive effect on improving team outcomes.[3,4]

Team goal setting results in markedly higher performance than no goal setting.[5]
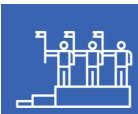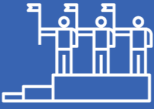
TEAM GOAL SETTING

What is the patient safety impact of this intervention? (contd.)

Creating cultures focused on high quality care requires clear, aligned and challenging goals at every level of the organisation that prioritise this standard of care.[6] Dawson et al.[7] found that where staff reported this type of goal in place, patients reported better care. Furthermore, patient satisfaction was found to be higher in healthcare organisations where staff indicated there were clear goals at every level, and they described experiencing good communication and high levels of involvement in their care decisions.

The most consistent predictor of team performance across many studies is the clarity of healthcare teams' goals.[8,9] Healthcare teams that have goals in place, and which seek feedback on their performance, deliver safer and higher quality health care than other health care teams.[10]

Enhancing understanding of role and responsibilities and expectations; Forum to explore misunderstandings/incorrect assumptions about colleagues' roles; Improvements in cross-monitoring behaviours and coordination of team

When roles are clear, team members are more motivated, less stressed and perform better. Role ambiguity and role conflict are key factors in the development of work stress.[11]

When objectives and roles are clear, teams perform significantly better, with fewer errors, greater productivity and higher levels of innovation.[2,12]

Role ambiguity is negatively associated with role performance,[13] team performance[14] and job satisfaction.[15]

Useful links for more information about this module

How to do a RACI chart - https://www.projectsmart.co.uk/how-to-do-raci-charting-and-analysis.php

Co-Lead
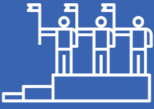
TEAM GOAL SETTING

Additional resources

If you are not sure if the role clarity intervention is needed in your team, the diagnostic tool below can be used in advance to assess the role clarity/ambiguity on the team. This can be conducted in advance to inform the session. It will take 5 minutes for individuals to complete it and approx. 30 minutes for one person to score all responses (the UCD Co-Lead team can advise and assist with this if required); 10mins discussion to evaluate whether there is need for in-depth discussion on roles and responsibilities.
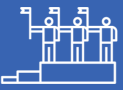
Diagnostic Tool

Completion of scale by all team members to assess goal (items 1-5) and role process (items 6-10) clarity in the team.[16]

Please indicate your response to the following statements using the scale below, where 1 indicates very uncertain and 6 indicates very certain: (* indicates item should be reverse scored)

1. I am certain of my duties and responsibilities

2. I am uncertain of the goals and objectives for my job*

3. It is clear to me how my work relates to the overall objectives of my work unit

4. I am certain of the expected results of my work*

5. I am uncertain as to what aspects of my work will lead to positive evaluations*

6. I am clear on how to divide my time among the tasks required of my job

7. I am clear on how to schedule my work day

8. I am uncertain how to determine the appropriate procedures for each work task*

9. I am certain the procedures I use to do my job are correct and proper

10. Considering all your work tasks, how certain are you that you know the best way to do these tasks?

High variance in scoring between team members or a score perceived as low overall score by the team suggests need for group intervention.

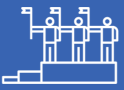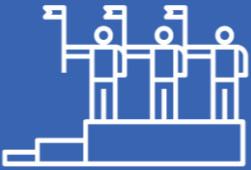## TEAM GOAL SETTING

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15. Sawyer, JE (1992). Goal and process clarity: Specification of multiple constructs of role ambiguity and a structural equation model of their antecedents and consequences. Journal of Applied Psychology, 77(2), 130-142.

SESSION OUTLINE

TEAM GOAL SETTING

SESSION OUTLINE
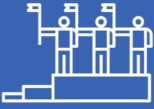
TEAM GOAL SETTING

SESSION OVERVIEW

Purpose:	This session will help teams to collectively formulate goals to work towards.
Timing:	60 min.
Setup:	Introduction > Goal setting > Goal agreement > Feedback
Outcomes:	The team will establish an agreed set of goals that align with their priorities and mission, and assign sub-groups to monitor progress.
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:	Print OUTCOME TEMPLATE and HANDOUT documents for participants.
Equipment:	Flipcharts, markers, pens.
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.
Timing:	It is important to monitor timings of session and move along when necessary. If goals are not decided during section 3 of the timetable, sub-groups can be convened to work to refine goals and measurement of outcomes.
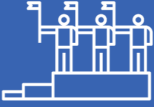
TEAM GOAL SETTING

START OF SESSION

1) Welcome and icebreaker (10 min.)

Review team vision and mission statement previously developed. Link this goal exercise to developing the means of achieving the team mission.

Ask participants to consider the question: "What would I suggest to improve this team's working/performance?" Use 1-2-4-all approach – allow one minute to reflect on the question; 2 minutes for discussion in pairs, and 4 minutes for group discussion and feedback from small groups (make notes on flipchart paper).

