GRS
Global Rating Scale

JAG
Joint Advisory Group
on GI Endoscopy

NHS
Improving Quality

The Productive Endoscopy Unit

Building teams for safer care™

Team Working

This document is for all endoscopists, endoscopy managers, administrators, matrons, endoscopy nursing and decontamination staff and improvement leads

Contents

Purpose of this guide

Endoscopy units in the UK who commit to the JAG Accreditation Pathway are assessed annually. The JAG (Joint Advisory Group) in Gastrointestinal Endoscopy is the body responsible for setting patient centred, workforce and training standards for endoscopy in all sectors and accrediting them. The JAG operates within the Clinical Standards Department of the Royal College of Physicians and its mission is to provide UK wide support not just for endoscopy services but for the workforce ensuring that they have the skills, resources and motivation necessary to provide the highest quality, timely, patient centred care.

This module will help you to improve patient safety in the Endoscopy unit as well as supporting the achievement of the Global Rating Scale (GRS) standards within the Workforce domain to help you achieve JAG accreditation.

The Clinical Quality domain of the GRS is designed to assess the quality and safety of a service without being excessively burdensome. Major functions of this domain are to:

- Respond to the challenges raised by the 2004 NCEPOD report – 'Scoping our Practice'. This report highlighted major issues with quality, safety and appropriateness of procedures
- Reassure the uninformed patient that they will be cared for in a safe and high quality environment.

This module is produced in conjunction with the JAG and is designed to aid achievement of the following GRS standards:

Standard Number 14: Workforce - staff orientation
15: assessment
16: staff cared for
17: staff listened to

STD NO	DESCRIPTION
E. Workforce - E2 Orientation and training	
14.5	A mentor is identified to support each new recruit
14.8	Feedback on training provision is gathered from staff at least annually
14.13	Recommendations from staff feedback on training provision are acted upon within six months
14.16	Adequate resources are identified to meet the education and training needs of the service, and timely training is not constrained by pressure from service work
E. Workforce - E3 Assessment and appraisal	
15.19	Feedback from staff on assessment and appraisal is acted upon within six months
E. Workforce - E4 Staff are cared for	
16.5	There is an ethos of supporting work/life balance for staff
16.11	All staff are invited to provide feedback at least once a year on how well staff are cared for
16.12	There is an agreed plan for managing risks caused by inadequate staffing levels or skill mix
E. Workforce - E5 Staff are listened to	
17.1	There are informal service team meetings
17.4	Team meetings are held at least every three months where staff members are able to contribute views and ideas on improving services for patients
17.5	There is documented evidence that staff contribute views and ideas on improving services
17.6	Staff are valued and their contribution to service development is recognised
17.8	There is documented evidence that staff ideas on improving the service are acted upon
17.13	The team participates in appraisal of policies and strategies and is encouraged to suggest improvements
17.17	There is documented evidence that action is taken in response to staff feedback within three months

The NHS Change Model also advocates teams having a shared purpose to improve outcomes for patients, a connection we sometimes take for granted of those working in the NHS. Our values can sometimes get eclipsed by structures and hierarchy and the Team Working module will help to unite us, to collectively work together to take action on what we hold in common to sustain the NHS through significant financial and quality challenges, to deliver the vision, outcomes and goals for all. Another of the eight components of the NHS Change Model focuses on ensuring teams are engaged and mobilised in an effective, collaborative and strategic way.

Engagement is founded on intentional relationships based around exploring shared values - this module will help teams to focus on building energy for change (see www.changemodel.nhs.uk). More information on building energy for change can be found in The Programme Leaders Guide.

By applying safety techniques taken from aviation and other high-risk industries, this guide will help you to recognise the importance of both the technical skills that you have and the non-technical skills such as communication. It will help you to understand the importance of good team working and the positive impact this has on the quality and safety of care your team delivers.

By implementing this module, you will gain an understanding of how the performance of your team can be enhanced by improved communication. It will show you how implementing tools such as briefing and debriefing can help your team to:

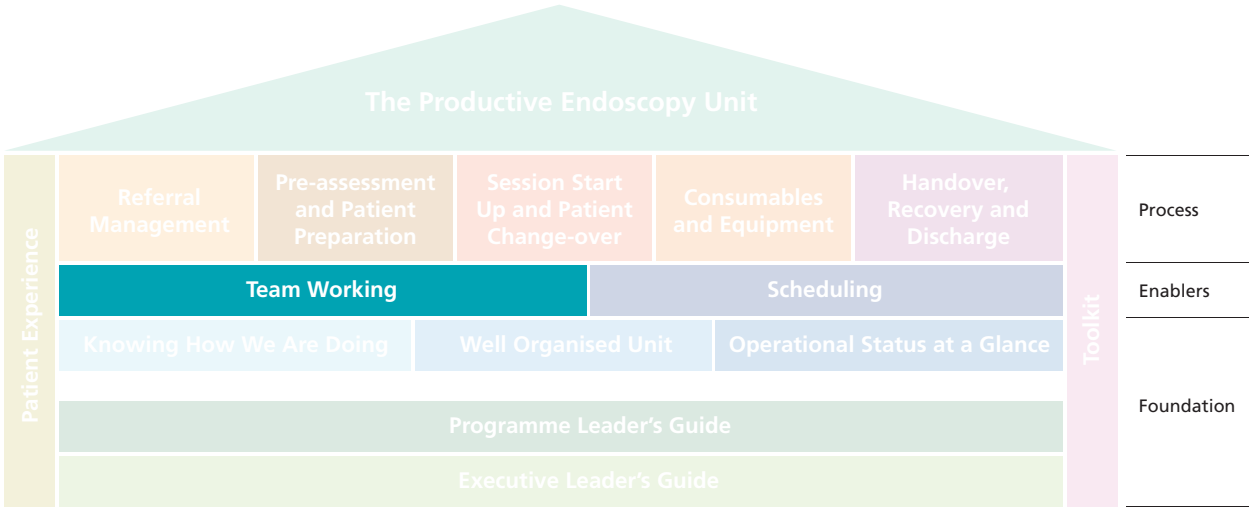
- Create a calmer working environment for staff and patients
- Avoid errors and prevent mistakes from occurring or causing harm to patients
- Reduce hierarchies and give everyone an equal voice
- Create a shared plan for the list to reduce the opportunity for surprises
- Review the list and identify any issues or glitches that can be removed/eradicated.

Better team-working and communication will ensure that everyone in the multidisciplinary team feels able to raise concerns and to ask questions. This not only improves patient safety but also increases staff wellbeing and creates an environment which supports learning and continuous improvement.

> Team working has enabled staff to improve the service to patients. The adapted WHO (World Health Organisation) checklist we are now using will help us to maintain a much safer team approach.

Endoscopy Unit Manager, Barts Health NHS Trust

These modules create The Productive Endoscopy Unit



1. What is the Team Working module?

What is it?

The Team Working module focuses on enhancing multidisciplinary team-working within endoscopy. By developing and implementing communication tools, such as briefing, debriefing, 'huddles' and the World Health Organisation surgical safety checklist (WHO checklist), teams can improve patient safety by reducing mistakes and errors and create a better working atmosphere for the endoscopy team. This can lead to an improvement in the safety culture in your endoscopy unit and reduce glitches, errors and avoidable harm to patients. Improved team working also has a positive effect on staff morale and efficiency. Teams may even then take this further, by working with other departments or wards to improve communications and reduce waste in the system.

Why do it?

- Improve patient safety by:
  - Continuously reviewing how you perform as a team
  - Introducing clear concise methods of communication – reducing the likelihood of misunderstanding
  - Providing all team members with a way to highlight their concerns when they think an error or incident may occur
  - Providing an opportunity to discuss and prepare for issues that may arise throughout the day.
- Enhance team communication by:
  - Understanding the factors that impact your own and your team's performance
  - Understanding yourself and your colleagues better and how you affect each other
  - Becoming aware of factors which undermine concentration and situation awareness
- Create a better working atmosphere and improve staff wellbeing
- Reduce wasted time through more efficient lists
- Create energy for change and drive for continuous improvement

> We have different people with different initiative and different intensity: different personalities make a difference to how smoothly the day runs.
>
> **Myrna Carreon**, Portsmouth Hospitals NHS Trust

What it covers

- An introduction to some aspects of human factors and non-technical skills definitions
- How to run a team working session for your endoscopy staff to help raise awareness of how humans make errors and how you can prevent them or reduce their impact
- How to implement some key processes:
  - Briefing and debriefing/huddles
  - Adapting and successfully implementing the WHO checklist.

What it does not cover

- This module does not tell you what to implement, but provides you with a process to evolve, test and implement your own methods to improve team working
- Skill mix and role redesign
- How the design of machines and the interface between man and machine can influence error rates (ergonomics)

> It's not just the senior staff leading this, it's a team approach.

Nicky Taggart, Endoscopy Manager, Royal Liverpool & Broadgreen Hospitals NHS Trust

> When we first started using Productive Endoscopy, I thought it was just about scheduling more patients and being more productive but the less obvious things that came out of it were more important, like getting ideas from the grass roots has a massive impact on morale.

Dr Ed Seward, Whipps Cross Hospital, Barts Health.

Learning objectives

After completing this module it is expected that your team will:

- Understand the impact that individual behaviours can have on team dynamics and performance
- Understand how they can contribute to the avoidance of errors and improve patient safety
- Understand the importance of, and be able to:
  - Conduct a brief and debrief and learn from experience
  - Apply the principles of the WHO checklist
- Implement and maintain local systems and procedures to support brief, WHO checklist and debrief
- Improve the quality of communication within the team using communication tools as per the toolkit.

What is team working and human factors - What is a team?

'A set of people working together' Oxford English Dictionary

A team is not only a set of people working together: it is a set of people working towards a common goal. In healthcare the collective common goal should always be focused on the patient. Non-technical skills (such as how to communicate effectively) will enhance individual and team performance to the benefit of the team as a whole, and make a significant contribution towards improving patient safety.

There are big differences in perceptions of team working. Doctors usually rate the communications within their team much more highly than nurses in the same department. This is partly due to the hesitancy of many nurses to speak up when they think something might be going wrong. That is why the application of communication tools can enhance team performance. This module covers some of the tools that can reduce the impact of human factors on individual performance and enhance the performance of the team as a whole.

Learning from other industries

There is compelling evidence that improvements in safety within healthcare depend on the application of scientific evidence about human performance[1]. Current research demonstrates that factors – human factors – known to affect the performance of healthcare professionals are similar to those in other high-risk industries, such as aviation, oil and nuclear power[2]. Many of these industries have a long history of learning lessons from incident investigation which take account of human factors and team performance. Healthcare is a relatively late starter.

> ‘It is only relatively recently that attention has been focused on patient safety as an issue. Despite the relatively high level of risk associated with healthcare – roughly one in ten patients admitted to hospital in developed countries suffers some form of medical error – systematic attempts to improve safety and the transformations in culture, attitude, leadership and working practices necessary to drive that improvement are at an early stage.
>
> **Chief Medical Officer Sir Liam Donaldson in his review Good Doctors, Safer Patients[3]**

A high-risk industry that is most frequently compared with healthcare is aviation. For several decades controlled studies of the performance of pilots has been carried out. Research has shown significant similarities in the relationship between individual and team performance and outcomes. This applies in aviation and in other high-risk industries, particularly in the non-technical skills of experts, such as leadership, team working, situation awareness, decision-making and structured communication. There is now an unprecedented opportunity for clinicians – doctors, all endoscopists and nurses – to learn about the psychology of human performance and to use it to achieve real improvement in patient outcomes.

1. Giddings AEB and Williamson C. The Leadership and Management of Surgical Teams. R Coll Surg Eng London 2007.
2. Flin R, O’Connor P and Creighton M. Safety at the Sharp End: A Guide to Non-Technical Skills. Ashgate, Aldershot UK 2008.
3. Good Doctors, Safer Patients. A Report by the Chief Medical Officer. Department of Health 2006.

Leadership in endoscopy

In the endoscopy unit there is generally no clear single leader.

- The nurse in charge (sister, team leader, etc) leads on staffing, organising equipment and the running of the unit and the lists
- The clinical lead will head on all clinical issues
- The endoscopist leads the conduct of the endoscopic procedure
- For GA lists the anaesthetist leads on supporting and sustaining the patient through the procedure

Although the team is essential in endoscopy - inevitably leadership is important and a strong clinical and nursing lead are vital components of a productive endoscopy unit. Each leader has a lead role at different times and for different elements. In this shared leadership environment team working becomes paramount to improve safety and deliver high performance. Each has a different perspective on what is going on, and this needs to be shared among all members of the team.

"I see the role of the clinical lead as being split into three. First and foremost is one of leadership - the lead has to take responsibility for strategic decisions in terms of endoscopy provision, answer specific endoscopy queries or complaints, and arbitrate in any disputes. It is important to lead by example, and I think it is difficult to be an effective clinical lead if they are not spending a significant time on the shop floor - scoping patients, picking up on issues as they arise and generally being as visible as possible. Staff morale can be poor in endoscopy - the unrelenting pressure can wear staff down and this needs to be addressed and dealt with by effective leadership.

