Literature Review

Transforming Safety Culture

Team Stripes - enabling high performing, reliable health care teams

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Introduction to Literature Review

This document presents a more extensive version of the literature review summarised in 'Transforming Safety Culture' white paper. Nine key themes emerged during the review of the literature, and they are presented here under their respective headings.

Safety depends on effective teamwork

> 'Teams make fewer mistakes than do individuals' (Baker, Day & Salas 2006)

Patient care is delivered by teams. Teams work together daily and are sometimes formed on short notice. Teams who are used to working together regularly will have developed routines and understand the knowledge and skills of their colleagues, whereas teams that are rapidly formed will need to rely on processes that will assist them to form and deliver safe care. Most of the time teams work well together to provide high-quality person-centred care, but there are times when the team finds it difficult to coordinate, communication is poor and the possibility for error increases.

Teams are made up of two or more people who have complementary skills and knowledge; are aware of their roles and responsibilities and work interdependently towards a shared or common goal (Salas, et al. cited in Shuffler et al. 2018). In health care there is a reliance on single professional groups (such as nursing, medical, pharmacy) to work effectively within their teams in a tribal way. The complexity associated with modern health care delivery has led the separate groups to recognise the importance of teamwork to achieve the shared goal of delivering safe, person-centred care. But, unfortunately, gaps in care coordination and communication are the most common system failures that lead to patient harm. Consider Jean who was introduced earlier. Her daughter observed multiple team members provide care to her mother, but what she didn't see was a coordinated approach which might have prevented her mother from developing a pressure injury and may have allayed her own distress as a daughter.

Patient safety and staff fulfilment are dependent on effective inter-professional teamwork (Welp & Manser, 2016). There is increasing demand on our health care system to provide treatment to patients who present with complex conditions that often include multiple comorbidities requiring multifaceted care on a frequent basis (Nancarrow, et al. 2013). In addition, new health care delivery models have seen the rise of health care sub-specialties. This means that a single patient might receive care delivered by more than one team who form the sub-specialties and who have the unique skills and knowledge to ensure a holistic approach to care.

Teamwork is not an automatic consequence of collocating individuals with the right skills and knowledge (RCP 2017). It requires the recognition and ability to combine the unique expertise of team members where all contributors work cooperatively towards a common and shared goal. That is the individual team members are willing to share their knowledge, are flexible when clinical

conditions change and look out for other team members to achieve the shared goal of safe person-centred care (Schmutz, Meier & Manser 2019). The make-up of a team is varied and will look different for each setting and for each patient.

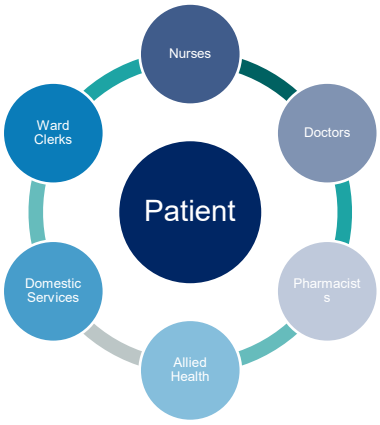

Figure 1: The patient at the centre of the healthcare team

Teams who engage in teamwork processes are 2.8 times more likely to achieve high-performance than teams that do not. (Schmutz, Meier & Manser 2019).

Beyond having the right skills and knowledge to carry out the task work, teamwork also requires other skills which Salas and colleagues (2009) refer to as the combined thoughts, actions and feelings of team members. Salas and colleagues (2005) describe the 'Big Five' in teamwork as, team leadership, mutual performance monitoring, back-up behaviour, adaptability and team orientation. Three supporting mechanisms - shared mental models, mutual trust and closed loop communication, are needed to combine these five factors (see Figure 5).

