Team Training

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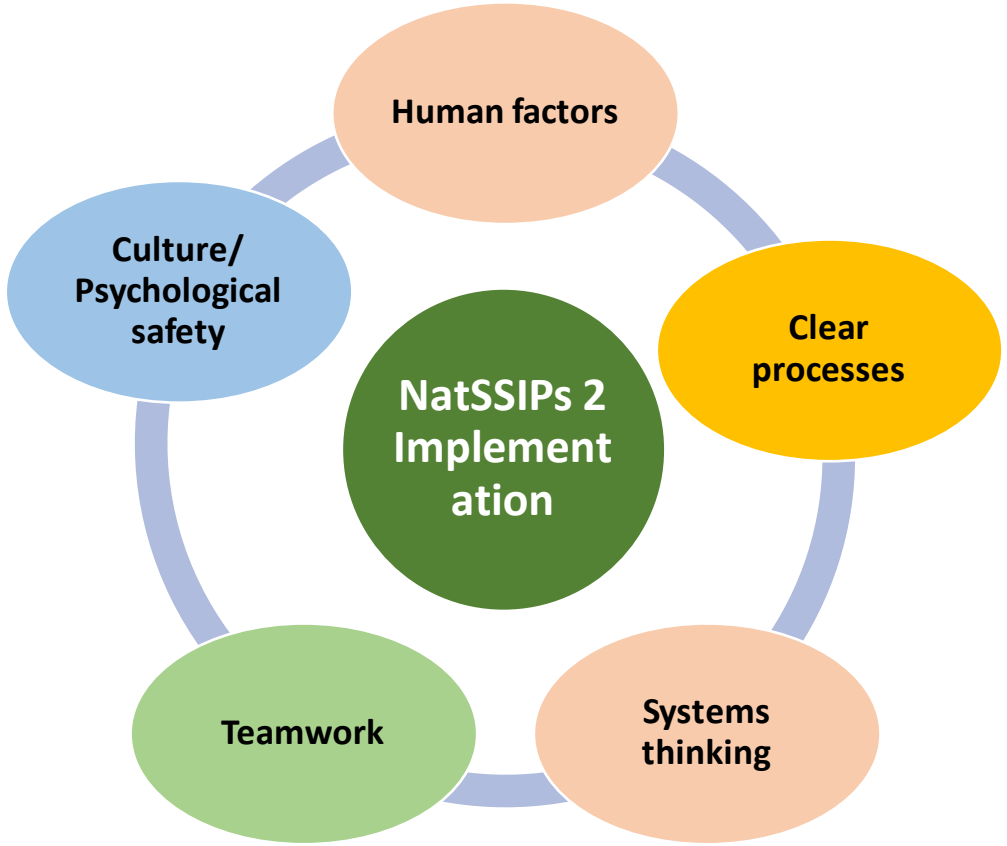


Organisational Standards

People for safety

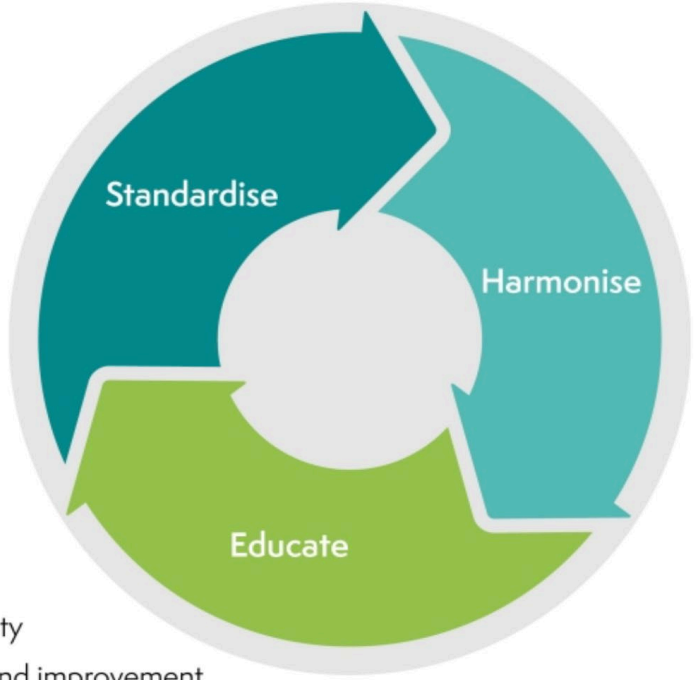
- Patients as partners
- Staff to deliver
- Roles in safety
- Training in safety
- Human factors understanding