"The second is to be a powerful advocate of clinical governance. The global rating scale makes this very easy - the rules for what is and is not acceptable are very clear and a good department will be able to discuss these openly. GRS is designed for all of us to deliver a safe, effective and patient-focused endoscopy service and the entire service needs to be orientated with this in mind. The clinical lead needs to ensure that this is at the very heart of the service and not just something that is addressed on an audit afternoon.

"The third important aspect for any clinical lead is to interact and support the nursing lead at every step. There are significant advantages to being a consultant, one has much more 'pull' over senior management staff and it is important to use your influence as much as possible to support your nursing colleagues. Senior nurses very much appreciate it when a consultant intervenes on behalf of a nursing colleague - it speaks volumes. A good nursing lead will thrive with this support and will be in a much better position to deliver service improvements which will allow a better service for patients and a more efficient and happier work place - everyone wins!"
Dr Edward Seward, Clinical Lead, Whipps Cross Hospital, Barts Health NHS Trust

What do we mean by human factors?

Accidents and errors in healthcare are common. Estimates suggest that around ten per cent of patients suffer harm at some point in their admission and that 50 per cent of these errors are preventable. More are caused by human factors than by technical errors. Errors of omission (e.g. not giving a drug) are far more frequent than errors of commission (e.g. giving the wrong drug or wrong dose). This is particularly important in the administration of the correct bowel preparation or managing anti-coagulation therapy in patients undergoing endoscopic procedures.

Eight key human factors

In endoscopy, safety and reliability is affected on a daily basis by the fact that human beings run the system. All humans are fallible, i.e. liable to make mistakes. Therefore any system that relies on human memory will fail. Eight important human factors have been identified to explain this. We each have some ability to control the impact of these factors, and therefore have a positive or negative effect on the team.

These eight areas of human performance are sometimes referred to as non-technical skills and how to communicate effectively, to distinguish them from technical skills and such as how to perform a procedure.

A list of further reading is provided in Appendix 2.

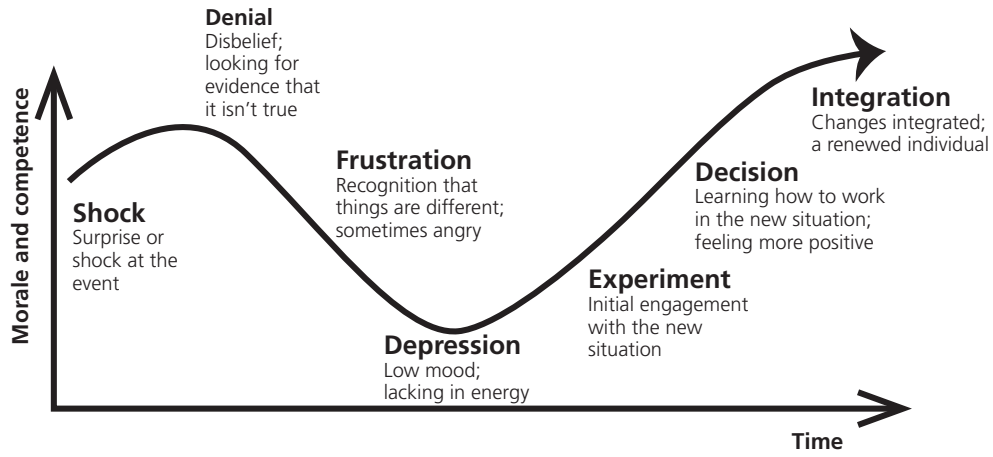
Eight key human factors - For a more detailed summary of each factor see Appendix 1.

The Kubler-Ross Change Curve

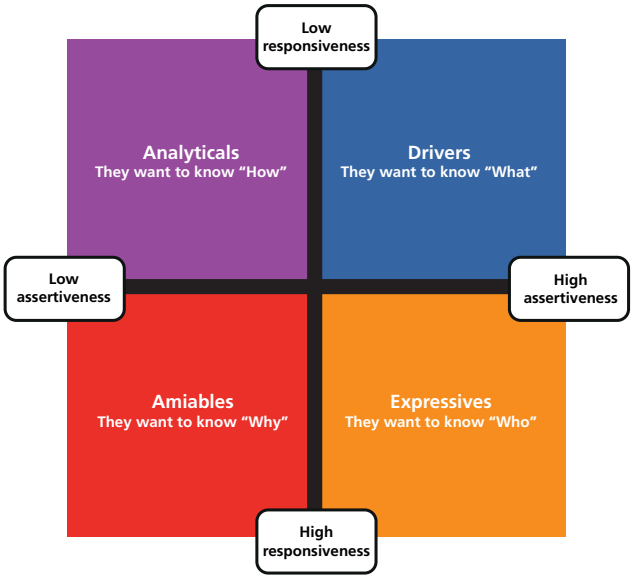
This process was developed by Elizabeth Kubler-Ross on the basis of her work with people undergoing change. It identifies the seven typical stages that people go through in response to change. To manage the process effectively it is essential that managers can first identify the stage that their team, and individuals in it, are at and then adopt appropriate strategies.

> Let's wake up to human factors – let's make a difference.
>
> **Martin Bromiley**, airline pilot, widower

The Kübler-Ross change curve

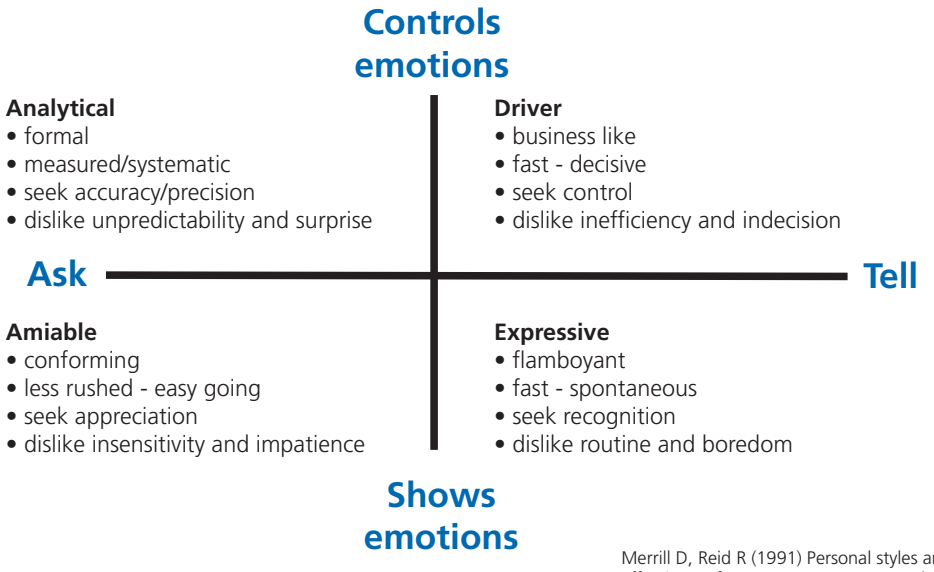


Merrill Reid Social Styles



Psychologists Merrill and Reid advocate that there are four social styles that affect the way that people interact with each other. Each personality type has different strengths and weaknesses. No matter what personality type you are, you need to fully understand the other three. Learning more about each of the personality types and understanding your own style, will help to develop versatility in dealing with others.

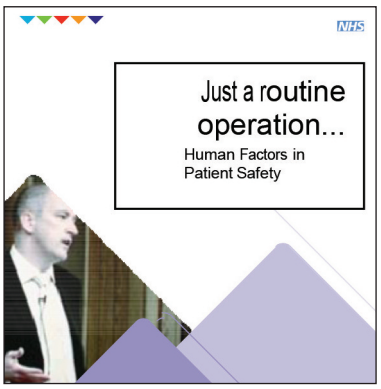
Personal Styles



Merrill D, Reid R (1991) Personal styles and Effective Performance, CRC Press, London

To learn more about the importance of human factors in both healthcare and aviation, watch 'Just a Routine Operation' at www.youtube.com/watch?v=JzlvgtPlof4

The Productive Endoscopy Toolkit and Executive Leader's Guide also provides more detail and exercises to help build understanding.



2. How will you do it in your endoscopy unit?

Why do we need a change model?

Though current models of improvement and change that have emerged in health over the past decade have delivered benefits, they have also resulted in fragmentation and significant duplication of effort, with a multiplicity of different change approaches being used.

The model brings together collective improvement knowledge and experience from across the NHS into eight key components, which applied together, makes change happen.

Shared purpose connects us with our commitment and contribution to our core NHS values that bring people into the NHS to deliver vision, outcomes and goals for all.

We need to know what problems we are trying to solve, and why it matters, the meaning, and a clear direction towards a worthwhile purpose.

Are we **engaging and mobilising** the right people? Engagement is founded on intentional relationships based around exploring shared values, at every level in the system. Engagement and mobilisation is about accelerating and aggregating the impact of our improvements – enhancing work that is often already underway.

Leadership for change is the description for the approach, skills and behaviours needed to lead significant change and underpins all aspects of the Change Model.

We need to accelerate the speed and extent of the **spread and adoption of innovation** in order to deliver the cost savings required while improving the quality of care we deliver. Everyone who works in the NHS needs to actively share and adopt great practice from others.

To begin to understand and improve team working in a manageable way, this module has identified three interventions:

- Briefing and debriefing (sometimes called 'huddles')
- WHO checklist.

Each intervention follows a Plan Do Study Act (PDSA) model for improvement or the 'A3 thinking' format; both of which are problem solving methodologies – see The Productive Endoscopy Unit Toolkit

Different groups of staff will be involved in the different interventions and the time it takes to implement and realise the benefits will vary. As a result it is possible to begin working on both simultaneously.

A3 thinking for problem solving

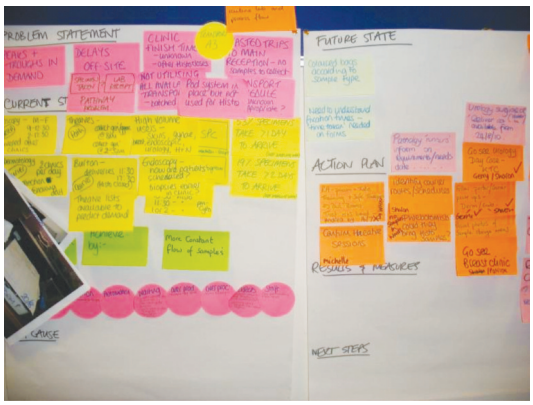
Put simply, A3 thinking is a structured way of problem solving, following a series of standard steps, with rigorous application of PDSA cycles, which is data driven with an output as a concise, condensed document or A3 report (11 x 17 inch paper).

It may utilise tools such as Pareto analysis, the five why's analysis and the fishbone (cause and effect) tools to:

- Understand the problem
- Identify the root cause(s)
- Develop countermeasures
- Create an action plan.

Why use A3 thinking?

- Proven problem solving methodology:
  - Visual
  - Simple (pen drawn)
  - Logical (follows recognised PDSA methodology)
  - Countermeasure, not containment ("band aid")
  - Move towards ideal system
- Used to document and share the learning
- Helps to standardise the new method



TITLE: A3 Problem Solving	VERSION: AUTHOR: DATE:
PROBLEM STATEMENT: PLAN	FUTURE STATE: PLAN
CURRENT STATUS: PLAN	ACTION PLAN: DO
GOAL: PLAN	RESULTS AND MEASURES: STUDY
WASTE IDENTIFIED: PLAN	
ROOT CAUSE ANALYSIS: PLAN	NEXT STEPS: STUDY


Whipps Cross University Hospital
NHS
UNIT BOOKING FORM

3. Team working session

Holding a team working session is the best way to raise awareness and engage the endoscopy team in this module within The Productive Endoscopy Unit programme. A successful team working session will ensure that a large multidisciplinary group of staff spend time together, sometimes for the first time, to understand more about team working and how they can work better together. They should leave the session with a clear action plan and feel enthused to make changes in the way they work together.

Aim

- To convince the team that care can be made safer and how frequently errors occur
- To learn how improved team working can reduce the frequency of errors and the impact of human factors
- To recognise the significant benefits this brings to patients and staff

Objectives

- Demonstrate how humans are fallible, i.e. liable to make mistakes
- Increase awareness of the influence of human factors on performance and safety
- Develop the knowledge, skills and strategies to overcome human factors
- Identify enthusiasts who will act as champions
- Develop an action plan to help the team get started

> The Transformation team at Guys and St Thomas' is supporting the Productive Endoscopy work that is underway by sharing our experiences of The Productive Operative Theatre. The Team Working Module was instrumental in bringing all the stakeholders together and creating a shared vision and plan for the future.

