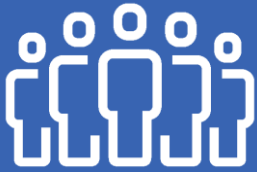




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## ABOUT THIS MODULE



**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.**

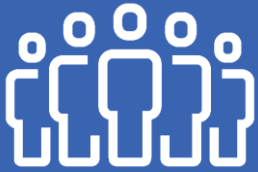
### What is the patient safety impact of this module?

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.



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## SESSION OUTLINE



**COLLECTIVE LEADERSHIP FOR  
SAFETY SKILLS**



## 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.

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## COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

(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.

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## 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.)



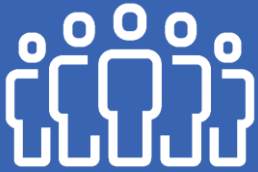
### 4) Close of session (10 min.)

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.



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## HANDOUTS



**COLLECTIVE LEADERSHIP FOR  
SAFETY SKILLS**





## 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



## 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		

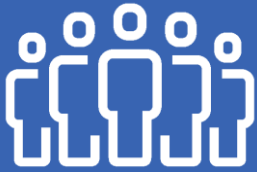


Source: Adapted from the H-PEPSS, Health Professional Education in Patient Safety Survey



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# 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				