Processes for safety

- Documentation
- Scheduling
- Induction
- Governance

Performance for safety

- Data for assurance and improvement
- External body engagement



Behaviours show

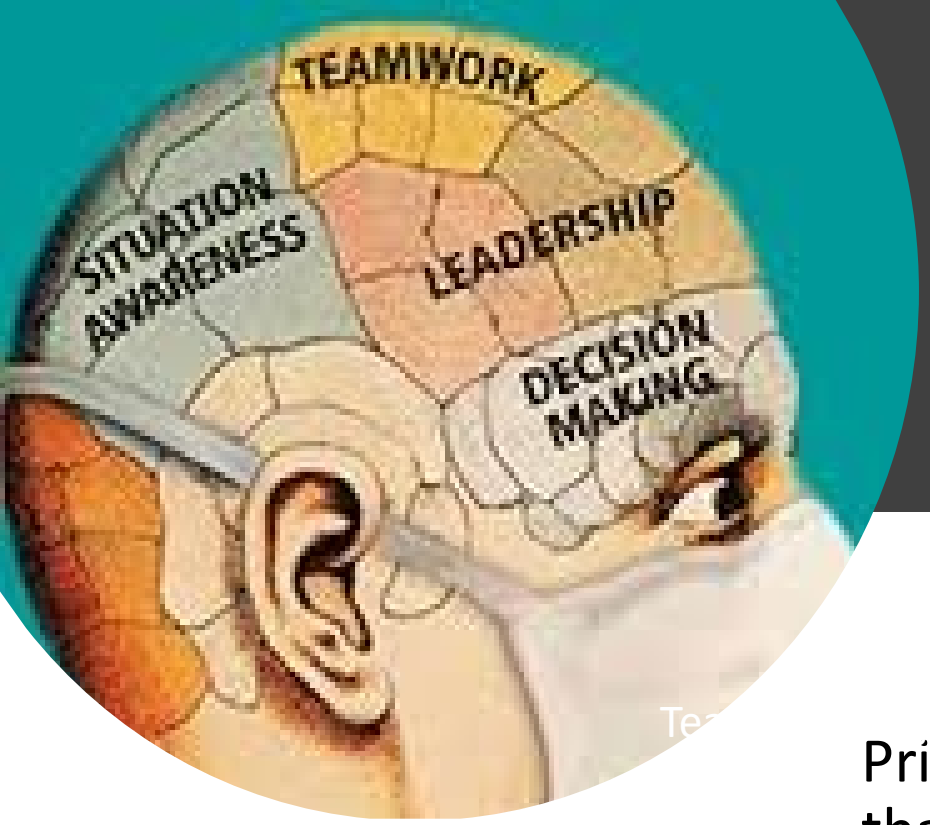
Patient focus
Teamwork
Kindness
Compassion
Safety knowhow
Understand HF
Leadership

Strong communication

Planning
Teamwork
Use of checklists
Better handover
Report excellence
Report incidents

Team engaged in

Solutions
Audit
Data
Improvement
Quality



Team Training Objective

Principle aim “to develop a strong and collegiate workforce that holds the values of safe and high-quality patient care at its core, creating the conditions that enable people to be and perform at their best every day”

What is Team Training?