Christopher Kennedy, Transformation Team at Guys and St.Thomas' NHS Foundation Trust

Most Trusts have a transformation team that can help run team working events.

Example of team working workshop run by Guys and St. Thomas' Transformation team

Workshop aim - to create a team working environment in Endoscopy that lives up to the state-of-the-art environment, in order to deliver the best possible service to patients

Objectives:

- To identify what strengths and good experiences the department already has
- To identify what ideal team working across endoscopy would look like within teams and across the unit
- To generate ideas on what could be done to reach the ideal state
- To agree simple actions collectively to improve team working.

The Transformation Team led the workshop where all endoscopy staff (doctors, nurses, administration, decontamination etc.) attended and were split into groups. They were asked to look at the following using 'appreciative thinking':

DISCOVER - What are the factors that create our Golden Moments?
DREAM - Our vision of the future
DESIGN - How should the department work together?

Feedback and momentum is crucial to keep the positivity current following the workshop. Commitment was made by managers and clinicians to adhere to the suggestions made by staff at the workshop.

> "Pick up on ideas quickly or they will fall away."
>
> **Nicky Taggart**, Endoscopy Manager, Royal Liverpool and Broadgreen Hospitals NHS Trust

Organising the session

- Decide whether you have the skills and knowledge within your organisation to run this session or whether you will need external support. To help you do this:
  - Seek expertise in human factors within your organisation, a likely department may be in a simulation suite, clinical education department, training department or nearby psychology faculty.
- Book the date well in advance, at least six to seven weeks ahead so that clinicians will be available to attend
- If you decide to run the session internally, you will need to schedule at least a half day session. It is a good idea to use an existing commitment such as an audit session if possible, as these are generally suitable times for all clinicians to be available. Running a whole day would be even better, provided you have presenters who are strong facilitators and there is enough time devoted to interaction and group discussion. Use mixed media – DVDs and audio as well as presentations
- Design and distribute an invitation to the session. You want to gain maximum attendance at this session, so it is important to think about strategies that will grab the attention of the reader. For example, some quotes from key clinicians will help demonstrate leadership commitment. Your communications department may be able to help you
- Ideally book a venue that is off-site, with sufficient capacity to allow attendees to sit around tables ('cabaret style')
- Think about room size and layout. Cabaret style seating allows teams to sit together and encourages them to interact during the session
- Provide food and beverages. This may be the first time that the whole team has attended a group event together. The informal parts of the day will contribute to engagement and better team working and help create an improved multidisciplinary team culture
- Encourage teams that work together to sit and work together during the session
- If you hold your session in the morning, closing the session in time for lunch will allow attendees to continue their discussions and network with each other
- Designate someone to take photographs – take lots during the session for story boards and newsletters following the event

Communication

Communication of the workshop needs to be both by invitation and by word of mouth. Try to identify a champion or leader in each professional group who will be able to influence their colleagues to attend. Executive support and leadership will also help generate good attendance, especially if other clinical activities are affected.

Resources

- Laptop, projector, and screen for presentations and loudspeakers for showing DVDs
- Flipcharts, notepaper, sticky notes and pens
- Name badges or blank name labels
- The Productive Endoscopy Unit posters
- Camera

Who should attend?

It is important that a multidisciplinary group of staff attend this session. The attendance should include endoscopy nurses (including pre-assessment), gastroenterologists, respiratory physicians (if your unit does bronchoscopy), urologists (if your unit does cystoscopy) and colorectal surgeons (including trainees), all endoscopists, anaesthetists if your department regularly performs GA lists, administrative, reception and decontamination staff, and anyone else you consider to be involved in helping to deliver safer care in the endoscopy unit. You should aim to include at least two-thirds of the staff that will be affected by any changes you plan to implement in your endoscopy unit.

The impact is further enhanced if the session can be followed up by some coaching of teams in their working environment to practice and improve these new communication skills.

> I had been having a discussion with Sister on the department about a problem that we had experienced of H pylori results not being recorded properly, resulting in the patient having to return for a repeat test. As the discussion began, staff nurses, HCAs and an admin clerk, started to get involved. I was delighted to see a frank, lively and open discussion occurring between all staff, they were interested and motivated and wanted to come up with the best ideas and solutions. As a manager it was fantastic to see the staff so enthused and engaged. I believe that this is a direct result of involving everyone in the productive process as they know their opinion really matters.
>
> **Nicky Taggart**, Endoscopy Unit manager, Liverpool and Broadgreen Hospitals NHS Trust

Running the team working session

Below is a suggested agenda for a team working session. Depending on availability of skills and resources to run this session, adapt it to your local situation and timing.

Approx time	Who	Item	Notes
10 mins	Senior clinical leader	• Welcome and introduction • Outline of safety in healthcare	Demonstrate features of briefing
15 mins	All	Why safety is important	A training DVD e.g. • 'Just a routine operation' • 'The Journey'- Royal College of Surgeons • 'Is 99% good enough'
25 mins	Small groups	Small group discussions on our own experience of mistakes or near misses	Introduce this interactive part by telling a story, then encourage people to work in small groups to tell personal stories
60 mins	Expert on human factors	• Why humans make mistakes • Learning from other high risk industries • Examples from healthcare	Useful to illustrate using short film clips such as the basketball film at *www.youtube.com/watch?v=vJG698U2Mvo,* changing colours card game, smoke-filled room experiment. Some of these are freely available on the internet
15 mins	Small groups	Revisit your own safety story	Small group discussions to see where understanding of human factors helps to explain what happened
30 mins	Senior clinical leader	• team working • Review of the evidence in healthcare • An overview of the key tools: --	Introduce the two tools Show relevant DVD

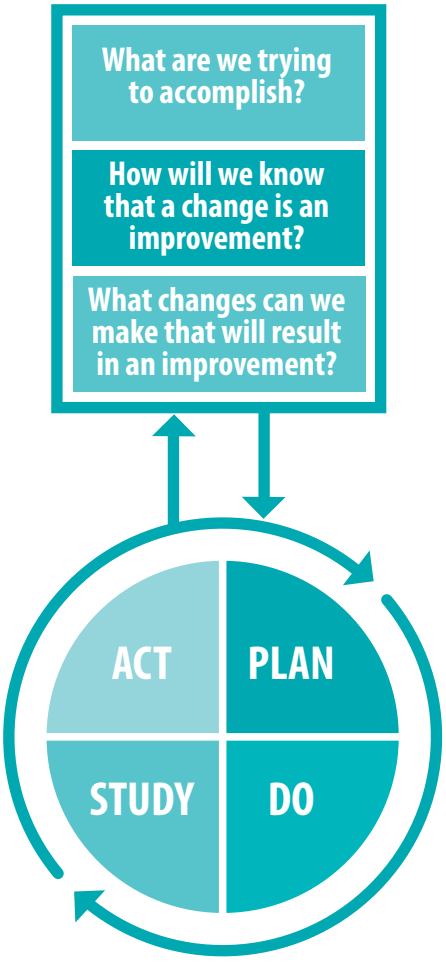
Approx time	Who	Item	Notes
15 mins	Improvement leader or clinical leader	Implementation: the need for local adaptation and customisation	• Introduce the model for improvement, outline the three questions, then describe rapid improvement cycles • Introduce the NHS Change Model
20 mins	Groups	Action planning	Ask each team to agree: • When they are going to begin testing each tool, what date? • Who will lead? • How they could measure the impact?
5 mins	Facilitator	Debrief the session	Demonstrate features of debriefing by debriefing the team working session: • What went well? • What would make it even better?

4. The three questions

Before you start implementing the team working module, make sure you are clear about the approach you are going to take.

Take time to read the module fully, so that you understand the full scope of what is involved. Form a small module team, and chose one or more module champions (ideally one from each key professional group). These champions may have been identified when you held the visioning workshop (see The Productive Leader's Guide) or at your team-work session (see section 2 of this guide).

Ask the team to work through the three key questions in this section.



1. What are we trying to accomplish?

The key idea in answering this first question is to provide an aim for your improvement that will help to guide and keep your efforts focused. Improvement requires setting aims; you will not improve without a clear and firm intention to do so. Your aim for the team working module should be time-specific and measurable, or SMART.

Setting a SMART aim
As a team set an aim for what you want to achieve from this module according to SMART principles:

Simple – give the aim a clear definition (e.g. reduce turnaround time)

Measurable – ensure that data is available

Aspirational – set the aim high to provide a challenge to the team

Realistic – take into consideration factors beyond your control which may limit your impact

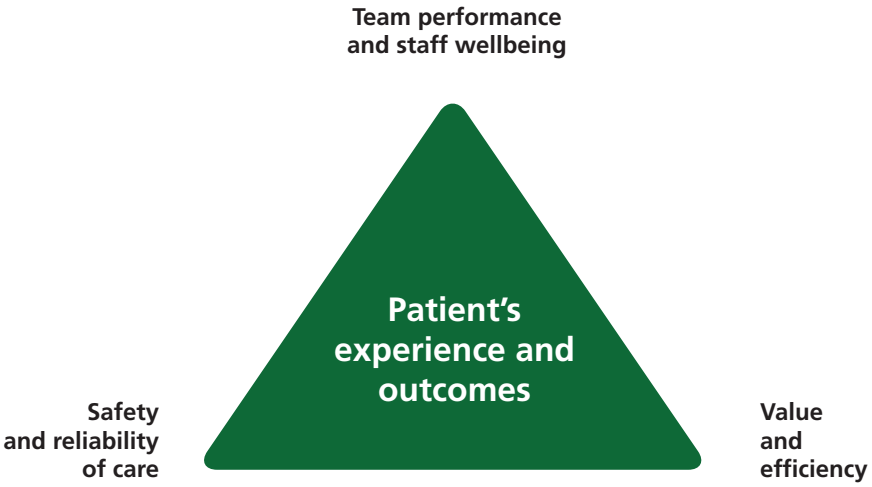
Time bound – set a deadline.

You have already developed a vision for your programme; ask the team how the team working module will contribute to delivering your overall vision.

Record your thoughts on a flipchart. Once agreed, communicate the module aim on Productive Endoscopy notice boards showing how it links to your vision.

2. How will we know that a change is an improvement?

As part of the Knowing How We Are Doing module you should have agreed a balanced set of measures across the four programme aims.



How will your improvements from using the team working module be represented in the balanced set of measures?

If it is not explicit you will need to include a new 'intervention' level measure or measures that will capture the impact of this module. The suggested measures sheet and driver diagrams in Knowing How We Are Doing will give you ideas about how to do this. Also see the measures and driver diagram on the Periop Care (generic or theatre specific) page of the Patient Safety First website at www.patientsafetyfirst.nhs.uk

The module measures workshop

You may want to run a module measures workshop with the team that is going to be involved with this module. A suggested set of slides for this session is available as part of the Toolkit that accompanies these modules.

The aims of this session are to:

- Refresh the team's understanding of how to use measurement to drive improvement
- Understand how the team working module fits into your agreed balanced set of measures
- Identify measures for this module
- Decide how to collect, analyse and review the information
- Complete a measures checklist for the module.

Once agreed, start collecting, analysing and reviewing data for your balanced set of measures.

Things to consider

Patient safety is adversely affected by mistakes and errors made by endoscopy staff or endoscopists. It is useful to obtain local data through a case notes review using the 'global trigger tool'. Incident reporting notoriously underestimates the number of errors occurring. In a recent study only six per cent of errors in patent care were actually reported.

Team working measures

Don't forget that some of the high-level outcome measures, such as reduced complications, will be hard to collect and may not show improvement for a considerable period of time. Process measures, or 'intervention' level measures such as the percentage of endoscopy lists with a team brief, are generally immediate and easy to collect. There is now strong evidence to show that such processes are associated with improved outcomes. It is also useful to gather data about staff reactions, preferably on a structured questionnaire, about how they feel about the process and how confident they were that they had all the information they needed at the start of the list.

There are more complex techniques for observing team behaviours and dynamics, but these generally require additional training and resources.

TIP: Here are some ideas of what you might wish to collect. You may already be collecting some of these. Your choice may be influenced by other modules.

- **Percentage of lists for which a briefing and debriefing occur**
- **Percentage of procedures where your version of the WHO checklist is completed**
- **The confidence of endoscopy staff that they had sufficient information at the start of the list**
- **Number of glitches per day/week/list**
- **Staff sickness/absence**

The underlying culture of your organisation is a key determinant. If you want to measure the team work climate or culture, you may wish to carry out an engagement survey using the survey tool in The Productive Endoscopy Unit Toolkit.

Safety and reliability measures

Serious untoward incidents are not a useful measure of safety[1]. They are valuable in helping to identify areas that need attention to prevent future errors but, as the culture of safety improves, you should experience an increase in reporting as staff become more confident that reports will be used for learning not for judgement.