2) Set 3-5 goals for the team (20 min.)

Give out Handout to read (5 minutes) and facilitate group discussion (15 minutes) on what the teams' goals should be. Communicate that these goals will be the team's targets to work towards for the year.

3) Group agreement on goals (25 min.)

Agree on the set of goals for the team that align to priorities and mission. Assign sub-groups to work on, monitor and report to team on progress at least on a monthly basis (sub-groups may need to meet/be in contact outside formal team meeting times where appropriate)
- Set specific and measurable outcomes to monitor performance
- Set specific, realistic time targets within which goals may be achieved

4) Close of session (5 min.)

Notes can be collected and collated by one individual to maintain a record of the discussion. Take note of the goals. This can be useful for inducting new members by making explicit the roles (and sub-teams/responsibilities) of everyone on the team. Confirm goals set by team for the year and ideas on how best to monitor progress towards those goals. Give brief feedback on the session.
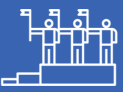
HANDOUT

TEAM GOAL SETTING

Co-Lead
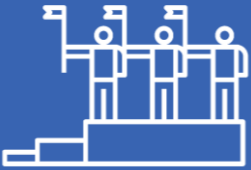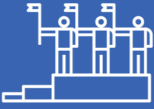
TEAM GOAL SETTING

About team goals

Once a team has developed its vision and mission statement, its next step is to develop the specific goals that are focused on achieving that mission. Goals refer to specific measurable results. A team's objectives may outline what will be accomplished by certain target dates.

For example, one of several goals for a community initiative to promote care and caring for older adults might be: *"By April 2018* (by when)*, to decrease by half a day* (how much) *patients' average length of stay on the ward* (of what)*."*

To make sure your goals are clear and reachable, each one should be challenging and SMART:

• **Specific** (simple, sensible, significant).
• **Measurable** (meaningful, motivating).
• **Achievable** (agreed, attainable).
• **Relevant** (reasonable, realistic and resourced, results-based).
• **Time bound** (time based, time/cost limited, timely, time-sensitive).
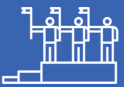
Types of goals

• Performance goals are goals that involve achieving some level of performance.

• Learning goals involve gaining knowledge or skills, new competencies or approaches

Teams may select to develop objectives in both categories. Goals should fit with organisational goals / values – how is the work of the team contributing to the organisation's pursuit of its goals?

According to West et al. (2017), most healthcare team goals should include:

1. Providing high quality and compassionate care.

2. Continually improving that care.

3. Ensuring other team members' wellbeing, growth and development.

4. Ensuring that working relationships and practices with other teams in the organisation are of high quality and continually improving.

Co-Lead
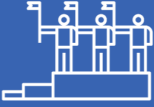
TEAM GOAL SETTING

Goal setting

Teams should seek to set a maximum of five goals at any time. For example, among their goals, the Mayo Clinic have defined these as key to achieving their mission:

- **Caring with awareness.** Provide high-quality, culturally appropriate care in a welcoming environment to all patients.

- **Reflecting our community.** Increase the diversity of the patients we serve in order to develop new treatments that lead to higher quality outcomes and a reduction in health disparities for all people.

- **Welcoming to all.** Ensure an inclusive work environment where participation of diverse employees is encouraged at all levels of the organisation.

From a team-level perspective, goals can be more targeted and specific to the working of the team and the team's local priorities (and still consistent with vision and mission statements). Examples of team goals could include:

1. The team will work to achieve a 90% patient satisfaction rating for the ward by December 2019 through improving the quality of information available to patients (measurement approach: intermittent patient satisfaction surveys/interviews)

2. The team will achieve a 50% increase in patient on remote cardiac monitoring by January 2019 (measurement approach: auditing of cardiac monitoring and patient records)

Charting progress

Progress towards these goals can be assessed and monitored using several evaluation approaches (some relevant to the whole organisation, others to specific teams within the organisation):

1. Patient and staff surveys and/or interviews

2. Process measures (e.g., thrombolysis pathway for stroke) to evaluate whether a team follows specific process steps which have been identified to provide timely and effective care.

3. Outcome measures – to evaluate the results over time. Examples include readmission rates and patient safety indicators, including number/frequency of foreign objects left in during procedures, accidental punctures or lacerations, and central venous catheter–related bloodstream infections.
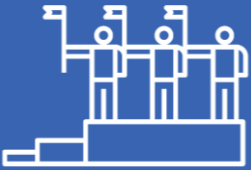
OUTCOMES TEMPLATE

TEAM GOAL SETTING

OUTCOMES TEMPLATE

TEAM GOAL SETTING

Co-Lead

GOAL	MEASUREABLE OUTCOME	TIMELINE	SUB-TEAM TO WORK ON AND MONITOR	PROGRESS MONITORING

Role clarity

ABOUT THIS MODULE

ROLE CLARITY

Co-Lead

ROLE CLARITY

What is the goal of this module?