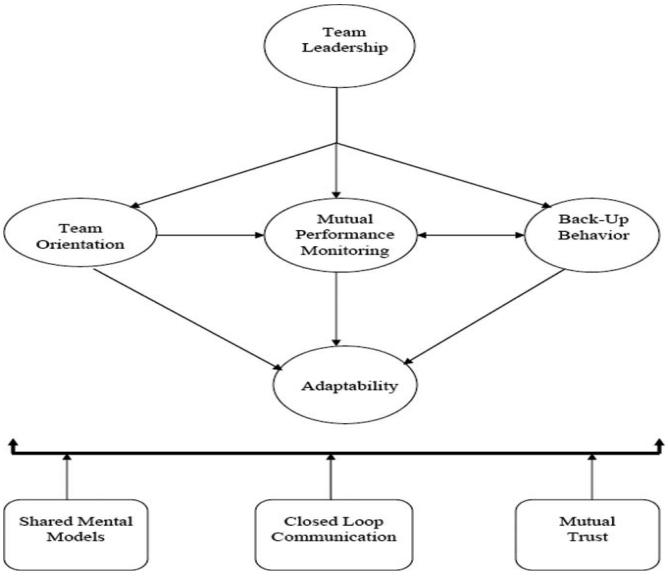

Figure 2: Big Five Model of Teamwork (Salas, Rosen et al. 2009)

The Salas model is a useful theoretical model applicable to any team. It defines the key characteristics of teamwork and the essential coordinating mechanisms required. To meet the

model in practice requires bringing together individuals who have the right technical or craft skills as well as the core (referred to often as non-technical) skills (see Table 2) and who can apply coordinated processes to achieve a shared goal. This exists in an engaged and productive workforce.

Core skills = interpersonal skills in:
Leadership
Communication
Decision-making
Situational awareness
Fatigue and stress management

Table 1: Core skills in teamwork

The role of clinical leadership

An essential characteristic of high-performance teams is strong clinical leadership; the type of leadership that guides with compassion and ensures a shared vision that aligns with the strategic vision of the organisation. West (2015) describes effective leadership as one which embodies transparency, equity, kindness and accountability.

Effective leadership in a traditional hierarchical model empowers the expertise that exists within their team. These leaders recognise the true value of their staff and lead in an environment which is psychologically safe. They value and model positive behaviours while ensuring that behaviours that pose clinical or personal risk are addressed (Leonard & Frankel 2012). Effective leadership is also dependent on staff who understand their responsibility and share the leadership, described by West and colleagues (2015) as collective leadership.

The role of leadership has been referred to throughout this document because of the clear evidence that links leadership and its role in achieving a culture of safety. For the context of this document the focus is on point-of-care leaders which is often expressed as an inter-professional co-leadership model within the (ideally) collective leadership domain. At the peak of the point-of-care hierarchy are the medical and nursing co-leads who work in a collaborative way to create an environment where staff are empowered to make good decisions which are aligned with the safety and quality agenda of their organisation. This is the ideal and won't automatically occur through the appointment of clinicians with the right credentials.

In a cross-case study review of five high-performing organisations in three countries, Baker (2011) identified ten key themes:

- Consistent leadership that embraces common goals and aligns activities throughout the organisation
- Quality and system improvement as a core strategy

- Organisational capacities and skills to support performance improvement
- Robust primary care teams at the centre of the delivery system
- Engaging patients in their care and in the design of care
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement
- More effective integration of care that promotes seamless care transitions
- Information as a platform for guiding improvement
- Effective learning strategies and methods to test improvements and scale-up
- Providing an enabling environment buffering short-term factors that undermine success.

The start of the COVID-19 pandemic posed enormous stress on point-of-care health care teams and placed immediate demand on leaders to create psychologically safe environments so that staff, particularly those in an unfamiliar area, felt safe to speak up and express concerns (Kerrissey & Singer, 2020). During this extraordinary time, teams, which are made up of clinicians and non-clinicians, sought predictable routines to help manage the potential chaos. What was essential, to maintain patient and staff safety and to build trust in newly formed teams, was the attention to evidence-based team communication processes (Tannenbaum, et al. 2020). For example, the use of 'briefs' or 'safety huddles'; personalisation through name badges which includes role as well as first name; and clear processes for handover (Kerrissey & Singer, 2020).