A simpler measure is a glitch count compiled from the issues and problems identified in debriefing (see The Productive Endoscopy Unit Toolkit). The glitch count is an important link between the team working module and the other improvement elements of the programme. If the programme team are not seen to be taking glitches seriously and taking steps to find and implement countermeasures, enthusiasm for debriefing will quickly diminish. Categorise the glitches so that you can uncover particular areas that need attention.

It is also useful to obtain local data through a case note review using the 'global trigger tool'. The underlying culture of your organisation is a key determinant, and you may wish to carry out a survey using a safety attitudes questionnaire.

1. Sari AB et al: Sensitivity of routine system for reporting patient safety incidents in an NHS hospital BMJ 2007; 334:79-81.

3. What changes can we make that will result in an improvement?

Having read the module and agreed on a clear aim, start to think about the changes you could make within your department that will result in improvement.

You will now have an overall idea of what you want to achieve from the team working module. With your team, work through a number of Plan, Do, Study, Act cycles, testing the implementation of practical ideas that will improve communication and the way the team works together. Start small with one team on one list, then learn and develop before working up to a full roll-out across the specialty or department. Remember, a solution that works well in one specialty may still need further adaptation for another specialty or department.

This module will focus on implementing:
- Brief and debrief
- WHO checklist.

Other ideas that will improve team performance include:
- Reducing interruptions and distractions (such as telephone calls, people entering or leaving the treatment room, music)
- Directing requests to a named person (rather than a general request to which no-one responds)
- Read-back (repeating a request back, such as the assisting endoscopy nurse repeating back that a specific polyp snare is requested)
- Checklists (not just the WHO surgical safety checklist, e.g. items to be checked on the resus trolley)
- Suggesting taking a break when fatigue may be impairing performance
- Encouraging all staff to speak up if they are concerned that an error might occur
- Using critical language to raise concern, such as 'I need clarity' or 'I am concerned'
- Other communication tools for escalation such as PACE: Probe – Alert – Challenge – Emergency.

These ideas can be introduced and discussed at the team working session.

The three questions – milestone checklist

When you have completed **all** of the items on this checklist you will be ready to move onto the next sections:

- Briefing and debriefing
- WHO checklist.

Checklist	Completed?
Read the module	
Decided and communicated a clear aim for the module	
Held a module measures workshop	
Decided how you will measure the improvements	
Identified changes that could be made	
Decided which changes to test first	

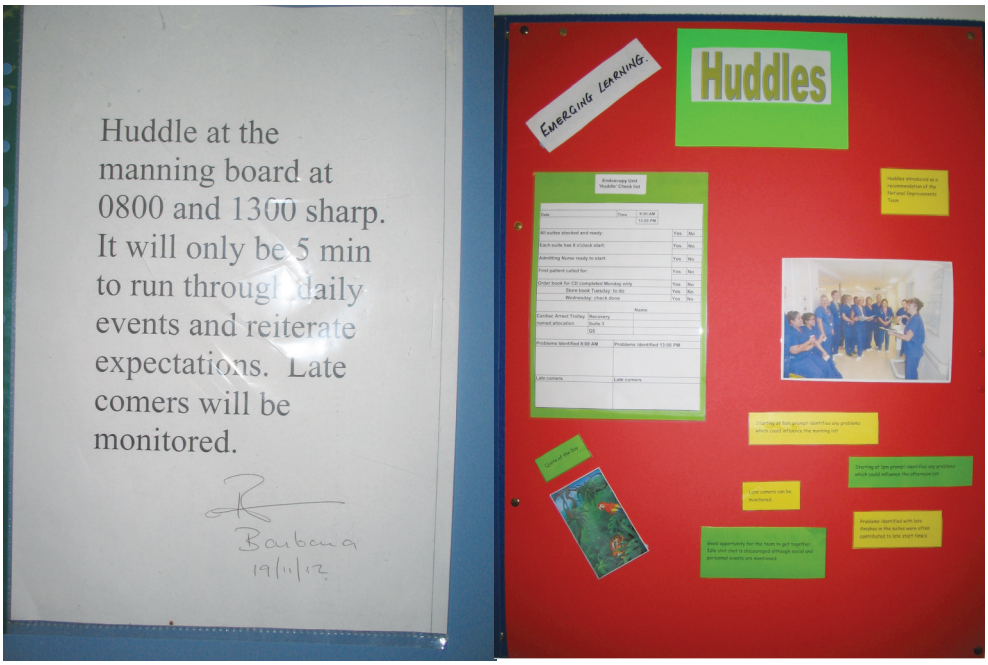
Effective team work checklist	Tick if yes
Did all of the team participate?	
Was the discussion open?	
Were the hard questions discussed?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not individuals?	

5. Briefing, debriefing and huddles

What is a briefing?

Briefing is a short, open team discussion which takes place at the beginning of the endoscopy list. It enables the team to rapidly form, plan for the expected and prepare for the unexpected. Everyone needs to know what should happen, what could go wrong, what could cause the team to experience a 'bad day'; this is referred to as situation awareness.

The aim is for the team to have a shared mental model of what is going to happen, and enable everyone to have a voice and share their knowledge and experience.



Example of a huddle at Portsmouth Hospitals NHS Trust

What is a huddle?

A 'huddle' is a short, focussed daily/each shift meeting with the sole aim of achieving success towards the team goals. It is conducted around the main data board so that 'visual' cues are used to discuss performance against aspiration.

Staff should stand in a semi-circle around the board so that everyone can see each other and all can see the metrics being discussed. Standing ensures that a 'sense of urgency' to get back to work is maintained. Typically, the team would limit their discussion to the 3 Cs:

- What is the concern?
- What is the cause of it?
- What is the countermeasure to be implemented today?

The sort of issues discussed would be:

- Staffing shortages (sickness) – cover to be provided
- Any issues with equipment downtime (washers/dryers) - interim measures for scope turnarounds
- Reasons for late starts to lists (from start stop audit data)
- Percentage compliance of completed paperwork (administrative and nursing teams)
- Patient satisfaction rates (plaudits 'v' complaints)
- Room utilisation audits
- Hand washing compliance
- Number of dropped slots/sessions
- DNA/cancellation rates etc.

The huddle should include anything that could potentially stop the smooth 'workflow' of that shift or get in the way of achieving the KPIs.

A huddle will typically take approximately ten minutes if using the structure of 3Cs for each problem. If an issue is likely to take longer to solve, the problem should be assigned to someone to liaise with others outside of the huddle and resolve it immediately. The solution will be reported back at the next shifts huddle. When the team are adept at problem discussion and solving in ten minutes, the chances are they will begin to attend huddles with solutions already in place to potential problems. No recap is given for latecomers – the expectation is that they will arrive on time the next shift!

Why briefing/huddles?

Briefing and huddles are an essential element of a high performing team. To get the best out of the briefing it is important to smooth the hierarchy within the team and establish an environment where the team can perform to their optimum ability, supporting each other as necessary.

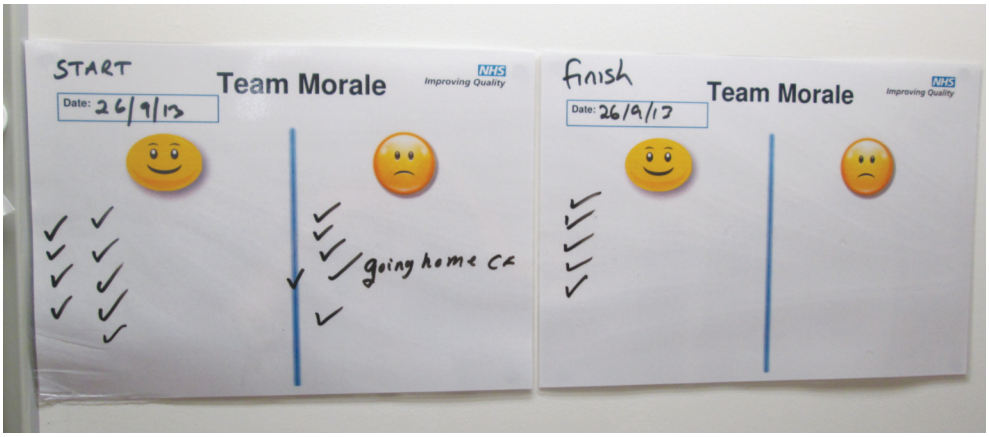
Briefing helps teams to:

- Use everyone's knowledge – any team member may hold that 'final piece of the jigsaw' setting an appropriate atmosphere so everyone feels able to speak up
- Plan for the expected and protect against surprises
- Prepare for the unexpected – when all the possibilities have been shared it leaves more capacity to deal with the unexpected
- Prevent safety lapses by creating an atmosphere in which all team members are focusing on the above issues, making it less likely that safety will be compromised.

It is important to brief when individuals come together with a task to do; it is only by having some form of discussion that all parties can begin to have the same situation awareness or mental model. We can all make huge assumptions in everyday life. By discussing or briefing, these assumptions can be varied or altered so the whole team is 'on the same page'.

It need not take a lot of time but it is time well spent and can reduce wasted time later by avoiding glitches. Re-briefs throughout the list can also be useful.

A team 'huddle'



What is a debriefing?

Debriefing is a post list or procedure learning discussion that enables the endoscopy team to reflect upon the list. It is only effective if it adheres to the principle of constructive learning in a no-blame atmosphere, best summarised as:
What went well? Even better if...

What are the principles of debriefing?

Firstly agree a suitable time for the debrief when as many members of the team as possible can be present. This might be at the end of the last procedure, or after the last patient goes to recovery. It is important for all relevant clinical staff to be there, some teams find it useful to have the recovery nurse present as well.

It is crucial to set the right tone to encourage participation and there are some skills to be learned to achieve this. Anyone should be able to raise any issue without fear. Senior staff need to be prepared to admit their own mistakes and should treat more junior members of the team with unconditional respect, acknowledging their contribution. This creates the kind of open communication that gets to the important issues and avoids blame.

If the debrief is used by any member of staff to criticise others directly, the atmosphere of trust will be lost, team members will quickly learn not to contribute and debriefing may be abandoned.

Done correctly, debriefing is a valuable opportunity to learn important lessons about how errors can be avoided and ensures all team members feel valued for their contribution.

TIP: Here is a list of principles for debriefing developed for healthcare by The Evidence Centre:

Have open dialogue
Examine progress
Analyse root causes
Learn lessons
Transfer lessons learnt
High note finish.

Why conduct a debrief?

A successful team debriefing is much more than a meander around a subject. It is difficult to do well and requires practice. The aim is to make all parties consciously competent but, more importantly, to know why they are competent so they can replicate it next time. It allows teams to capture successes and improvement issues and prevents them from making the same mistakes again.

Just because it all went well does not mean that all team members knew why that was the case; it is possible that they may change their practices next time – no feedback is not an option!

It provides the opportunity:
- For improvement
- For learning not blaming
- To say thank you
- To improve staff wellbeing.

It is very important the debrief is not seen or used as a forum for criticism of individuals. You should be encouraging the concept of a just culture and not a blame culture.

What is a re-brief?

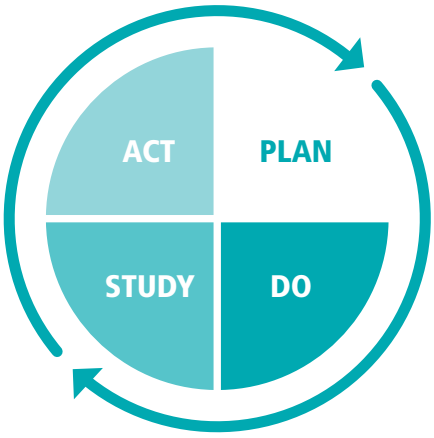
A re-brief is an additional briefing, which may take place during the course of an endoscopy list. It is most likely to be used when there is a change of plan or a change of staff within the team, for instance at the change of shifts.

Why do it?
It is important to re-brief when the team or situation changes to maintain situation awareness in the whole team. Teams should learn to do it when another member joins the team, e.g. at shift changeover, or a member of staff returns after a break. Re-briefing helps that member of staff join the team rapidly, understand and focus on the work in hand, and share the goals of the team.

It may also be necessary when there is a change of plan, for instance if a simple polypectomy changes to an endomucosal resection.

Re-briefing improves team communication and situational awareness.

Plan



There are a number of steps to work through to help you plan tests of change (PDSA cycles) for implementing briefing and debriefing (huddles).

The module team needs to understand the important of involving all groups of staff to make sure the solutions tested in PDSA cycles meet everyone's needs.

Ensure strong and visible leadership

- Discuss implementation with the executive leader and senior clinicians
- Ensure executive support and visibility for this area of work
- Discuss how you will implement all the steps below and any support you may need
- Discuss how the executive leader will support this work
- Identify any team working expertise within the organisation who could support this work
- Decide whether you will need external support from training provider

Communicate, engage and raise awareness

As part of the start-up phase for implementing briefing/debriefing/huddles, it is important that the clinical team or showcase endoscopy staff understand what briefing and debriefing is, why it is important and what benefits it will deliver. You can never communicate too much, so use several of the suggestions listed below to ensure your team are fully informed and ready to go.