This module will help to enhance team members' understanding of each other's roles and responsibilities in the team.

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**
- **Cohesion and coordination**
- **Cross-monitoring**

Who is this module for?

All team members.

What is the patient safety impact of this module?

When roles are clear, team members are more motivated, less stressed and perform better. Role ambiguity and role conflict are key factors in the development of work stress.[1]

When objectives and roles are clear, teams perform significantly better, with fewer errors, greater productivity and higher levels of innovation.[2,3]

Role ambiguity is negatively associated with role performance,[4] team performance,[5] and job satisfaction.[6]

ROLE CLARITY

Additional resources

If you are not sure if the role clarity intervention is needed in your team, the diagnostic tool below can be used in advance to assess the role clarity/ambiguity on the team. This can be conducted in advance to inform the session. It will take 5 minutes for individuals to complete it and approximately 30 minutes for one person to score all responses (the UCD Co-Lead team can advise and assist with this if required). 10 minutes discussion to evaluate whether there is need for in-depth discussion on roles and responsibilities.

Diagnostic Tool

Completion of scale by all team members to assess goal (items 1-5) and role process (items 6-10) clarity in the team.[7]

Please indicate your response to the following statements using the scale below, where 1 indicates very uncertain and 6 indicates very certain: (* indicates item should be reverse scored)

1. I am certain of my duties and responsibilities

2. I am uncertain of the goals and objectives for my job*

3. It is clear to me how my work relates to the overall objectives of my work unit

4. I am certain of the expected results of my work*

5. I am uncertain as to what aspects of my work will lead to positive evaluations*

6. I am clear on how to divide my time among the tasks required of my job

7. I am clear on how to schedule my work day

8. I am uncertain how to determine the appropriate procedures for each work task*

9. I am certain the procedures I use to do my job are correct and proper

10. Considering all your work tasks, how certain are you that you know the best way to do these tasks?

High variance in scoring between team members or a score perceived as low overall score by the team suggests need for group intervention.

ROLE CLARITY

Additional resources

Below is an example of a way for teams to visualise their member's roles, from "High Performing Interdisciplinary Teams" by Jeff Capobianco, of the National Council for Behavioural Health.[8]

¹Solid circles indicate the highest expectations.
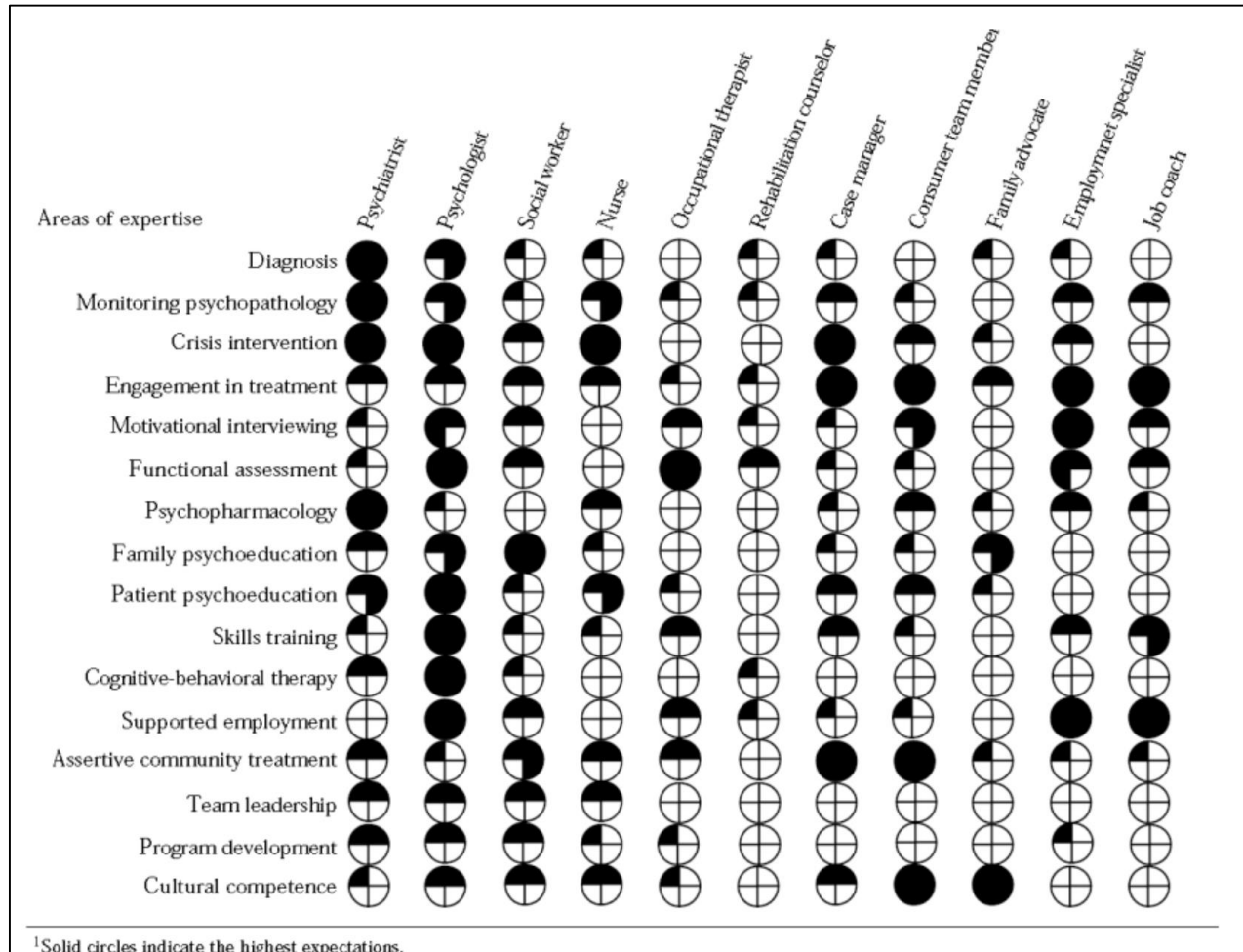
ROLE CLARITY