Health care is complex and unpredictable as we have been reminded with the recent pandemic. To manage the complexities that arise, no one individual can provide the standard of care that is required to maintain safety and quality for our patients and ourselves. Safe health care delivery therefore relies on interdependence (Rosen, et al. 2018). Lessons learned from successful organisations include leaders who embraced continuous improvement in a learning environment, with attention to staff capability building in improvement and a measure of success linked to best patient outcomes rather than to fiscal targets. Visit the CEC website for more detailed information on leadership.

Towards high reliability organisations

> We can assure our patients that their care is always provided by a team of experts, but we cannot assure our patients that their care is always provided by expert teams
> (Frankel, A., Leonard, M & Denham, C 2006)

As described earlier, teamwork happens when a group of people combine and not only bring the necessary technical and core skills but have the flexibility to build and maintain these skills in the pursuit of a shared goal. In the face of this, there is a heightened awareness of potential risks, and errors will be minimised, driving an environment of continuous improvement.

The literature on high reliability organisations (HROs) focuses on those industries that demonstrate near perfect performance where an error has the potential to cause catastrophic harm. Baker, Day and Salas (2006) argue that teamwork is an essential component of HROs. In health care there are millions of occasions of care provided annually and therefore, plenty of opportunity for serious adverse events which can be considered catastrophic to those involved, patients and staff regardless of how many people are affected. Fortunately, most of the care we provide in NSW health is safe and harm free.

However, with the increasing complexity of modern health care and the subsequent increased potential for preventable harm, health care has turned its lens to learn and adapt some of the habits of HROs. For example, situational awareness has become a part of the lexicon, and health care has adopted habits such as safety huddles to identify, anticipate and mitigate risk early, which can reduce the incidence of serious preventable harm (Aboumatar, et al. 2017). However, there is a belief that it would not be possible for a highly reliable health care organisation to be error free, but there is a higher chance it could be harm free (Sutcliffe, Paine & Pronovost, 2017). The literature describes five characteristics of HROs (Table 3).

Characteristics of High Reliability Organisations	
Preoccupation with failure	Process failures are addressed immediately and mitigated for at every level of the organisation
Reluctance to simplify explanations for operations, successes and failures	Successes and problems are subjected to a deep analysis and not explained away
Sensitivity to operations (situational awareness)	The conditions are set for openness by communicating frequently with employees who are hands-on and meeting them at the place where the work is done
Deference to expertise (point-of-care teams)	They know where the subject matter expert sits, and who has the specialised knowledge which helps them keep their skills and train others
Commitment to resilience	Prepare in advance for emergencies, anticipate trouble spots and improvise when needed with clear means of communication

Table 2: Characteristics of HROs (Agency for Healthcare Research & Quality [AHRQ])

In the context of unit-based teams, HROs are the consequence of high-performing teams. High-performing teams are considered those that share the common characteristics of teamwork, positive safety culture, continuous improvement and reward and recognition.

Teams working in times of crisis

During the 2020 COVID-19 pandemic crisis, there was an urgent need for rapidly formed teams to establish trust to reduce stress and minimise harm to staff and patients. Evidence-based practices which were already embedded or new to a department were either introduced, adapted or enhanced such as (physically distanced) 'huddles' or 'debriefs'. These tools have been especially useful to recognise the wins and successes, to communicate updates and to ensure shared mental models.

Mindful working

The evidence is strong on the role of mindfulness techniques for increased awareness and focus (Mrazek, et al. 2013). Through learning and applying behaviours which help to manage and lessen distractions, mistakes and the likelihood of error can likewise be reduced (Spinelli, et al. 2019). Mindfulness, in the context of this document, is the awareness of present moment events occurring both internally (thoughts and emotions) and externally (local environment) and observed without judgement (Sutcliffe, Vogus & Dane 2016). There is emergent literature on the role of mindfulness and high performance and the ability for teams to navigate the complex health care landscape.