- One-to-one discussions or meetings
- Posters and newsletters
- Information on your Knowing How We Are Doing board including measures and quotes from clinical staff
- Email

Identify and support clinical champions

Engaging clinicians in this project is crucial (see The Programme Leader's Guide). To help with this you will need to recruit and support clinical champions within each professional group. The team-work session may provide a good opportunity to identify champions. See The Programme Leader's Guide for more information on selecting champions, and their role.

Capture quotes from your clinical champions to include in communications to the wider endoscopy team. Quotes are a powerful means of communicating positive messages, particularly from influential clinical staff.

Review ideas that have worked elsewhere

With your team look at examples that have worked well in other places to inspire you to develop your own brief and debrief that will fit your local requirements. Some sites have implemented briefing and debriefing together, others have separated them.

Example one: Implementing team briefing/de-briefing (huddle) - Portsmouth Hosptials NHS Trust

False

Endoscopy Unit
'Huddle' Checklist

Date	Time	8:00 AM 13:00 PM		
All suites stocked and ready			YES	NO
Each suite has 8 o'clock start allocated			YES	NO
			Name	
Cardiac arrest trolley allocated		Recovery		
		Suite 3		
		G5		
Admitting nurse ready to start			YES	NO
First inpatient called for			YES	NO
Stop/Start audit handed out			YES	NO
Order books completed:				
Monday only CD Book All Suites x5			YES	NO
Tuesday allocation to do top up book			YES	NO
Wednesday stock book D and G level ready to go			YES	NO
Problems identified/instructions				
8:00 AM		13:00 PM		
Late comers/off sick				

Problem

- Sporadic communication on a daily basis across the whole team led to fire fighting and crisis management
- Unknown staffing levels (administrative, clinical, decontamination) at the outset of the day as there was no means of 'reporting in'
- Confusion over what tasks had already been done and which were still to be completed before patients could be accepted safely to each session

What we did

- Huddle checklist - version five so far!
- Continually looking at making it more user friendly
- It is a quick tick box
- Highlights problems
- Sickness and late comers highlighted
- Form kept and used for audit
- Using the 3Cs structure
    - What's our concern?
    - What's the cause?
    - What's the countermeasure?
- Huddles have reduced from 15mins to 5mins by using 3Cs
- Issues are solved in real time – before being allowed to escalate e.g. sickness cover or unexpected problems (i.e. fuse blew in drying cabinet room which required on the day troubleshooting)

Example two: Engaging staff - Royal Liverpool and Broadgreen University Hospitals NHS Trust

Feedback from patients on the endoscopy staff is always positive, highlighting their caring nature. However issues around staff attitude and communication with each other had been highlighted in the staff survey. There are three different staff groups within the department, clinical, administration and decontamination staff. Communication between these large groups of staff was not always as good as it should be and there was a lack of understanding and appreciation of how each other work.

What we did

A series of engagement events were held with the staff so that the issues could be discussed. The sessions held over the course of two months, away from the department, allowed staff to identify solutions to the problems.

The staff created an agreed:

- Behaviours framework
- Mission statement
- Vision and values framework
- Mobile phones policy
- Local sickness policy.

All of the policies had an agreed escalation pathway for non-compliance.

It was important that the staff agreed the content of these documents, creating the vision and values that they hold as a unit. This was done by allowing everyone a voice, full ownership and agreement into how staff should behave in the workplace.

Impact

- Staff have an understanding that certain behaviours are unacceptable and have clear guidance on how this impacts on other teams
- Junior staff feel that they can address attitude and behaviours through the right channels
- All staff know that unacceptable behaviours will be formally challenged
- Creating the philosophy of care, encompassing vision, values and mission statement, has given staff clear direction, sense of purpose and instils the ethos of working for a common goal

> It's about that culture shift and I won't pretend it's easy.

Nicky Taggart, Endoscopy Manager, Royal Liverpool and Broadgreen University Hospitals NHS Trust

Example three: Ideas, issues and niggles boards to generate engagement - Portsmouth Hosptials NHS Trust

Problem

- In the daily grind of work it is often easier to find a work-around solution to a problem and 'get on with it' than try to battle with fixing the broken system
- Staff of all grades, who work in the system, are the real experts in the endoscopy process but all too often they have raised ideas and their voice has not been heard – usually as people are too busy to do anything about it
- More often than not staff stop generating good ideas and become 'sucked into' the system
- The team recognised that there were lots of issues that all staff knew were problematic – but had neither the inclination or the permission to sort out

What we did

- Put up magic white boards in the office areas, staff room and decontamination room
- These were labelled as 'issues and niggles' and ideas
- Staff were encouraged to write on these anonymously

Impact

- The comments posted came in thick and fast and as it was so 'visual' it created a sounding board for most people
- Most issues were well known but it did highlight some that had not been identified before

Admin

Good things/that work well

- Individuals are doing their best
- Staff goodwill
- Dedicated Individuals
- Competent staff
- When fully staffed the day works well
- Trays in reception/organised paperwork
- Staff use their initiative to get the jobs done - if they see that something needs sorting then tend to do it

Issues/Niggles

Teamwork:

- Disjointed team - separate office does not help
- Too much negativity
- Divide of staff (not just physically) - renders us dysfunctional
- Rota not working well - time spent on some tasks is too long
- Supervisors need to prioritise/need training/support - lack of organisation
- There are times when a supervisor isn't present - p/t issues
- Understaffed
- Starting work at different times to cover reception - need rota
- Morale is low due to people not working as a team
- 'Space' (lack of!) and environment is a factor impacting on morale, no windows is oppressive

Communication:

- Lack of communication from nursing team - admin team get bad press from nurses
- Lack of communication within the admin team
- Do not feel fully informed about what's going on
- Often only get to know of changes when you do something wrong
- No team meetings to talk things through - no time to look at emails
- Perception that nothing would get resolved by holding meeting and could fuel negativity
- People did not speak up at previously attempted team meetings - perception among the team that openness might not be met favourably
- Things 'appear' without discussion (I.e. graphs in main office on wall)
- Sister introducing new procedures but not fully communicating them
- Perception that admin staff are sometimes spoken down to by nurses
- Sometimes, staff are 'snappy' with each other
- Nurses don't tell patients why they are waiting past their appointment time
- Pettiness with each other
- Perception of different rules for staff - inconsistencies
- Problems sometimes fester as no channel to discuss openly - skirt around issues instead of us nipping them in the bud
- Fear to say something in case HR become involved
- Often feel undermined - not enough support/ongoing training

Workload/Process:

- No standardised way to do things in our own way
- Too many things to do when on reception
- Notes going missing - nurses taking them but don't leave a note and do not always return them directly back to the same place - big problem once the notes have been prepped
- CEA not being signed (apathy form nurses)
- Paper diary is never in same place - nursing team often wander off with it
- Bowel prep sent out via post in normal brown envelopes - often tear
- Keep running out of stationery
- Should adhere to 1 x DNA policy - rather than re-book repeat offenders

- Phones are sometimes left off the hook
- Make more mistakes when under pressure
- Customer service does not come first - just doing everything possible to get the job done - staff feel demoralised as they want to do a good job/offering the best service
- Bookings for Gosport - clerk at GWH will cancel but will not book appointments
- Booking private patients/manometry patients
- Forgetting to write on the bed state when patient arrive - need a better way to collect bed state list
- Collating notes and discharging them whilst sitting on reception - cannot get through workload
- No cover for G5 - getting bed states the following day is difficult
- Cancel/rebook build up due to person on phones not always in the same place as the diary
- Phones are manic!
- Extra lists at weekends create larger workload for which admin are not resourced
- Pre-assessment ringing in for bowel prep - even when info sent which states 'for info only' as they query that they are missing something
- Not discharging Gosport patients when cancelled
- Working from one day to next itsn't ideal - often make temporary notes as a result
- Constantly fighting for OGD slots!
- Histology needs marrying up - 2 days/week dedicated to this - but often not enough - histology can take 8 weeks to come back - therefore, lots of phone queries from patients. Printing results off Scorpio can be time consuming.

Environment:

- Photocopier in reception is noisy and distracting
- Not confidential in waiting area
- Workspace cluttered
- Depressing waiting environment for patients - no pictures/distractions
- Unprofessional looking reception area - with notes piled at the back - due to lack of space

Ideas:

- RAG jobs to be done (to aid prioritisation)
- Need rota to cover reception a 08:00hrs
- Nurses doing discharging (leave green copy on top only)
- Tracer cards when nurses take notes
- Competency grid
- All staff having access to all systems - and keeping login details updated
- Implement electronic booking
- Electronic sign in reception so clinic running on time/late messages can be scrolled
- Tape a red pen on string to the desk
- Manning the phones should be where the notes/referrals are kept
- Break the rota into half days (whole day on one take is too long)
- Don't leave the office unmanned
- Signage - please give priority seating to patients
- Do not leave message on patients with appointment details - get them to phone into the department instead
- Explore having an OGD only list
- Need diary in one place - and person on phones with it
- Try Daily Huddles

> Often just airing a grievance or niggle will help staff find an immediate solution.

Koralie Bird, Endoscopy Sister,
Portsmouth Hospitals NHS Trust

> Make sure that you do actually address the issues and ideas raised, otherwise staff will become disengaged in the process very quickly!

Susie Peachey, National Improvement Lead, NHS Improving Quality

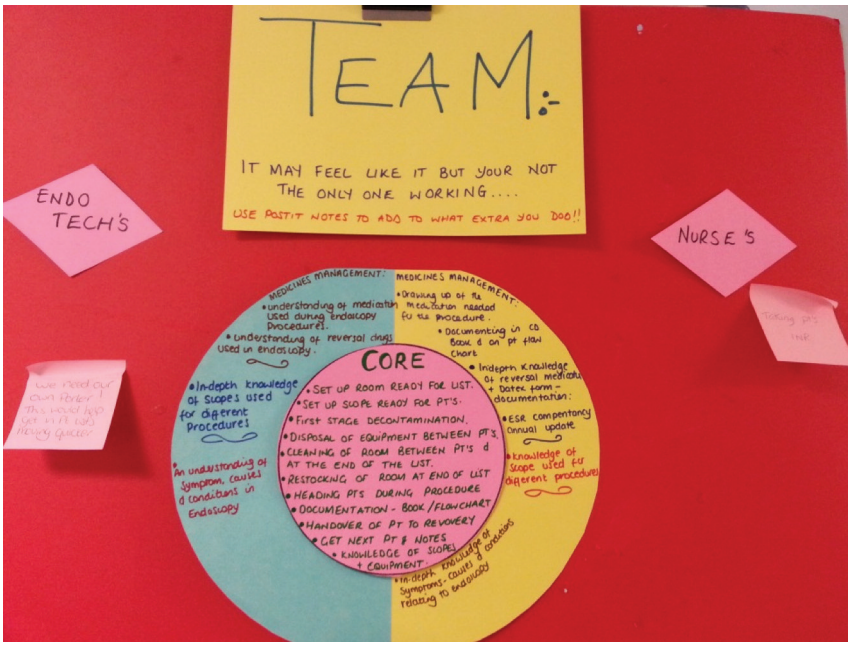
Example four: Understanding each other's roles - Portsmouth Hospitals NHS Trust

Problem

Conscious that the administrative and nursing teams worked independently, with very little opportunity in the working day for the different staff groups to appreciate each other's roles, there was a fear of fostering an 'us and them' culture.

What we did

- Clerical staff were offered the opportunity to don scrubs and observe in the procedure rooms
- The nursing team were also rostered to spend time in the office area
- The admin team were invited to attend the nurses' meeting on a Friday morning



Impact

- As the teams have become better acquainted with what each other actually do on a day to day basis they tend to value and respect each other more
- The 'blame' that was occurring by both sides behind the scenes has vastly been reduced, as the different staff groups are now more thoughtful towards each other and consider the ramifications of 'not completing a task', and relying on the other to finish the job (i.e. nurses not 'dumping' notes on staff desks without explanation)
- All staff now appreciate the distinction between the nursing and admin roles as well as the difference between the roles of the nurses and healthcare support workers

> Understanding each other's roles allows us to be more tolerant of the issues that different staff roles face each day.
>
> **Koralie Bird**, Endoscopy Sister, Portsmouth Hospitals NHS Trust

Example five: The staff survey and huddles - Gateshead Hospitals NHS Trust

An annual staff survey is a Joint Advisory Group accreditation requirement and as part of the commitment to improving the working environment for individuals and the team overall, by improving staff satisfaction and team working on the unit. Results of every question are analysed and the findings generate a report which contains a 12 month action plan targeting areas where low scores of satisfaction were achieved.