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SESSION OUTLINE

ROLE CLARITY

SESSION OUTLINE

ROLE CLARITY

SESSION OVERVIEW

Purpose: This session will enhance participants' understanding of their roles and responsibilities, and those of others on the team.

Timing: 60 min.

Setup: Introduction > Discussion > Group exercise > Feedback

Outcomes: Through group discussion, participants will gain understanding of various team members' roles, and teams will implement ways to maintain and monitor role clarity.

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 outputs from vision and mission session.

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, session materials should be shared in advance via email.

Before the session, the diagnostic tool (see "About this module") can be completed as online or paper-based anonymous survey. Facilitator can score results and report back to team for brief 10 min discussion on perception of need for role clarity intervention.

ROLE CLARITY

START OF SESSION

1) Welcome and introduction (10 min.)

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

The aim of this session is to explore and enhance role clarity among team members. There is strong evidence from the literature that when roles are clear, team members are more motivated and less stressed, and performance improves. In instances where there is poor role clarity, this has a negative impact on individual performance, team performance and job satisfaction.

2) Opening discussion / icebreaker (10 min.)

Ask the team to reflect on the below question:

Identify at least one quality appreciated about another professional group working on the team (e.g., a nurse would highlight something he/she appreciates about physicians/HSCPs/another professional group on the team)

Use 1-2-4-all approach – allow one minute to reflect on the question; 2 minutes for discussion in pairs, and 4 minutes for group discussion and feedback from small groups (make notes on flipchart paper).

3) Group exercise and discussion to explore role perceptions / expectations (20 min. + 10 min. feedback)

If possible, create sub-groups that are discipline-specific: ask nurses to work together on this task in one group, doctors in another, HSCPs, HCAs, etc. as appropriate for your team.

If this is not possible, cluster professionals to create 2-3 sub-groups by combining professions (e.g., by putting nurses and HCAs together).

One person in each small group should make bullet point notes for purposes of summarising discussions, with particular emphasis on how people describe their roles and key responsibilities.

(Continues on next page)

ROLE CLARITY

(contd.)

Ask individuals to reflect quietly for 1 min. on the following questions and to make notes for discussion in their sub-group.

Then ask sub-groups to spend approx. 5 min. discussing perspectives. These answers will be fed back to the wider group for discussion:

1. How would you describe your role?

2. What do others perceive as your role?

3. Choose another professional group represented here today (or on the team) and describe what you believe their role to be.

Facilitators should then lead a group discussion and ask team to reflect on what has been said. Begin with any major discrepancies/misunderstandings and talk though these issues. Facilitators should ensure the discussion remains respectful and inclusive.

Questions below may help stimulate discussion:

1. Were you surprised to hear other team members' role descriptions or to hear their perspective of your professional role?

2. What roles/aspects of roles lead to confusion on our team? Why?

3. Is it clear how individual/professional group work together to achieve the goals we have set for our team?

4. *If time permits:* Are there tasks that you do because you feel you are good at them or you like doing them or you feel it is helpful to other people, even though they are not necessarily part of your role?

5. *And/or:* Ask each individual to identify one thing that others could do to make it easier for them to do their job. What can we do to help each other?

3) Close of session (5 min.)

Give brief feedback on the session. Notes can be collected and collated by one individual to maintain a record of the discussion. This can be useful for inducting new members by making explicit the roles of everyone on the team.

Collection of notes from small tables to document key roles and responsibility for each team member present (or for professional groups if more appropriate to the team)

Is there a way to visually represent the goals of the team and how your roles and tasks/responsibilities within those roles fits into the team goals?