Mindfulness practices can be formal or informal. Formal practices are intentional and done at a set time such as meditation or breath awareness. Informal practices are done throughout the day, such as being mindful while eating, walking or when in a conversation. These practices help to train the mind to be present in whatever activity you are engaged in at the time. When practised on a consistent basis, mindful awareness can assist health workers to address the stress and chaos, common in health care, with calm and focus.

In NSW Health the Meditation, Wellness and Compassion (MWAC) program uses an evidence-based, practical and secular approach to prepare staff to become facilitators in mindfulness techniques. Multiple Local Health Districts (LHDs) and Specialty Health Networks (SHNs) are engaged in the program and a critical mass of skilled facilitators, who teach mindfulness techniques to health care workers, is evolving.

Collective mindfulness, as a concept, was first described by Weick (1993) relative to HROs. Weick's description of collective mindfulness in HROs is indicated by the five characteristics listed in Table 3. The idea refers to the shared awareness and attention of a team to the events emerging within a specific context. How much individual mindfulness contributes to the ability of a team to achieve collective mindfulness is the subject of ongoing research (Sutcliffe, Vogus & Dane 2016). Saban and colleagues (2019), report that individual and collective mindfulness played an important role in the positive experience described by patients in an emergency department. Through developing

mindfulness skills at an individual level and combining these with techniques to enhance collective mindfulness, teams have more chance of high performance. One practical way for teams to contribute to a state of collective mindfulness is through the judicious use of shift safety huddles. Behaviours such as safety huddles require continuous support and uptake by all unit level staff until they become a habit (Sutcliffe, Paine & Pronovost 2017).

The benefits of individual and collective mindfulness include enhanced physical and mental wellbeing as well as task performance and decision-making (Sutcliffe, Vogus & Dane 2016). Patients who are cared for by health workers who practise mindfulness are more likely to experience patient-centred communication and report a higher level of care satisfaction (Beach, Roter, Korthuis et al. 2013). Dean and colleagues (2017) report that the introduction of a structured program of mindfulness engendered higher levels of empathy in Australian undergraduate health care students (Dean, et al. 2017). Other benefits for health workers include increased self-compassion and personal wellbeing (Morgan, Simpson & Smith 2014).

In practice: A simple technique to bring your attention to the present is to pause before entering a patient's room. Observe your sensations at that moment: Are you hungry? Tired? Do you feel any pain? Where are your thoughts? Are they with the patient you just saw or the patient further down the corridor? Take a deep breath to release the distractions and bring your mind to the present moment. Or simply pause before a patient encounter and pay attention to the experience as you wash your hands to bring your mind to the present moment.

Staff wellbeing

The quality of inter-professional teamwork has a direct correlation with clinician emotional exhaustion and clinician-rated patient safety (Welp, et al. 2016). Clinicians who are emotionally exhausted have lower levels of engagement and are less likely to be able to contribute to team functioning (Welp, et al. 2016). In addition, there is a relationship between staff work experience and the patient's reported experience of care. Staff who are less than satisfied with their work environment have compensated by labelling and choosing to care for those patients who are considered less demanding (Maben, et al. 2012).

Considering the ability for disenfranchised and, as is often the case, distressed health care staff to build walls of defense and develop a type of empathy distress fatigue (Hofmeyer, Kennedy & Taylor 2020), the teamwork discourse has had to expand. Out of necessity the language of teamwork and team effectiveness now extends to include the overlying concepts of kindness and compassion (Campling, 2018).

Patient and staff safety are reliant on individual accountability and effective teamwork which, in turn, depends on multiple factors and includes staff wellbeing. When a person's wellbeing is

negatively impacted it can manifest, in its extreme, as burn-out, emotional exhaustion, depression and anxiety. The impact of burn-out will creep into the general health of a person and can lead to substance abuse, relationship issues, and lowered immune response (Sexton, 2019).

Contemporary health care places excessive demands on patient care staff, for example through the increase in complex new technology and the need to constantly upskill. Patient acuity is rising and there is persistent pressure for beds and patient movement. Humans are fallible and, when under excessive stress or fatigue, will have an increased potential to make errors of judgement. This knowledge is central to the work of human factors' engineering. For further information on human factors in health care visit the CEC webpage.