There are 45 questions covering four key areas including:

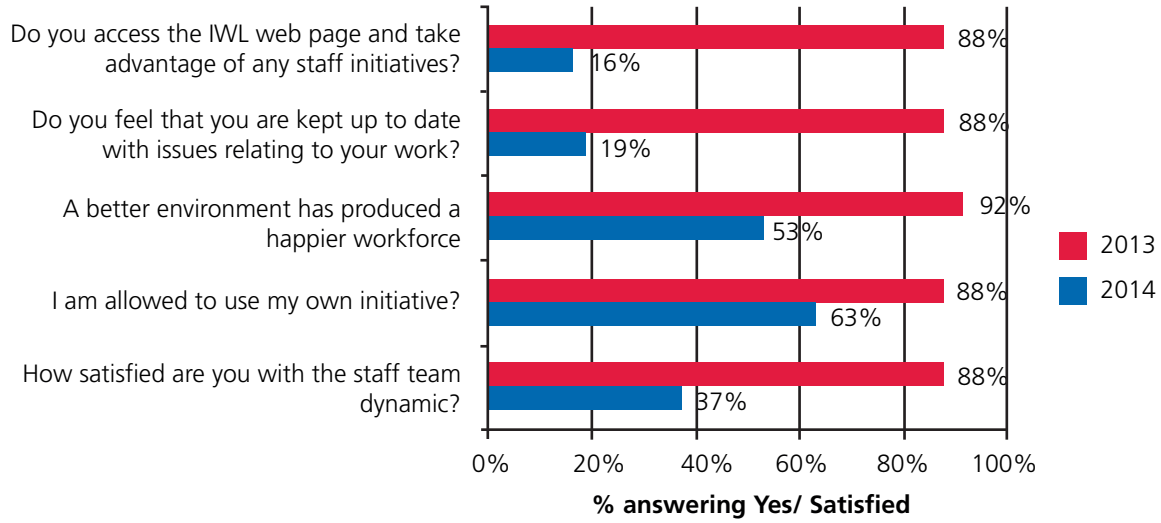
- Your role
- Your appraisal
- Training, learning and development
- Communication.

What we did

The annual survey is distributed and returned anonymously every year. In 2013 the number of staff completing the survey rose to 25, from 19 in 2012.

Impact

- Results of the 2013 survey showed 14 out of 46 questions (30%) had an equal score compared with the 2012 survey, and 24 (52%) had a higher satisfaction score
- The most significant improvements in satisfaction were demonstrated in the following areas



- 23 questions achieved a top score of 100% – significantly staff felt that:
  - The team worked well together (16% increase from previous year)
  - They could raise concerns about quality issues (16% increase from previous year)
  - They have had an appraisal in the last 12 months (100% both years)
  - They find their manager supportive (100% both years)
  - They find their work colleagues supportive (100% both years).

- The staff survey action plan was further augmented by the unit's participation in The Productive Endoscopy Unit programme test work
- As a result of completing other modules such as Knowing How We Are Doing and Operational Status At A Glance some actions have already been implemented to address areas of concern highlighted in the most recent staff survey. For example, communication of operational issues on the unit has already been improved through the implementation of daily huddles before the start of each list.

Example six: Working with other departments in the Trust - Chesterfield Royal Hospital Foundation Trust

Problem

- Endoscopy specimens being taken to Histology late in the day - as a result specimens were not being checked until the next day
- Large batches of samples delivered at once
- Exacerbated by the way the specimen pots were packaged for transportation - pots were just loaded randomly into a transport tin and the request forms stored in a separate compartment

Endoscopy and Pathology staff then had to match the specimen to the request form at the Pathology reception, a time consuming practice.

What we did

In order to resolve the problem endoscopy and histology staff met to assess the situation. It was decided that in addition to endoscopy staff taking specimens to the laboratory twice a day in large batches, histology would also come and collect specimens twice a day - mid morning and mid-afternoon. This decreased the amount of pots to be checked each time. Endoscopy staff also agreed to change the way the pots were packaged for transportation - instead of all being put in a tin together they would be packed in individual biohazard bags along with the relevant report, making samples safer to transport.

Impact

By making these small changes, endoscopy staff taking specimens to be checked in the histology department had their wait reduced by 96%, allowing endoscopy staff to return to the department more quickly, therefore benefitting both departments and ultimately the patient pathway.

> We had better communication and inter-department understanding following the piece of work and both departments and our patients had benefits from the work.
>
> **Sharon Metcalfe**, Project Lead

> We had to spend lots of time in the Histology department delivering specimens and waiting for them to be checked before completing this piece of work – now sample drop off takes just a few minutes, enabling us to get back to the patients.
>
> **Jemma Abbott**, Staff nurse

Before the changes

After changes made

Agree a prototype for testing

Review the examples of 'huddles' and team briefings in this module with your team. You may also know of other examples in use elsewhere in your Trust.

Ask the team to select a prototype to test and make any alterations which are immediately obvious.

You need to agree where and when briefing will happen, and who should lead it. The expectation should be that everyone working in endoscopy for that list should be present including the endoscopist, and any trainees. Some sites have involved the recovery nurse especially if the local custom is to allocate one for each list.

TIP: Thought needs to be given to where briefings will take place. It should be where all staff are easily accessible and soon enough after seeing the patients for their thoughts to be fresh. If the best place is the coffee room then that is where it should happen.

Decide when to debrief: chose an appropriate time, towards the end of the list preferably. Discuss team dynamics and any glitches or issues which affected the list, with a clear action plan to carry forward. Give ownership of the resulting action to a named person.

Key questions to ask in a debrief:
- What went well?
- What could we change for the better?
- What would we do different next time?
- Whose responsibility is it to make this happen?

Ensure you get the views of the whole team. It may be helpful to start with the most junior members of the team to emphasise that their contribution is important.

6. World Health Organisation (WHO) adapted endoscopy safety checklist

What is the WHO safety checklist?

A safety checklist is a standardised method of completing safety checks for each patient immediately prior to their procedure, involving the whole endoscopy team in order to:

- Check the right patient
- Reduce clinical incidents, deaths and complications
- Reliably deliver high quality care
- Produce a more efficient endoscopy list
- Create team-work.

The World Health Organisation safety checklist is designed to promote effective team-work and prevent problems, unnecessary errors and complications. It was tested in hospitals in Seattle, Toronto, Tanzania, Auckland, Amman, Delhi, Manila and London.

Following the success of the global pilot in six nations (including England), the World Health Organisation launched the WHO safety checklist in 2008. It was originally designed to be used in theatres but has been usefully adapted for use in Endoscopy units. It has three elements:

- **Sign In** before sedation or anaesthesia is administered
- **Time Out** immediately before the procedure starts
- **Sign Out** final checks before the patient is removed from the endoscopy unit.

ENDOSCOPY SAFETY CHECKLIST

"Implementing the endoscopy safety checklist is a really quick, simple and reliable way to ensure patient safety is optimum at all times. Despite initial resistance it soon becomes integral to your endoscopy processes and becomes normal practice very quickly. It takes seconds to do and reassures all parties that patient safety is a priority for your Endoscopy Unit."

Harriet Watson – Consultant Nurse, Guy's and St Thomas' NHS Foundation Trust

Example

Below is an example of the WHO safety checklist adapted for use in endoscopy.

Endoscopy Safety Checklist

Guy's and St Thom NHS
NHS Foundation Trust

STAGE 1 SIGN IN:

START TEAM HUDDLE - indications for procedure, any special equipment required etc.

To be read out loud once the patient in treatment room, but BEFORE IV sedation is given, using the patient's notes

All team members to introduce themselves to each other and the patient by name & role?

Nurse verbally confirm with the patient and team

Patient Name ☐

Hospital Number ☐

Consent form signed ☐

Indication for procedure?

Yes ☐

Are there any specific endoscopic equipment requirements?

No ☐

Yes ☐

Antibiotic prophylaxis / difficult airway / aspiration risk?

No ☐

If Yes - is equipment available ☐

Risk of blood loss?

No ☐

If Yes - Adequate IV access / fuilds planned & available

Nurse: Any patient specific concerns?

Pacemaker / ICD ☐

Takes warfarin / clopidogrel? INR checked ☐

Blood Glucose ☐

Allergies ☐

Antagosists to be azodiazepines and opioids available ☐

Other ☐ List

_____

Patient identification to be here

STAGE 2 SIGN OUT:

To occur at the "lights on" phase before the patient leaves the endoscopy treatment room.

Nurse: Documentation

Photos labelled and attached to notes? ☐

Has the register been completed? ☐

Nursing Documentation complete? ☐

Have drugs administered been recorded

Yes, have they been sign for? ☐

Have the specimens been labelled correctly?

Patient details checked? ☐

Number and description of biopsies? ☐

Documented in nurse care plan? ☐

Endoscopist:
Correct patient on reporting software?
Any specific post procedure instructions to be documented on endoscopy report.
e.g. Observation frequency
NBM status
Oxygen Therapy
IV Therapy
Restart Warfarin

Any other specific instructions?

No ☐

Yes ☐ (e.g. CNS required, Outreach escort ITU/Theatre transfer. PEG care plan commenced)

END: TEAM HUDDLE - equipment problems, ditch count, recovery instructions etc - document in notes.

Check list Co-ordinator: _____

Signature: _____

Date: _____

Endoscopy Safety Checklist - Notes for use:

- The entire team must pause to ensure the safety checklist is completed
- Both stages must be followed and completed with formal pauses in care: Stage 1 – Sign In and Stage 2 – Sign Out
- The whole process should only take a total of 2 minutes (divided into stage 1 and 2)
- All the team must confirm each item
- All the items must be verified without a reliance on memory
- The Check List co-ordinator should be the Nurse in Charge in the Treatment/Procedure Room.

NB: This safety checklist is a sample only and can be adapted for local use

Baseline Observations **Date:** **Time:**

BP .....mmHg **Pulse .....bpm** **SpO2 .....**

Resp.....per/min **Temp.....** **CBG.....(If required)**

AMENDED W.H.O. PATIENT SAFETY CHECKLIST

Pre Procedure Assessment (Recovery)

Patient has confirmed Identity and Procedure	Yes	No	
Name Band in Situ	Yes	No	
Consent form Signed	Yes	No	
Intravenous Access in Situ	Yes	No	NA
Dentures / Crowns / Loose Teeth	Removed/ With patient/ NA		
Glasses/ Jewellery	Removed/ With patient/ NA		
Nil By Mouth	Last ate food at: Last had fluids at:		
Bowel Prep Given **Type:**	Yes	No	NA
Blood Results Checked	Yes	No	NA
Allergies & Reactions			
Phoshate Enema Prescription **Endoscopist Name:** **Adminstered by:** **Sign:** **Date:** **Time:**	**(Stamp Here)**		

EXAMPLE OF ADAPTED WHO CHECKLIST FROM Whipps Cross Hospital, Barts Health NHS Trust as a part of the ICP (integrated care pathway)

Why do it?

The WHO checklist ensures that the endoscopy team spend time together before the procedure, at the start of the procedure and at the end of each case, to ensure all necessary steps have been followed as a team and every precaution taken to eliminate chances for errors or mistakes. Implementing the checklist in your endoscopy unit will help you and your team to:

- Reduce the incidence of harm, risks and glitches
- Increase reporting of incidents, risks, glitches or errors avoided or prevented (‘near misses’)
- Improve patient satisfaction and clinical outcomes
- Improve team working
- Optimise communication.

> The beauty of the safety checklist is its simplicity and – as a practising surgeon – I would urge teams across the country to use it. By using the checklist for every procedure we are improving team communication, saving lives and helping ensure the highest standard of care for our patients. The amazing results from the global pilot puts this beyond any doubt.
>
> **Professor the Lord Ara Darzi of Denham**

Learning from aviation

In aviation, checklists came into their own in 1934, after the crash of Boeing's new aeroplane, the 299. Everyone was horrified when at the launch event, and with Boeing's most experienced test pilot in the cockpit, the plane fell out of the sky and burst into flames. It was described by the press as "too much plane for one man to fly."

Four checklists were developed to ensure that each stage was signed-off before proceeding.

A team of former pilots who lead work with clinicians on increasing reliability and safety say:

> "The model 299 was not 'too much plane for one man to fly', it was simply too complex for one man's memory. These checklists for the pilot and co-pilot made sure that nothing was forgotten."

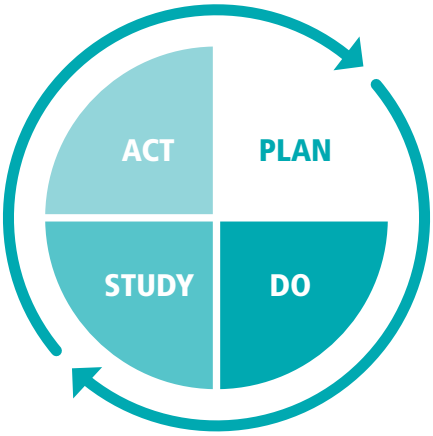
In the end, the model 299 became the US Army Air Force's plane of choice with over 12,000 of them built, and became known as the B-17, the Flying Fortress.