Collective leadership for safety skills

ABOUT THIS MODULE
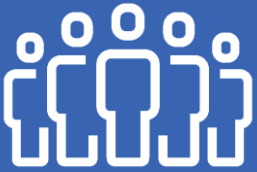
COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

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.

SESSION OUTLINE

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

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 areas where these could be improved. Participants will aim to develop a plan for safety skills development in all members of the team.

Timing: 60 min.

Setup: Introduction > Presentation > Exercise x 2 > Feedback

Outcomes: Through individual reflection and group discussions, participants 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 flipchart scribe to record ideas, discussion points, and outputs.

ADVANCE PREPARATION

Materials: Printed H-PEPPS Scale Team AND Individual adaptations.

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. Preparation for this will include sharing of materials in advance via email.

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

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.

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. I was tired after finishing a long work shift.

Often it just requires that we 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 behaviour.

Co-Lead

(contd.)

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. Write the problem inside a circle or node at the centre of the flip chart.

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.

Co-Lead

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

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

Slides 4-6:

Use the PowerPoint, handouts and flipchart 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: Hand out the Safety Skills Individual Assessment sheet and ask team members to individually complete this. (Allow 5 min.)

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 just ranked themselves on. (10 min.)

Now focus on the 3 or 4 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 3 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.)
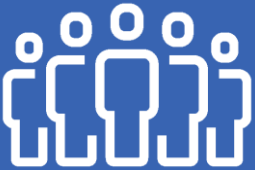
4) Close of session (10 min.)

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

HANDOUTS

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

Co-Lead

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

Assessing individual safety skills

Read each item and rank yourself **honestly** on a scale of 1-10 (1= extremely poor, 10= excellent). Place your ranking in the 'my skills' column.

Factor	Item	My skills (1-10)
Working in teams with other professionals	Managing inter-professional conflict	
	Sharing authority, leadership and decision-making	
	Encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues	
Communicating effectively	Enhancing patient safety through clear and consistent communication with patients	
	Enhancing patient safety through effective communication with other healthcare providers	
	Effective verbal and nonverbal communication abilities to prevent adverse events	
Managing Safety risks	Recognising routine situations in which safety problems may arise	
	Identifying and implementing safety solutions	
	Anticipating and managing high risk situations	
Understanding Human and Environmental factors	Understanding the role of human factors, such as fatigue, which effect patient safety	
	Understanding the role of environmental factors such as work flow, ergonomics and resources, which effect patient safety	
Recognise and respond to reduce harm	Recognising an adverse event or close call	
	Reducing harm by addressing immediate risks for patients and others involved	
Culture of Safety	Taking a questioning attitude and speaking up when I see things that may be unsafe	
	Creating a supportive environment that encourages patients and providers to speak up when they have concerns about safety	
	Understanding the nature of systems (e.g., aspects of the organisation, management or the work environment including policies, resources, communication and other processes) and system failures and their role in adverse events	

Source: Adapted from the H-PEPSS, Health Professional Education in Patient Safety Survey

Co-Lead

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

Assessing safety skills in the team

Read each item and discuss and rate your team **honestly** on a scale of 1-10 (1= extremely poor, 10= excellent). Reflect on your individual scores when doing this. Record the rating in the Team skills column.
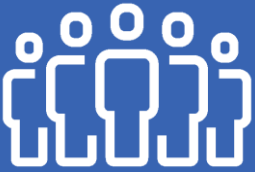
Factor	Item	Team skills (1-10)	Team priority ranking
Working in teams with other professionals	Managing inter-professional conflict		
	Sharing authority, leadership and decision-making		
	Encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues		
Communicating effectively	Enhancing patient safety through clear and consistent communication with patients		
	Enhancing patient safety through effective communication with other healthcare providers		
	Effective verbal and nonverbal communication abilities to prevent adverse events		
Managing Safety risks	Recognising routine situations in which safety problems may arise		
	Identifying and implementing safety solutions		
	Anticipating and managing high risk situations		
Understanding Human and Environmental factors	Understanding the role of human factors, such as fatigue, which effect patient safety		
	Understanding the role of environmental factors such as work flow, ergonomics and resources, which effect patient safety		
Recognise and respond to reduce harm	Recognising an adverse event or close call		
	Reducing harm by addressing immediate risks for patients and others involved		
Culture of Safety	Taking a questioning attitude and speaking up when I see things that may be unsafe		
	Creating a supportive environment that encourages patients and providers to speak up when they have concerns about safety		
	Understanding the nature of systems (e.g., aspects of the organisation, management or the work environment including policies, resources, communication and other processes) and system failures and their role in adverse events		

Source: Adapted from the H-PEPSS, Health Professional Education in Patient Safety Survey

OUTCOMES TEMPLATE

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

Co-Lead **OUTCOMES TEMPLATE** **COLLECTIVE LEADERSHIP FOR SAFETY SKILLS**

PRIORITY RANKING	SAFETY SKILL	AGREED ACTIONS TO DEVELOP THIS SKILL WITHIN OUR TEAM	RESPONSIBLE PERSON	DATE TO REVIEW PROGRESS
1				
2				
3				
4				
5				

Risk & safety management at team level

ABOUT THIS MODULE

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

Co-Lead

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

What is the goal of this module?