- Facilitated sessions involving the whole MDT
- Expect attendance from all key professions and grades
- Understand and manage the environment that teams work in
- Build empathy by understanding and valuing different people within the team
- Embracing diversity
- Influence team behaviours and develop a safety culture
- Learn the factors that impact individual and team performance
- Understand and develop team psychological safety

Key Domains

Key Domains – From National Patient Safety Syllabus and Patient Safety Curriculum

- Systems Thinking
- Human Factors
- Risk Management
- Safety Culture

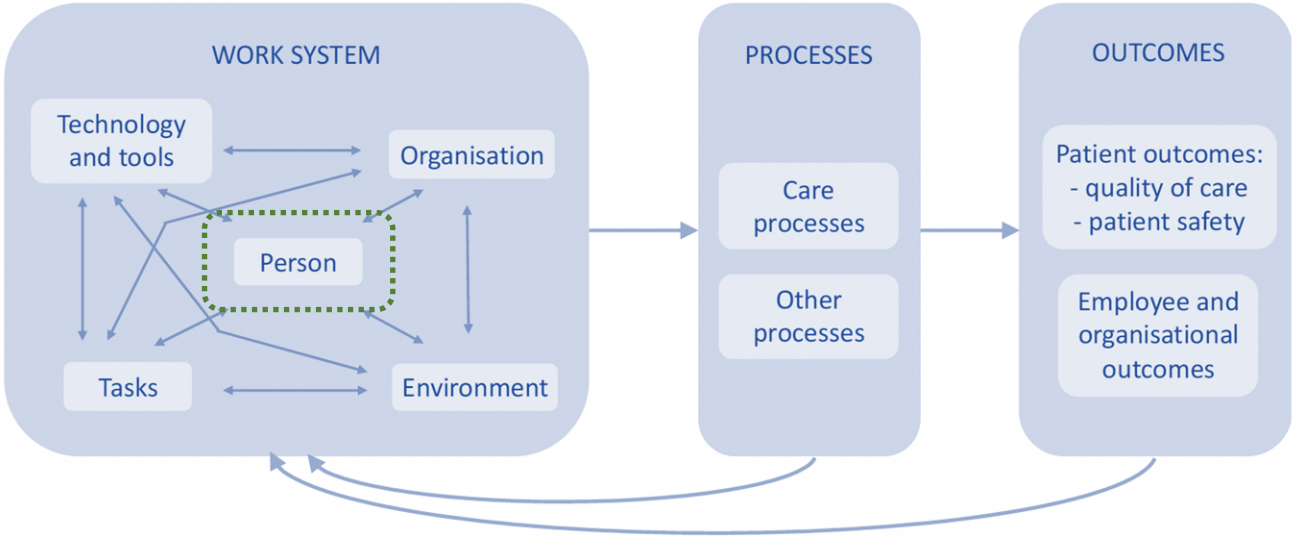
Where have our courses been running?

- Initiated by Annie Hunningher at Royal London Hospital in 2010
- Moved to other sites within BartsHealth
- General theatres, maternity, cardiac theatres, cardiology cath labs
- Over 80 teams trained
- Eight at St Bartholomew's Hospital in the last 12 months

Format of the course

- **Lectures bringing background knowledge**
- **Facilitated workshop sessions**
  - **Small breakout groups each with a cross-section of the MDT**
  - **Presentation of discussion to the whole group**
  - **Entire group discussion**
  - **Generate list of main themes and actions to take back to workplace**
- **Expect attendance from all key professions and grades**

1) People within the system



Workshop 1

Systems science and people

Discussion areas

- Ensure people feel **valued**
- Understand people's situation
- Increase **positive feedback**

