



Co-Lead

ABOUT THIS MODULE



HIGH RELIABILITY AT TEAM LEVEL



HIGH RELIABILITY AT TEAM LEVEL

What is the goal of this module?

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

What is the collective leadership focus of this module?

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

What areas of team behaviour does this module focus on?

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



Who is this module for?

All team members.

What is the patient safety impact of this module?

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

References

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



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SESSION OUTLINE



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SESSION OVERVIEW

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

ADVANCE PREPARATION

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





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START OF SESSION

1) Introduction (5 min.)

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

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

2) Icebreaker (5 min.)

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

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

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

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

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4. Group discussion (10 min.)

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

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

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

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

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

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



5. Team discussion (30 min.)

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

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

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

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

6. Close of session (5 min.)

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



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FACILITATOR NOTES FOR PRESENTATION



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



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- 7) Reflection and discussion exercise (see slides/session outline)
 - Team members should reflect individually on the question presented for 2 minutes, followed by 3 minutes of discussion in pairs or small groups)
- 8) High reliability organisations share some common characteristics.
 - They strive to do zero-harm and operate entirely error free.
 - There are systems and routines in place to minimise the risk and/or consequences of inevitable human error.
 - Authority patterns are based on functional skill and expertise, rather than formal hierarchical rank – especially in times of high-tempo. In emergencies, the authority patterns are based on pre-determined, pre-programmed allocation of duties, which requires simulation and practise.
 - And they encourage the reporting of errors, as well as the discussion of near-misses and potential errors, as these provide insight into potential system weaknesses. Any error reported is discussed in order to learn as much as possible to avoid future more serious errors. This requires an environment with a no-blame culture where staff feel safe reporting or bringing attention to any and all incidents.
- 9) Five key processes have been identified that underlie high collective safety awareness and high reliability in teams. These are:
 - Preoccupation with failure, which means that all team members are consistently aware of, thinking about, and preparing for the potential for failure
 - Reluctance to simplify interpretations, which means that team members avoid simplifying their understanding of how and why things succeed or fail in their environment, but seek to discover the underlying mechanisms and challenge assumptions.
 - Sensitivity to operations, which essentially means “situational awareness” – awareness of context and how that may impact on safety.
 - Commitment to resilience, which means coping with, containing, and bouncing back from mistakes.
 - And deference to local and situational expertise rather than formal rank, especially in high-tempo or emergency situations.
- 10-11) Group and team discussion – see session outline





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HANDOUTS



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1: PREOCCUPATION WITH FAILURE

What it is:

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

How to achieve it:

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





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2: RELUCTANCE TO SIMPLIFY INTERPRETATIONS

What it is:

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

How to achieve it:

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





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3: SENSITIVITY TO OPERATIONS

What it is:

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

How to achieve it:

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





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4: COMMITMENT TO RESILIENCE

What it is:

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

How to achieve it:

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





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5: DEFERENCE TO EXPERTISE

What it is:

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

How to achieve it:

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





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