This module will help teams explore the nature of risk and safety, and reflect on past, current, and future safety practices. At the end of the session they will have created a list of measures being gathered on quality and safety of care, as well as any additional processes that may require measurement.

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**

What areas of team behaviour does this module focus on?

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

Who is this module for?

All team members. Input from diverse team members can contribute to risk management and patient safety improvement.

What is the patient safety impact of this module?

Through undertaking this module, teams will build upon their existing awareness of risks and safety. By developing a common understanding of existing risks and action areas, teams will collaboratively improve the patient safety environment.

SESSION OUTLINE

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

SESSION OVERVIEW

Purpose: This session will help create an understanding of the nature of risk and safety as a team and how to understand if care has been safe in the past, is in the present, and will be in the future.

Timing: 60 min.

Setup: Introduction > Exercise > Feedback > Homework

Outcomes: List all current measures being gathered on the quality and safety of care we provide as a team and list any additional processes that require measurement.

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 outcome template handouts.

Equipment: Flipcharts, markers, pens.

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.

UCD Co-Lead

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

START OF SESSION

1) Welcome and introduction (10 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 the topic to practice: To improve patient safety we need to first discuss what "safety" means for the team and know what methods, tools and indicators are being used, and should be used, to measure safety.

Note that the aim of today's session is to create an understanding of the nature of risk and safety as a team and how to understand if care has been safe in the past, is in the present and will be in the future.

List the 6 key questions (Health Foundation 2016) that will be central to the team's discussion:

1. What are we doing well in terms of safety as a team?

2. Has the patient care we've provided been safe in the past?

3. Are our team's clinical systems and processes reliable?

4. Is the team's care safe today?

5. Will the team's care be safe in the future?

6. Are we as a team responding and improving?

2) Icebreaker (5 min.)

Take a minute of personal reflection to think about the questions below and then share your thoughts with a colleague sitting next to you. Facilitator then asks each member of the team to feedback one sentence to the larger group.

1. What does safety mean to me?

2. How would I describe the safety culture within the team?

3) Group exercise (20 min.)

If possible create sub-groups that are multi-disciplinary. Distribute the handout and ask each group to use this template to answer the 6 key questions outlined in the introduction; identifying current safety measures and potential risks that may require measurement within the team ONLY. Each small group should to fill in the handout to summarise their discussion.

(Continues on next page)

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

4) Group Feedback (20 min.)

Facilitators should lead a group discussion and ask each subgroup to feedback what they have discussed. One facilitator should list the measures discussed (can use template, flip board etc.). Facilitators can use the prompts below to help generate discussion if required.

1. What are we doing well in terms of safety as a team?

Look at the positives in terms of safety; what areas in particular work well in terms of measurement? What can the team learn from these areas?

2. Has the patient care we've provided been safe in the past?

Explore what data your team measures to know if and how care has been unsafe in the past few months, years.

> *Possible Examples:*

• Hospital mortality statistics – can these be broken down by area for your team?

• Systematic chart review can look at any harm that may have arisen?

• What type and number of incident reports were raised from your team in the last few months? Have they been responded to? Has the person who raised the incident report been kept informed of progress on what is happening to that report?

3. Are our team's clinical systems and processes reliable?

Reliability is defined as a reflection of how well a measure provides consistent results in different circumstances.

What standardised processes do we use as a team? How are they measured?

> *Possible Examples:*

• As a team are we carrying out audits of how we do things in order to learn or improve (and not simply carrying out audits in order to comply with regulations)?

• Do we regularly carry out checks on equipment to ensure all is functioning as it should be, checks on materials, stocks etc at local level to ensure supplies are adequate.

(Continues on next page)

Co-Lead

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

(contd.)

4. Is the team's care safe today?

How do we know if the care provided by our team is safe? What are we measuring as a team to know our care is safe today?

> *Possible Examples:*

- Are all team members able to speak up about safety concerns? (If you think this needs to be improved then see the intervention 'TALKING ABOUT SAFETY/PLAYDECIDE PATIENT SAFETY GAME')

- Does the team follow and apply the HSE Open Disclosure Policy?

- Have any patient experience surveys been carried out? Can you get the results of these broken down to the team level and discuss the results together as a team?

- Are safety huddles carried out by the team? (If you think this would be good for the team then see 'SAFETY PAUSE HUDDLE" intervention)

5. Will the team's care be safe in the future?

What do we measure to know as a team if our care will be safe in the future?

> *Possible Examples:*

- Does the team plan and anticipate when care might be at risk from a safety perspective (e.g. staff shortages, seasonal increase in patients, patient transfer)?