In an early meta-analysis Parks and Steelman (2008) found a direct link between staff who participated in organisational wellness programs and lower absenteeism and higher job satisfaction. The attention to staff wellbeing as a predictor of effective health care delivery (Sikka, Morath & Leape 2015) has gathered momentum and peaked during the COVID-19 pandemic crisis.

The pandemic crisis produced significant stress for health care workers in relation to the surge in patients who needed treatment, the availability of personal protective equipment, personal risk of contracting the disease and fear of passing the disease on to family members or the community (Kerrissey & Singer 2020). In response there was an explosion of guides and material to support staff wellbeing and reduce staff distress and burn-out. Ultimately the ability for staff to provide effective person-centred care will be impacted by how well they feel cared for themselves (ACSQHC 2011).

Leadership strategies to promote resilience (Wu, Connors & Everly 2020)

- Provide a clear optimistic vision and realistic plan
- Act decisively
- Facilitate open, honest, frequent communication
- Normalise feelings of fear and concern among staff
- Provide access to peer support or other wellness programs
- Offer thanks and express gratitude to staff

The patient as partners in their care

Person-centred care is a wide-ranging concept and has been variously defined (Randall, 2016). In health care delivery, it is globally considered the gold standard approach (ACSQHC, 2019). A person-centred approach is a way of delivering care that considers the whole person and not just a patient with a medical diagnosis. Partnering with patients is a person-centred care approach. By

including patients/families/carers as partners we are showing them respect and valuing their insight and experience which connects to their health care rights. Also, it is a recognition that patients are highly invested in their own health outcomes. Patients who are involved in their own health care are more likely to follow treatment regimens (Randall, 2016).

> 'The quality of work produced by the health care system or macrosystem can only be as good as the work generated by the smaller units or microsystem' (Nelson, et al. 2002)

Multiple resources have proved useful in empowering patients to become active participants such as decision aids, education, support groups and open access to health care records. The CEC's REACH program was designed to enable the partnership through helping patients, their families and carer(s) to escalate their concerns with staff about worrying, often subtle, changes in a patient's condition. There are also strategies available to clinicians to support effective partnerships such as models of integrated care and education and training.

At the point-of-care patient safety depends on the patient/family/carer and health care provider partnership. Patients or their advocates need to be cared for in an environment which enables them to ask questions about their treatment choices and to provide input to their treatment decisions. Engaging patients and their advocates will help to reduce harm and injury. This can be done through improved communication strategies such as at bedside handover and multidisciplinary bedside rounds. When harm does occur, techniques such as open disclosure and involving the patient and/or their advocates in debriefs will help to build trust. This trust will be enhanced when their suggestions are adopted and actioned, or they are invited to co-design improvement.

Episodes of patient harm or adverse events can be decreased when patient advocates are actively involved in decisions about their care (Khan et al. 2016). Also, when patients, with experiential knowledge of a disease and its treatment effects, are enabled to partner in their care, the chances of adverse events are reduced (Pomey, et al. 2018). These partnerships also help to dilute clinician factors such as fatigue, cognitive bias or anchoring (Pomey, et al. 2018).

Patients and their advocates need the support and resources to become partners in their care. An environment which is psychologically safe and exists within a culture of learning, will provide the best skills to support this approach to care (Frankel, 2017). More information on partnering with patients can be found here.

Clinical Microsystems – understanding context

A cluster of high-performance teams does not automatically lead to an HRO. Each team, while working in a context-specific way, understands its connection and the impact of their work on other teams which make up the organisation. This is the role of clinical microsystems. The work on clinical microsystems arises from systems thinking theory.