Actions

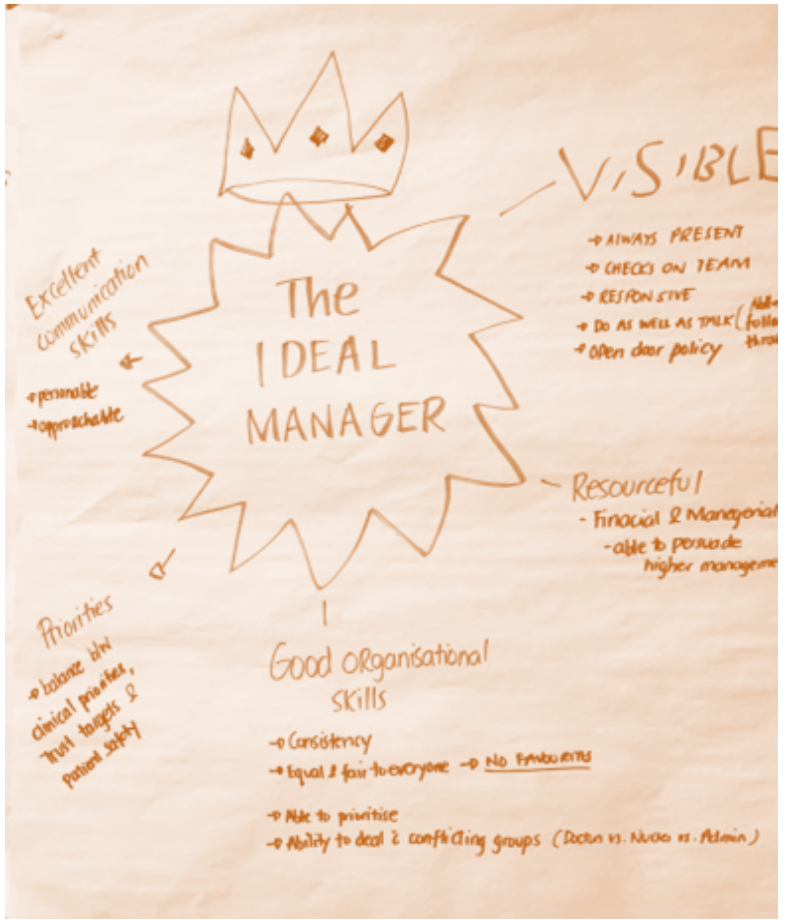
- Consider shadowing other's roles
- Include "wellbeing" question in team brief
- Greatix completion

2) Team behaviour

"Improvements in team processes are associated with improvements in clinical outcomes" (Schmutz 2013)

Workshop 2

Exemplary team member



Actions

- Ensure defined process for calling for help for a struggling trainee
- Knowledge /documentation of surgical preferences
- Ensure entire team focus at time out
- Reduce disconnect between managers and front line staff

Civility saves lives

The Impact of Rudeness on Medical Team Performance: A Randomized Trial

Arieh Riskin, MD, MHA[a,b], Amir Erez, PhD[c], Trevor A. Foulk, BBA[c], Amir Kugelman, MD[b], Ayala Gover, MD[d], Irit Shoris, RN, BA[b], Kinneret S. Riskin[e], Peter A. Bamberger, PhD[a]

Exposure to incivility hinders clinical performance in a simulated operative crisis

Daniel Katz,[1] Kimberly Blasius,[2] Robert Isaak,[2] Jonathan Lipps,[3] Michael Kushelev,[3] Andrew Goldberg,[1] Jarrett Fastman,[1] Benjamin Marsh,[1] Samuel DeMaria[1]

- Consider how to help people when they are stressed (and consequently being rude)
- Simulation/situational training to understand own response as well as best language to use to manage a situation

3) Communication

- Challenges
- Communication tools
- Checklists

Workshop 3
Communication

Scenarios

Team brief

Emergency handover

Bad behaviour

Some areas of discussion:

- Ensure **engagement** of all team members e.g. junior/senior, introvert/extrovert, new/experienced
- Care with abbreviations - often not understood. *"I thought a VATS was a piece of equipment"*

4) Situational awareness and failures




Workshops

Enhancing domains of team performance, incidents, learning from excellence

Scenarios

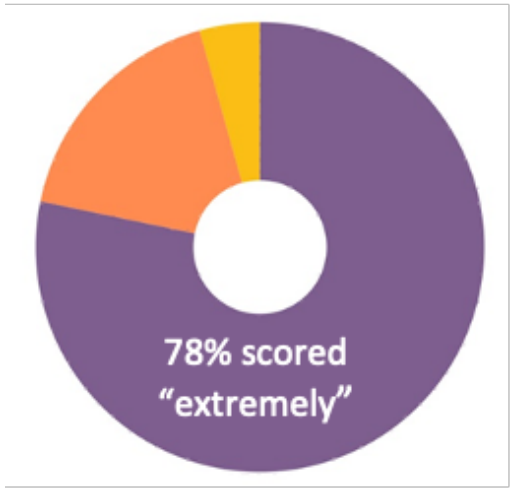
- Patient identification issues
- Major haemorrhage
- Lost needle