- Is there a way of reporting and removing frustrations for team members (frustrations can often signal hazards)? (If you think this would be beneficial for your team then see the 'REMOVING FRUSTRATIONS/DEALING WITH SUGGESTIONS' intervention)?

- Are team indicators of safety explored – e.g. team injury rates, team absenteeism rates?

- If organisational level/national surveys are carried out is it possible to obtain results for your team?

6. Are we as a team responding and improving?

Have we learned as a team from previous incidents?

> *Possible examples*

- What, if any of this data do we feedback to team members to give them a sense of how the team is performing in terms of safety? (This will be explored at the next session 'MONITORING AND COMMUNICATING SAFETY PERFORMANCE at the TEAM LEVEL / PECT (Patient/Environment/Care/Team)' intervention)

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

5) Homework (or 5 min. if time allows)

The information gathered from today's session will feed into the team's next safety-focused intervention on MONITORING AND COMMUNICATING SAFETY PERFORMANCE AT THE TEAM LEVEL(PECT).

Prior to that session, ask the team to reflect and note what additional measures are recorded by the hospital in terms of risk and safety that are relevant to the team.

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.

OUTCOMES TEMPLATE

RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

UCD Dublin | Co-Lead

OUTCOME TEMPLATE | RISK AND SAFETY MANAGEMENT AT TEAM LEVEL

Area of the framework	Current measures being gathered as a team	Any gaps where we need to begin measurement	Measures recorded by the wider hospital relevant to our team
What are we doing well in terms of safety as a team? *Look at the positives in terms of safety; what are we doing well as a team?*			
Has the patient care we've provided been safe in the past? *What does your team measure to know if and how care has been unsafe in the past few months, years?*			
Are our team's clinical systems and processes reliable? *What standardised processes do we use as a team? How are they measured?*			
Is the team's care safe today? How do we know if the care provided by our team is safe? What are we measuring as a team to know our care is safe today?			
Will the team's care be safe in the future? *What do we measure to know as a team if our care will be safe in the future?*			
Are we responding and improving as a team? *Have we learned as a team from previous incidents?*			

Monitoring & communicating safety performance

ABOUT THIS MODULE

MONITORING & COMMUNICATING SAFETY PERFORMANCE AT TEAM LEVEL

Monitoring & communicating safety performance at team level

What is the goal of this module?

This module builds on the Risk and Safety Management module, to provide team members with a structured tool and overarching perspective on the ways in which they can track safety performance. During the session, the team will collectively decide on what safety measures they will monitor and display on the ward.

What is the collective leadership focus of this module?

- **Mix of leadership and followership: People leading on topics where they have expertise and motivation**
- **Sharing leadership roles and responsibilities**
- **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**
- **Cross-monitoring**

Who is this module for?

All team members. The four components that make up patient safety (patient, environment, care, team) are made up of contributions from varied staff members, and insight from diverse individuals will ensure that as many potential safety measures as possible are discussed for inclusion into the monitoring tool.

What is the patient safety impact of this module?

Greater team-level awareness and cross-monitoring of the patient safety components within the ward will facilitate a culture of improvement through realistic and specific goals.[1,2]

References

1. Vincent C, Burnett S, Carthey J. (2013) The measurement and monitoring of safety: Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring. London: The Health Foundation. ISBN 978-1-906461-44-7
2. The Health Foundation. (2016) A framework for measuring and monitoring safety:A practical guide to using a new framework for measuring and monitoring safety in the NHS. London: The Health Foundation. ISBN 978-1-906461-53-9

SESSION OUTLINE

MONITORING & COMMUNICATING SAFETY PERFORMANCE AT TEAM LEVEL

SESSION OUTLINE

Monitoring & communicating safety performance at team level

SESSION OVERVIEW

Purpose:	This session will give the team members an understanding of the importance of having a 'big picture' view of safety (patient, environmental, care and team components).
Timing:	60 min.
Setup:	Introduction > Reflection > Exercise > Feedback
Outcomes:	The team will decide what measures they want to monitor and display on the ward in relation to quality and safety.
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 handouts.
Equipment:	Flipcharts, markers, pens.
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.

Co-Lead

Monitoring & communicating safety performance at team level

START OF SESSION

1) Welcome and 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 the topic to practice: By deciding what is meaningful to measure as a team, our awareness of important safety factors will be heightened which can serve to reduce errors and enhance patient safety.

The aim of this session is to give the team members an understanding of the importance of having a 'big picture' view of safety (patient, environmental, care and team components). The desired output from the session is a list of measures that the team will monitor and display on the ward in relation to quality and safety.

2) Icebreaker (5 min.)

Take a minute of personal reflection and ask each member of the team to identify one risk/safety issue that has been normalised (or that people have become accustomed to) within the team. Facilitator then asks each member of the team to feedback their thoughts to the larger group.

3) Reflection on Risk and Safety Management and Goal setting session (10 min.)