Clinical microsystems (units) in health care are found at the point-of-care, where hands-on patient care is delivered in a context. They are made up of clinical and non-clinical staff, patients and their

family/carers. They have a common aim, work together using shared processes and are part of a larger organisation. Examples of clinical microsystems are myriad and include intensive care units, outpatient departments, emergency departments and delivery suites, for example. Each one is connected to the other although there are more natural associations that form between the microsystems, for example, delivery suites, post-natal units and newborn care centres. Microsystems are often described as the working hub of larger organisations or health care systems (Nelson, et al. 2002).

In a study of twenty high-performance teams Nelson and colleagues (2008) identified nine success characteristics (Table 4) which were shared by the teams. The nine essential characteristics interact dynamically with one another and will vary in meaning depending on the context and the associated patient populations. For example, the prominent characteristics in an aged care unit will likely differ from the prominent characteristics in an acute hospital surgical unit.

Essential characteristics of clinical microsystems	
Leadership	Interdependence of care team
Safety Culture	Information and information technology
Macro-organisational support	Process improvement
Patient focus	Performance improvement
Staff focus	

Table 3: Essential characteristics of clinical microsystems

A clinical microsystem self-assessment tool is used to help teams identify potential areas for improvement. A limitation of similar tools is the risk that the self-assessment will become a checklist and could detract from the ability of the team to be creative, identify their own context-relevant improvement priorities and think beyond their own unit. That is, not all improvement priorities will be limited to change within a single unit. It is often necessary for a unit to collaborate with another or other unit(s) to affect change, for example, an emergency department and a medical unit or an operating suite and a surgical unit. This was our experience with a previous CEC program which used a self-assessment. Some teams used the tool in a single discipline way, as a list of headings to be achieved and therefore, potentially missed underlying risks and priorities. This experience has contributed to the design of the Team Stripes framework to ensure that teams are able to contribute, reflect, recognise and prioritise their improvement.

The work of clinical microsystems recognised that for a unit, and therefore an organisation, to produce quality work, attention needs to be given to the people who produce the work. One way for an organisation to understand how those who produce the work experience their work, is through questionnaires; but not through questionnaires alone, and not without a clear process for reporting

back and acting on the data that arises. The ability for a team to identify their strengths and areas to develop will engender learning and improvement.

A culture of safety

What we observe, measure and experience is defined as the culture of a unit. Through an understanding of clinical microsystems, the culture in one unit contributes to and informs the culture of an organisation.

Culture is what a new person observes, learns and, most often, copies when they join a team. It's what is commonly referred to as 'the way people go about their work'. Culture is the collective values and behaviours a team exhibits, which includes the way they communicate. This can be positive or not, as in the case of teams who do not consider the views of team members who perceive health care from a different lens to their own. For example, one person might view a patient from a clinical lens while another might view the patient from a social or cultural lens; or more broadly, when one provider group makes decisions about a patient's care without considering the perspectives of other groups.

Safety culture forms a part of the overall culture and refers to the attitudes and actions of staff relative to safety (risk), such as the safety of patients, staff and visitors to a health care organisation. James Reason (1998) described five elements of safety culture: the addition of Restorative brings together elements of Reason's Safety Culture Model, specifically the 'Just' and the 'Learning' elements, e.g. assign no blame and attempt to learn from what the error has taught us about our practice and our system and high-trust addresses the need for trust as the foundation from which openness, learning, reporting, etc. can occur.

Elements of a Safety Culture	
Informed	Processes are in place to ensure all staff are supported to apply new systems and processes and these are communicated through a variety of modes such as verbal, poster or electronic modes
Reporting	There is a desire to use voluntary reporting systems and processes are in place to ensure feedback is provided following submission
Learning	Interrogating not only when things go wrong but also 'near-misses'
Adaptive	Staff have the support to adapt to the dynamic health care environment which changes rapidly in terms of patient acuity, leadership and team members
Just	An atmosphere of trust where staff feel safe to speak up for safety
High-Trust	Staff and leaders demonstrate trustworthy behaviour and have strong interpersonal work relationships, which enable psychological safety in discussions about harm, error, and near-misses.
Restorative	Staff, teams, and leaders aim to repair trust and relationships that may be damaged by an incident

Table 4: Elements of the CEC Safety Culture Framework

Each clinical unit or context will manifest its own safety culture with the collective context-driven safety cultures contributing to the overall organisational safety culture.