Supporting memory

The activities within a busy endoscopy treatment room are complex and require standardisation. Human short-term memory can store seven facts at one time. Therefore, human error will be built into our processes if we do not support our memory with useful and simple tools, such as checklists, to prevent us making mistakes.

> All teams have their characters. Often, it's very obvious that when different combinations work together the outcomes of the day are better or alternatively lists run late and rooms are never stocked. Auditing the room starts, changeovers and 5S are key to having those challenging conversations about individuals raising their game.
>
> **Lisa Smith,** National Improvement Lead, NHS Improving Quality

Plan



There are a number of steps to work through to help you plan tests for implementing an amended WHO safety checklist. The module team needs to understand the importance of involving all groups of staff to make sure the solutions developed and tested in PDSA cycles meet everyone's needs.

Ensure strong and visible leadership

The senior team of the organisation needs to understand that the introduction of the checklist represents a cultural change which will require support in implementation. The chief executive and other key executives will need to provide personal leadership and ensure a high level of support, to make sure the change endures and the tool is consistently applied.

Executive actions to support implementation might include:

- Discussing the implementation of the checklist at a Trust board meeting (e.g. as part of the visioning workshop or on the board reports - see the Programme Leader's Guide)
- Reviewing this guide at an executive board meeting
- Stating the commitment to use the checklist within corporate objectives
- Visible support from the executive leader to the implementation team and clinical champions
- Using all forms of internal media: team briefings, magazines, online bulletins, etc.
- Building in visits to endoscopy as part of an executive safety walk round
- Following up progress to ensure the change continues and spreads
- Reviewing the number of issues highlighted by the checklist or 'glitch count'
- Planning formal reviews into the audit programme
- Publishing reports on progress.

Identify a list to begin testing

The decision about where to start should be based on several factors:

- Where there is existing enthusiasm from staff and an awareness of the tools
- Where there is a desire to implement the tools

Plan

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Identify a list to begin testing

The decision about where to start should be based on several factors:

- Where there is existing enthusiasm from staff and an awareness of the tools
- Where there is a desire to implement the tools
- Staff are willing and able to spread the implementation to other lists and staff within the organisation
- Where there are known safety issues.

Communicate, engage and raise awareness

As part of the initial phase of implementation, it is important that the clinical team or showcase endoscopy list/team understand what the WHO checklist is, why it is important and what benefits it will deliver. You can never communicate too much, so use several of the suggestions listed below to ensure your team are fully informed and ready to go.

- WHO checklist meeting
- One-to-one discussions or meetings
- Posters and newsletters
- Information on your Knowing How We Are Doing board including measures and quotes from clinical staff
- Email

The Patient Safety First campaign seeks to provide NHS staff with the knowledge and support they need to improve the safety of patients. It has developed excellent tools to assist in implementation of the checklist and reduce the potential for harm.

See the Patient Safety First guides:
- Surgical safety checklist for chief executives
- The 'how to' guide for implementing human factors in healthcare
- The 'how to' guide for reducing harm in perioperative care.

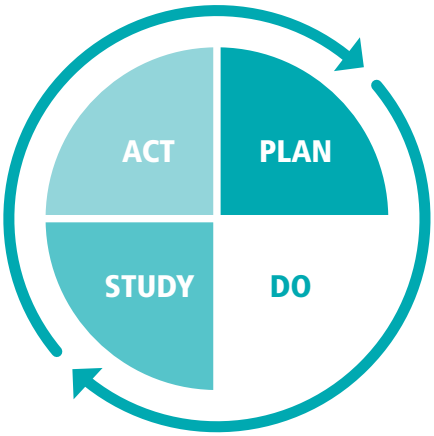
Plan – milestone checklist

Move on to **Do** only if you have completed **all** of the items on this checklist.

Checklist	Completed?
Ensured strong and visible leadership	
Identified a clinical team or list to begin testing	
Communicated, engaged and raised awareness	
Identified and supported clinical champions	
Reviewed ideas that have worked elsewhere	
Agreed a prototype for testing	

Effective team work checklist	Tick if yes
Did all of the team participate?	
Was the discussion open?	
Were the hard questions discussed?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not individuals?	

Do



Once a version of the checklist has been identified that you would like to try, you will need to test it on one list in the endoscopy department. Do not expect staff to take to this new idea immediately, experience has shown that implementation works best when the whole endoscopy team are involved, and are encouraged to develop their own version. You may need several iterations of the PDSA cycle to devise a customised version of the checklist for your endoscopy unit.

Test the WHO checklist with the endoscopy team

Once the team have decided on the version of the checklist they would like to test, they need to decide how to present this to the team. Some teams have developed a paper or laminated A4 version for the person leading the checklist to hold. Others have incorporated it into an ICP (Integrated Care Pathway)

Establish ground rules for the checklist. You may decide to introduce briefing and debriefing before the checklist or both at once. Start with one team on one list and increase coverage once you have a version that is working.

You need to agree exactly when it will happen, and who should lead it. The expectation should be that, for the time-out, everyone working in the treatment room for that list should be present including the endoscopists and any trainees. Theatre teams do it at the point when they would otherwise be making the incision or before the surgeon scrubs. In endoscopy units timing of this needs to based around the patient being brought into the endoscopy treatment room, bearing in mind that the patient will be alert to the discussion (i.e. not anaesthetised).

Support the team to work with the tool

It is important for the team to understand that the checklist is an extra 'double checking' step prior to the start of the procedure. Emphasise that there is room for customising and adapting it. Try some ideas that the team want to test even if you are not sure they will work and then use the small-scale 'tests of change' method to review and refine the process until everyone is happy with it. Many of the items in the National Patient Safety Agency version of the WHO checklist may be appropriately covered by a team brief.

Beware of overcomplicating the documentation, it might put people off. Start with something simple and see how the team react, but also find a way to capture when the checklist identifies and averts a potential error.

Continue to monitor progress

As with briefing, identify any important issues that arise during the testing phase and need to be resolved or escalated to the executive lead. In the early phase it is crucial that staff know that their concerns are being heard and acted upon.

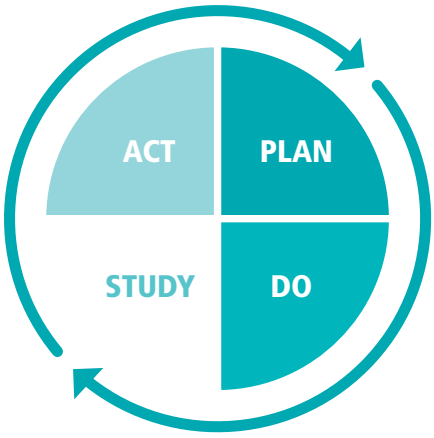
Do – milestone checklist

Move on to **Study** only if you have completed **all** of the items on this checklist.

Checklist	Completed?
Tested the WHO checklist with the team on a endoscopy list	
Supported the team to work with the tool	
Continued to monitor progress	

Effective team work checklist	Tick if yes
Did all of the team participate?	
Was the discussion open?	
Were the hard questions discussed?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not individuals?	

Study



Implementing the amended WHO checklist may require several PDSA cycles. It is important to keep track of your measures for success so that you can assess the impact of changes made soon after you make them.

Assess the impact on your key measures

Refer back to the Knowing How We Are Doing module, and particularly the 'collect, analyse and review' sections. The measures for the WHO checklist may be qualitative (how people feel about new ways) as well as quantitative (how many patients had the full checklist carried out, what potential glitches were identified and averted). Measures you might use include:

- Are the staff implementing the customised WHO checklist?
- Has it made any difference?
- What sort of glitches are coming up regularly?

Collect feedback from the staff

What is the feedback from staff on your WHO checklist prototypes? Collect anecdotes and examples where potential errors – minor and major – have been averted. See how you can disseminate these stories to convince sceptics that the checklist is having a positive impact. Make sure that you keep the wider endoscopy team informed, tell them what you are doing, why you are doing it, how you are doing it and what has been achieved as a result. Use every opportunity to engage the clinical staff.

Update your Knowing How We Are Doing board

Use your Knowing How We Are Doing board to demonstrate progress on key measures as well as quotes, comments and stories.

Implement review process

Review the WHO checklist with the team. Find out how people reacted to the checklist – did it help them to understand what was going to happen? Did it help staff to identify and prevent any problems? Review and capture good news stories for your Knowing How We Are Doing board and for wider communication.

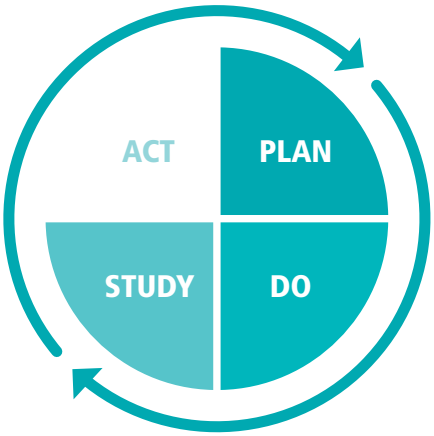
Study – milestone checklist

Move on to **Act** only if you have completed **all** of the items on this checklist.

Checklist	Completed?
Assessed the impact on your key measure	
Collected feedback from staff	
Updated your Knowing How We Are Doing board	
Implemented review process	

Effective team work checklist	Tick if yes
Did all of the team participate?	
Was the discussion open?	
Were the hard questions discussed?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not individuals?	

Act



Once you have successfully developed and tested your customised version of the WHO checklist on one endoscopy list, you will need to plan for roll-out across all endoscopy lists, and how to sustain the use of the tool in the long term.

Decide if the tool is ready to be implemented

If you are doing many small PDSA cycles with various modified prototypes, the team need to decide if the tool is ready to be implemented. The options can be summarised as:

- Adopt
- Amend
- Abandon.

If the decision is made to abandon a particular version or way of using the checklist, consider what alternatives might work better in your unit. The most frequent mistake is to develop over-complicated paperwork, separate from the main documentation. Once you have an acceptable prototype, consider what documentation really matters in your organisation and then see how you can integrate it with existing systems. For example, you might be able to record completion of the three stages of the checklist on the endoscopy management system. Alternatively the checklist can form part of the patient care plan.

How can you make it stick?

Sustaining new ways of working is always a challenge. This is where your champions come in – once they have worked out a successful new way of working they are unlikely to want it to be abandoned. The other key is continued measurement, and displays of the percentage of implementation of the WHO checklist for each endoscopy list. Once compliance reaches significant levels you might consider identifying who is doing well and who not so well, but this can be seen as punitive and is probably best reserved until you have just a few stragglers.

If you have a substantial problem persuading clinicians to use the WHO checklist find out what the difficulty is. Perhaps your prototype suits one professional group better than another and a new version may need to be tested. Ultimately if most staff have adopted the WHO checklist you may need the support of clinical directors, executive leads and other senior people to influence the stragglers. Eventually use of the WHO checklist will become an element in appraisal and revalidation.

Once the new way has been established, include it in the existing structures:

- Induction for new staff
- Standard procedures and policies
- Documentation (including IT).

See also the Sustainability Model and Guide on the NHS England website. There is a brief account of this in the Programme Leader's Guide.

Plan for roll-out to all endoscopy lists

Spreading your local adaptation of the WHO checklist may start to happen organically if the various clinical groups decide to adopt it, but you should be prepared to support spread. The steering group or the programme team may have clear thoughts on where to spread first, and how to migrate it into all lists and how to link roll-out to briefing and debriefing. As with briefing and debriefing, you must be open to the prospect of further modification of the checklist as you roll-out. What works for an OGD or flexible sigmoidoscopy list may need considerable adaption for an ERCP list. The content will also vary depending on whether teams have implemented briefing and debriefing. There is no particular order in which briefing and debriefing and the WHO checklist should be implemented.

However good you think your checklist is, do not be tempted to send out an instruction to all staff to implement it. Experience has shown that, at best, staff will grudgingly carry it out until you are no longer watching them. At worst, they will simply refuse. They have to be won over by engaging them, showing them the evidence that it works (qualitative and quantitative) and involving them in modifying the process to be fit for purpose in their particular clinical context. This takes time and perseverance.

We recommend that you put the WHO safety checklist into use in planned stages, list by list. This also provides an opportunity for tailoring to meet specialty needs and for helping each team to understand the reasons for using it.

Use the PDSA approach, suggested in this guide, to support teams in developing solutions which work for them and are consistent with other processes. For example, if a team carry out team briefings/huddles, including introductions, it makes no sense to repeat introductions at time-out unless key members of the team have changed.

Act – milestone checklist

Checklist	Completed?
Decided if the tool is ready to be implemented	
Agreed how you will make it stick	
Planned for roll-out to all endoscopy lists	

Effective team work checklist	Tick if yes
Did all of the team participate?	
Was the discussion open?	
Were the hard questions discussed?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not individuals?	

7. Learning objectives complete?

Five objectives were set at the beginning of this module.