Actions

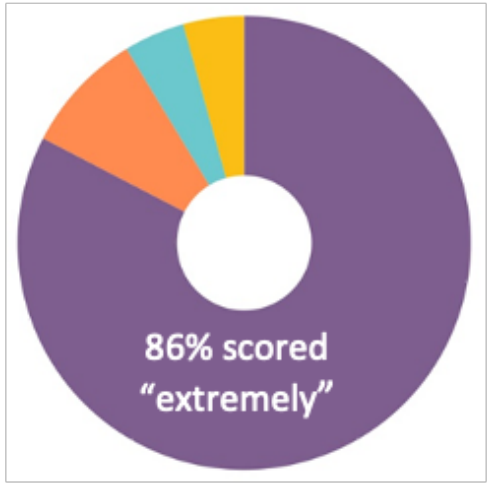
- Maintenance of awareness of consequences in failing to follow procedures
- Early anticipation of issues
- Appropriate delegation
- Simulation training for emergencies
- Reduce distractions/noise in emergency scenario
- Improvement of incident feedback

Feedback: The Headlines

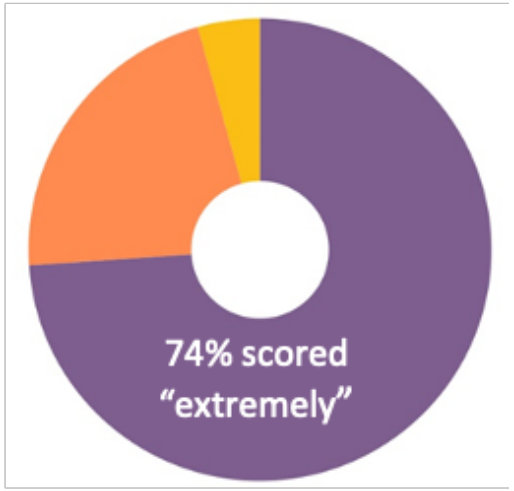
My understanding of human factors has improved



My understanding of effective teamwork has improved



My understanding of civility and the impact of behaviour has improved



"The things that I will take away from the day are…"

- Confidence in dealing and **communicating** with difficult people and In challenging situations
- Assurance in **raising concerns** and checking up on colleagues for wellbeing
- Ability to **maintain civility** among team members despite pressurised and difficult situations

Overview of curriculum modules

Curriculum structure

Curriculum level 1	Curriculum level 2	Curriculum level 3		Curriculum level 4		Curriculum level 5
1.1 Essentials for patient safety	2.1 Access to practice: systems thinking and risk management	3.1 The safety landscape	3.6 Human factors and clinical practice	4.1 Managing human performance variability in patient safety	4.5 Risk evaluation in clinical practice	5.1 Integrating human factors
1.2 Essentials of patient safety for boards and senior leadership teams	2.2 Access to practice: human factors and safety culture	3.2 Systems approach to patient safety	3.7 Non-technical skills in clinical practice	4.2 Task analysis and support	4.6 Mapping techniques to identify risks to patients	5.2 Risk, escalation and governance in patient safety
		3.3 Patient safety regulations and improvement	3.8 System-based approach to learning from patient safety incidents	4.3 System-based interventions in patient safety incidents	4.7 Designing for systems safety	5.3 Creating a culture of patient safety
		3.4 Organisational culture and learning	3.9 Avoiding blame and creating a learning culture through a just culture approach	4.4 Safety II and resilience	4.8 Process reliability and safety assurance	5.4 Part 1 The safety case
		3.5 Patient and public involvement in safety	3.10 Medico-legal and professional responsibilities		4.9 Evaluating safety culture	5.4 Part 2 The safety case

Note: the ordering and numbering of the curriculum levels 3-5 necessarily differs from that of the five domains of the original syllabus (see diagram on page 79 to see how the syllabus domains and curriculum modules relate to each other).

Human factors | Risk management | Safety culture | Systems thinking

How to make this fully accessible and Sustainable

- Increased Funding
- Faculty development
- Trained educators
- Trained Safety Specialists
- Trained ergonomists
- Built into services as business as usual
- Safety Culture
- Linked to National Patient Safety Curriculum