Measurable outcomes of clinical units with a positive safety culture include:

- Stable workforce with high engagement
- Minimum preventable patient harm
- Continuous learning and improvement
- Innovative change and improvement opportunities identified by hands-on staff
- Benchmark average length of patient stay

We coach clinical teams to measure safety culture using the Safety Attitudes Questionnaire as part of a discovery phase towards understanding the experiences of the people who generate the work and to identify improvement priorities. Clinical teams most commonly attend to communication processes and teamwork as areas for improvement to enhance a culture of safety.

Psychological safety

> We are almost hardwired to be worried about the impression we make on others
> Amy Edmondson, professor, Harvard Business School

Team psychological safety is defined as the belief that teams are safe to take inter-personal risks which is therefore associated with team learning behaviour (Edmondson, 1999). In other words, team members feel safe to take risks at a personal level and seek help or admit error. A climate of psychological safety is essential in a learning and just culture where team members are more likely to speak up, without fear or embarrassment, about errors or 'near-misses' (Edmondson, 1999).

Psychologically safe environments allow diversity of thinking and enable teams to not only share innovative or creative ideas but to also provide feedback and to ask for help. It arises from the mutual trust demonstrated in high-performance teamwork.

Consistent with high-performance teams, patient safety will be enhanced in the presence of psychological safety, through team member collaboration and their ability to contribute to safety and quality improvement (O'Donovan, 2020). In an early study which examined whether better teams made fewer mistakes, Edmondson (1996) found to the contrary. Instead, what her research found was that teams who had the qualities for high-performance, including supportive leadership and valued relationships, had a higher error rate. Further exploration found that these teams did not necessarily commit more errors but had a higher reporting rate and were able to discuss and learn from the errors (Edmondson 1996). This is due to the ability of staff to speak up.

Psychological safety in teams takes time, consistency, and trust to build but can be shattered in an instant when a team member feels ridiculed or threatened. When team members experience rudeness they are less likely to be collaborative and adverse consequences in diagnostic or task performance are a consequence (Risken, et al. 2016). Left unaddressed the result is measured in poor patient outcomes and a negative impact on patient and staff experience. The difference for psychologically safe teams is the ability for a junior staff member to phone a senior consultant in the middle of the night when they are unable to find answers for a patient's clinical signs of deterioration without fear.

Leaders promote psychological safety through behaviours more than through words. For example, through leader visibility, frequent check-ins with team members and providing, as well as receiving, feedback. This includes fostering healthy conflict and embracing curiosity. Team members who are psychologically safe are more likely to bring their full selves to work. For more information on psychological safety see be a voice for safety.

'Just like me', is an exercise to remind us that we are all humans and is a useful activity to reflect on before we jump to blame and judgement or criticism. The reflection has been attributed to multiple sources including the Dalai Lama and Pema Chodron.
Pause and consider:

- This person has beliefs, perspectives, and opinions, just like me.
- This person has hopes, anxieties, and vulnerabilities, just like me.
- This person has friends, family, and perhaps children who love them, just like me.
- This person wants to feel respected, appreciated, and competent, just like me.
- This person wishes for peace, joy, and happiness, just like me.

Discussion

The research on teams has taught us that teamwork is a complex phenomenon and does not occur as an automatic consequence of mixing the right people with the right skills and knowledge. Teams depend on strong leadership that sets clear direction where team members understand their roles and responsibilities. Safe, quality patient care is best delivered in an environment where members feel safe to speak up, innovate and receive feedback. Attention to staff wellbeing along with recognition and reward is viewed as a necessary resource to ensure safe health care delivery.

With established communication processes to assist care coordination, team members recognise the need to rely on the different skills members bring to the team and to work interdependently towards a shared goal. For the broad health care system to achieve high reliability, context-specific attention needs to be given to the smaller systems that make up the organisation.

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http://www.cec.health.nsw.gov.au/improve-quality/team-stripes

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