Test how successfully these objectives have been met by asking endoscopy team members (of differing professional groups and grades) the questions in the following grid.

The results of this assessment are for use in improving the facilitation of this module and are not a reflection on staff aptitude or performance.

If all the responses broadly fit with the answer guidelines then the learning objectives of the module have been met.

Note the objectives where the learning has only been partly met and think about how you can change the way you approach the module next time so that the responses are fully met.

It sometimes helps to re-read the module and reflect on the experiences in implementing the module first time round.

Question (ask the team member)	Answers for outcome achieved
What impact do individual behaviours have on the team dynamics and performance?	Understanding and able to summarise the eight human factor elements and provide examples of how their individual or observed staff performance has changed • Self awareness • Behaviour and conflict management • Communication • Leadership • Team-work • Information processing • Decision-making • Situation awareness
What contributions can individuals make to avoid errors and improve patient safety?	Examples of specific interventions under each of the headings above
What do you understand about the importance of, and are you able to: • Conduct a brief and debrief (huddles) and learn from experience • Apply the principles of the WHO checklist	Essential to high performing teams • Rapidly form a team • Level hierarchy • Planning for the unexpected • Reviewing what went well, how the team can improve next time • Evidence of implementing briefing, debriefing (huddles) and the WHO checklist, and other communication tools
What systems and procedures need to be in place to support brief, WHO checklist, debrief and SBAR?	Mechanism for brief, debrief and WHO checklist to take place in unit for every list • Data capture of key metrics to measure success • Frequent review of the glitches arising from debrief • Staff training and prompts in the unit to support use of the tool
What tools can improve the quality of communication within the team to deliver safer, more effective care to patients?	• Understanding and applying structured communication tools (see Appendix 1) such as PACE and SBAR

8. Appendices

For more information on change management please see part two of the Executive Leaders Guide.

Appendix 1

What do we mean by human factors in patient safety?
There are eight key human factor elements affecting patient safety in the endoscopy unit. Understanding and awareness of your own performance, and that of others, is critical to improve team working.

1. Self-awareness

What is it?
Self-awareness is an understanding and appreciation of how we prefer to think and act, and how those we come into contact with prefer to think and act.

Why is it important?
By enhancing our understanding of ourselves and others we can act appropriately to help our fellow team members. It can also increase awareness of how stress, workload and fatigue can polarise peoples' actions and reactions. For example, outgoing expressive personalities may become insulting under stress or may become very quiet.

How can you do it?
For a full assessment of personality types, use Myers-Briggs (MBTI), or for more concise exercises by Merrill and Read in understanding and valuing differences – see the Change Management section of the Executive Leader's Guide.

2. Behaviour and conflict management

What is it?
Behaviour and conflict management analyses how you act, what you are judged by; what others see of us.

Why is it important?
- It helps us to recognise and accept that we can choose our behaviour, and that we are responsible for our behaviour
- Behaviour breeds behaviour
- It helps us understand how unintentional or unguarded behaviour, especially by those with leadership roles, can adversely affect the team and hence impair patient safety.

How can you do it?
Using concepts from transactional analysis, you will understand that at any given time, each of us expresses our personality through a combination of behaviour, thoughts and feelings. According to transactional analysis, these fall into three categories, adult, parent and child mode. The optimum way to communicate with each other is adult to adult mode.

Adult mode behaviour is associated with objective unemotional interaction, focusing on facts and issues, not personalities.

Parent mode behaviour: this is a state in which people copy their parents or other parental behaviour. Our parent mode is formed by external events and influences upon us as we grow through early childhood. Sometimes this could take the form of being overly critical or possibly too nurturing. Whichever side of our 'parental behaviour' you show will determine the type of response you receive, usually invoking a child-like response. For example, a senior matron may take on the parent role, and scold another adult colleague as though they were a child. This is not conducive to effective team working.

Child mode takes control when we allow anger or despair to dominate reason. This is our reaction and feelings to external events that we use our childhood memories of things we saw, heard, and felt when we were children.

Parent/child communication is generally a less effective mode of communication.

For more on this see Eric Berne 'Games People Play: Understanding the basic principles of Transactional Analysis'.

3. Communications

What is it?
How we communicate – verbally and non-verbally.

Why is it important?
- Too many misunderstandings create an unsafe environment. For example, drug administration errors, poor handovers and wrong equipment
- Poor assertion – hierarchy, result of inappropriate behaviour

Professor Albert Mehrabian has pioneered the understanding of communications since the 1960's. He established this classic statistic for the effectiveness of spoken communications:
- 7% of meaning is in the words that are spoken
- 38% of meaning is in the way the words are said
- 55% of meaning is in facial expression and body language.

Working in the endoscopy environment can restrict some members of the team in communicating in an effective manner whilst wearing gowns, protective glasses, heavy xray protection. Therefore, endoscopy teams need to be extra careful with the words that are spoken, and the way that they are said. Try saying the following sentence seven times and each time placing the emphasis on the next word in the sentence!
'I never said he stole that money'. Notice how the meaning is different each time?

How can you do it?
Body language should not be relied upon, but as illustrated above it is what we use most of the time in our day to day work. Avoid inappropriate question types, the most dangerous being the *leading question* for example:
'this is the common bile duct – isn't it?'

Be aware of people's 'attention loop' and remember that while you are transmitting a message the person receiving it has to listen to the words, then make sense of them, and then formulate their response. Often it is a good idea to allow pauses between sentences. PACE is an excellent tool to aid assertiveness, gradually escalating from *prompt* right through to *emergency.*

SBAR – Situation, Background, Assessment, Recommendation

What is it and how can it help you?

SBAR is an easy to remember mechanism that you can use to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety.

The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition.

The tool helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail.

For more information visit the NHS National Patient Safety Agency website at www.npsa.nhs.uk

PACE – Probe, Alert, Challenge, Emergency
There are many factors that can block good communication during critical events, including differences in seniority or experience, job position, personal power, personal agendas, fear of 'loss of face' and plain stubbornness.

One form of graded assertiveness that has been developed, can be remembered with the word PACE.

PACE consists of four stages or tiers of communication. Each one is a measured escalation that systematically (if the problem is not resolved), transfers power from the other, to shared, and finally to self.

Here is one example to give you an idea of PACE in action.

1. **Probe**: "Do you know that this patient has a serious allergy to Latex?"
2. **Alert**: "I think there might be Latex in the gloves you are using. Let's just check on the box."
3. **Challenge**: "It is against our policy for you to do this procedure wearing Latex gloves if the patient has an allergy. You should not continue."
4. **Emergency**: "Step away from the patient. You will not continue with this. I am contacting the consultant immediately."

By using the four stages as a guideline, you have a structured momentum that empowers you to move forward despite perhaps feeling uncomfortable doing so.

4. Leadership

What is it?
Leadership is a combination of personal qualities, drive and emotional intelligence. Effective leaders:
- Communicate task responsibilities
- Balance legal responsibility/situational leadership
- Involve and maximise all resources
- Communicate expected standards
- Establish authority
- Model appropriate behaviour.

Why is it important?
Excellent leadership skills are critical to high-performing teams, and carry a significant level of influence on the other seven elements of human factors within the team, and the outcome of the

team's performance.

How can you do it?
Each member of the endoscopy team has a leadership role. Everyone has a responsibility to practice good leadership skills, such as drive, management skills, motivation, situational and emotional intelligence.

Situational leadership – effective leaders balance all three needs of the team, task and individual appropriately.

Emotional intelligence – broadly this describes the ability to assess and manage your own emotions and those of others and particularly of teams.

Practical application of these skills might include leading the briefing and debriefing, and the WHO checklist. Another example might be encouraging the use of common politeness, saying 'thank you', encouraging mutual respect, being self-aware and always using appropriate 'adult' behaviour.

5. Team work

What is it?
People working together towards a common goal in a supportive manner.

Why do it?
Effective team work is key to an efficient, safe and harmonious endoscopy room.

How can you do it?
Effective team members:
- Are assertive when required
- Admit overload
- Keep calm under stress
- Anticipate each other's needs
- Put team needs before their own
- Are supportive and exhibit many of the behaviours of the leader:
  - Communicate effectively; thinking ahead; talking ahead; link to situation awareness
  - Lead or are prepared to lead
  - Work supportively; paying attention; avoiding distraction
  - Handover briefings
  - Include the patient as part of the team.

6. Information processing

What is it?
The way the brain works – and how we can all make mistakes.

Why is it important?
We are all fallible, the potential for error is always present, but we can also be the hero.

How can we do it?
Our brain is like a very complex computer; we often become overly reliant on our short-term memory. It is important to recognise that we can only focus on one piece of information at a time.

Things to look out for:
- ***Selective attention:*** 'cocktail party' effect or distraction from the main task. If you are talking to someone and you hear your name mentioned by someone not in your conversation, you will automatically divert some of your attention away from the person talking to you
- ***Divided attention:*** this is often referred to as multi-tasking. We do not, in fact, multi-task, but some people are particularly skilled at switching from task to task very quickly
- ***Focused attention:*** being unaware of other noises or things happening around you; becoming task-fixated
- ***Sustained attention:*** human limitations make this difficult to do. For example, World War II radar controllers were expected to concentrate on their screen for long periods of time, and often missed aircraft appearing on their screens because they had been concentrating too hard for too long on a single task
- ***Perception:*** making sense of situations by comparing to your personal insights and observations.

7. Decision-making

What is it?
Is the process of making a judgement about the best course of action to take in a particular situation.

Why is it important?
The majority of decisions are made intuitively and may not be reliable due to insufficient information. Correct diagnosis of the situation in an endoscopy room is crucial to a successful outcome. It is important for every team member to recognise that changing a decision in the light of new information is appropriate and is not indecision.

How you can do it?
Most decision-making happens subconsciously and is based on pattern-matching from a previous experience.

You might improve your decision-making process by following this simple acronym:
- Time: do we have time or can we make time?
- Diagnose the problem: utilise all team members
- Options available and associated risk: involve the whole team
- Decide what to do: probably the lead clinician, although it may be delegated
- Assign tasks to team members
- Review again: can anyone come up with other options?

8. Situation awareness

What is it?
Situation awareness is being aware of what is happening around you, to understand how your own actions will impact on your objectives, both now and in the near future.

Why is it important?
A lack of situation awareness, for example fixation on a single task to the exclusion of all else, has been identified as one of the key factors in accidents attributed to human error. Consequently other complex, high risk industries such as aviation and the military focus attention on understanding and improving staff situational awareness skills.

How can you do it?
It is relatively simple. We all have our unique mental picture of what is happening around us at any point in time. This mental picture or mental model is made up of all the information that is going into our brain that is being picked up by our five senses. It is our personal understanding of:
- Noticing what is happening
- What others around us are doing
- Foreseeing what will happen next
- What the implications might be and sharing them with the team.

The three main elements are:
- Patient: most clues come from the state of the patient
- Procedure: understanding the implications of the procedure
- People: the experience/ability of team members and where can you get it from: experience, teaching, expectations and briefing.

Appendix 2

References and further reading

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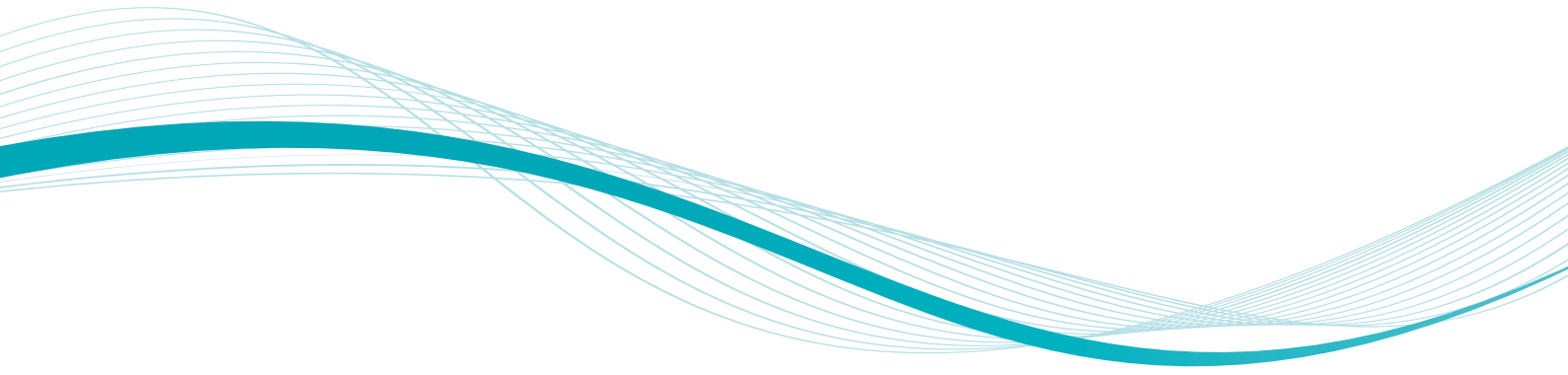

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