This session follows the RISK AND SAFETY MANAGEMENT intervention where we recorded all current measures being gathered on the quality and safety of care provided as a team and additional processes requiring measurement. Facilitators should reflect on what was discussed using the outcome template from the previous session, exploring how the team answered the following 6 key questions (Health Foundation 2016);

1. What are we doing well in terms of safety as a team?
2. Has the patient care we've provided been safe in the past?
3. Are our team's clinical systems and processes reliable?
4. Is the team's care safe today?
5. Will the team's care be safe in the future?
6. Are we as a team responding and improving?

Monitoring & communicating safety performance at team level

(contd.)

Facilitators should briefly ask for feedback on the homework exercise from the last session by asking the question:

Has anyone considered any additional measures that are recorded by the hospital in terms of risk and safety that are relevant to the team?

The team should also reflect on the goals they have developed from the GOAL SETTING session. These goals will help inform what is meaningful to measure as a team.

4) Group Exercise: Deciding on what your team wants to monitor in relation to performance (10 min.)

If possible, create sub-groups that are multi-disciplinary and distribute the handouts (Patient/Environment/Care/Team framework).

Following the team's reflection on the previous session (what is currently being measured by the team and hospital and gaps in measurement), the facilitators should ask the subgroups to choose:

1. One measure they believe is meaningful in each domain (patient/environment/care/team) that is currently being measured which can be displayed on the ward.

2. One measure they believe should be monitored in the future relating to the team's goals or gaps in measurement acknowledged in the previous session.

Each small group should fill in the handout to summarise their discussion.

Note: Facilitators should emphasise that it is important that the measures chosen mean something to the team and will motivate them.

Monitoring & communicating safety performance at team level

5) Group Feedback (25 minutes)

Facilitators should lead a group discussion and ask each subgroup to feedback what measures they have chosen. One facilitator should list the main points of discussion (can use template, flip board etc.).

When the team decide what is meaningful to measure, they should then discuss:

1. How they will evaluate these measures?
2. Who will monitor and update the measures on the board (sub-team)?
3. How frequently should the board will be updated (weekly, monthly, quarterly).

6) Close of session (5 min.)

Give brief feedback on the session. Notes can be collected and collated by one facilitator to maintain a record of discussion. Take note of the measures chosen, how they are to be measured and the sub-team members associated with each measurement.

HANDOUTS

MONITORING & COMMUNICATING SAFETY PERFORMANCE AT TEAM LEVEL

EXAMPLEPATIENT / ENVIRONMENT / CARE / TEAM

Patient	Environment	Care	Team
PRESENT: Choose one patient related measure that is meaningful to the team. Number of complements received by ward staff this month: **10** Number of complaints received by staff this month: **2** **Sub-team:** Aoife, Lisa (Responsible for measuring/ collecting data and inputting it on the board)	**PRESENT:** Choose one measure relating to the ward environment that is meaningful to measure. Monthly hand hygiene audit results: **86% compliance** **Sub-team:** Sylvester, Marie	**PRESENT:** Choose one measure associated with the care that the team provides. Days since last infection Urinary Catheter: **7** CVC Lines: **20** PICC Lines: **14** **Sub-team:** Sharon, Una	**PRESENT:** Choose one measure relevant to the team or use this section to celebrate team success, to display staff photos or provide staffing updates. One of our goals as a team is to _improve role clarity_ among our staff and patients. Here are our team members: **Sub-team:** Steve, Sandra
FUTURE: One of our goals as a team is to _improve patient satisfaction_ on the ward. We plan to monitor Patient Experience Survey results and implement targeted interventions to improve their experience on the ward **Sub-team:** Eilish, Zuneera	**FUTURE:** One of our goals as a team is to reduce the number of infection rates on the ward by 10%. We will be monitoring incidences of CDiff, VRE and MRSA on the ward monthly. **Sub-team:** Kirsten, Tony	**FUTURE:** One of our goals as a team is to _improve communication_. We will be auditing when Ward Huddles are taking place and who is attending. These huddles help our team to look ahead to potential hazards/risks on the ward **Sub-team:** Andrew, Roisin	**FUTURE:** One of our goals as a team is to _improve team morale_. We will be introducing a jug of joy on the ward. When staff finish their shift they will drop a red marble (bad day) or green marble (good day) to help us as a team understand the overall experience of staff. **Sub-team:** Marina, Aisling

Co-Lead

HANDOUT

Monitoring & communicating safety performance at team level (PECT)

WHAT MEASURES ARE WE EXAMINING AND WHAT WOULD WE LIKE TO MEASURE AND DISPLAY?

Patient	Environment	Care	Team
PRESENT:	PRESENT:	PRESENT:	PRESENT:
Sub-team:	Sub-team:	Sub-team:	Sub-team:
FUTURE:	FUTURE:	FUTURE:	FUTURE:
Sub-team:	Sub-team:	Sub-team:	Sub-team:

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