Professor Lynn Robinson is the Director of Research and Development at the Centre for Innovation in Professional Learning (CIPL), The University of Queensland, where her interests are in large-scale professional workforce capacity development, particularly using online networks. Before joining CIPL in 2010, she had a long career in the health care sector encompassing general practice, hospital administration, health system reform and health systems research. She has had a lifelong interest in education and has taught many thousands of health professionals on topics related to clinical leadership, teamwork, innovation and quality and safety.

Multimedia resource

In addition to the lecture transcript below, this lecture is available as a multimedia presentation (audio over PowerPoint slides).
## Delegated practice: teamwork

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**Delegated practice: teamwork**

**Professor Lynn Robinson**
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<td>Delegated practice is fundamentally linked to teamwork. And teamwork needs work in all circumstances, so we are going to take a little time to look at some of the particular challenges that we find in the real world of our health care system working in teams. And, of course, we can’t finish without talking a bit about how to build in quality into everyday practice.</td>
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- Teamwork as a key part of delegated practice models of care
- Challenges to teamwork and the supervisory relationship
- Building in quality systems
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| 3            | Allan S. Frankel | “Currently, 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.”

[1] This is a quote from Allan Frankel, a clinician and leading figure in American research and teaching for patient safety, and a passionate advocate for training in teamwork for clinical teams.

There’s now a compelling body of evidence that the effectiveness of teamwork is just as important if not more important to quality and safety than the individual competencies of the clinicians who deliver the care. Yet it is not always a focus for clinicians or health organisations.

We will focus on it here, as delegated practice models of care require excellent teamwork, not only from the clinical supervisor and assistant (you could say, at the least, this is a team of two) but also from the various members of the team to which they contribute.
### What is a team?

#### More than
- a group who work together
- good interpersonal relationships
- communicating and/or delegating
- collaborating

#### Team is a group who work together and...
- share a purpose or goal
- have explicit ways of making team decisions
- have specific roles, skills and responsibilities
- are dependent on each other to carry out specialised tasks

Teamwork is such a widely used term that we hardly pay any attention to its real meaning. In some ways, its meaning has become so non-specific that it does not contribute much to our understanding of how to create or contribute to effective teams.

Let me make for you a subtle but important distinction between a group who have good relations with each other, and a team, which is quite another thing.

This list is fairly straightforward in its distinctions. A team is a group, but not all groups are teams.

Moreover, studies of high performing teams show two very practical and obvious features that are common to all high performing teams. One is that members are conscious of their membership of the team and have a commitment to it and each other as a team.

The second is that the team spends time and effort on being a team, above and beyond the day-to-day execution of the teams’ technical work. This doesn’t
Delegated practice: teamwork

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<td>mean going off to boot camp in the bush together necessarily. But it does mean things like discussing roles and processes, taking time to debrief and reflect as a team, collectively monitor the performance of the team. High performance teams do this in a myriad of ways – it doesn’t have to be a formal team meeting, although if the team is new, this is probably the only way to get started. Indeed in many very high performing teams, you see this type of work about teamwork happening regularly on the fly. The important thing is that a team does work to be a team, not just the work of the team.</td>
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<td>So, let’s do a bit more on teamwork. I think what joins us altogether in teams in health care, is that we do have a shared commitment to our patients. This can almost universally be relied upon, and is actually the glue that holds our teams together. And therefore I think that it can almost be universally relied upon that people do accept accountability for their roles in patient care, and this should be supported and affirmed on a regular basis.</td>
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<td>But we need to conscientiously do more than just make that assumption that we’re all here for the same reason and we’re all committed, although that’s an important underpinning.</td>
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<td>So what can we do explicitly to actually make team cohesion an everyday reality?</td>
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<td>I mentioned earlier the need for actually establishing clear lines of communication and processes for communication. While as health professionals we generally have pretty good interpersonal skills and communication skills, there is no substitute for formalising this and having</td>
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|              |       | everybody agree to what the communication lines should look like, and to hold each other accountable for them.  

It’s important to also have clear understandings of boundaries. It’s hard to do this in a well-functioning team, because as people grow in their roles and their skills and their confidence in each others’ competence, boundaries in fact can be dynamic, and it’s desirable that they are. But it’s important that the constant renegotiation of these boundaries again is explicit, so that everyone understands where their roles starts and stops. And if the situation alters, whether they maintain the authority to continue on with the plan, or whether they need to go back and check with their supervisor.  

It’s critical that there be respect for the skills and contributions of all team members, and so that we might all be different with different roles, we’re still equal in the team, equal in that we all take a shared commitment and accountability to patient care. It’s vital, as in all areas of health care quality achievement, that we create a culture in
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<td>our teamwork of openness, collaboration and learning from mistakes, avoiding at all costs the blame game. And having a culture of safety, where people can report variations, report difficulties etc., and even as I said earlier, comfortable to say, ‘Look, I’m really not comfortable in taking on that care process or task. I need further training’, or ‘I think this patient is particularly challenging and there are things going on here that I think make this different, from the normal care that I’m accustomed to carrying out with limited supervision.’</td>
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Now, there are many, many special issues, and you'll discuss these more in your group activities.

But let's have a look at a few here. One of the ones that is common in Australia, is the issue of whether clinical supervision needs to be constant and present, or whether in fact it can be 200 kilometres away. And where in between, in any instance, we can make it work.

Naturally the further away the supervisor is on a moment-to-moment basis, the more challenging the teamwork becomes, and the more important it is that you actually create those tools of teamwork like care plans, regular meetings, observational visits – whatever you’ve decided with your team is the most appropriate way to ensure that the care plan itself is carried out and the patient’s safety and well-being is ensured, and that team members are all comfortable with that.

One of the under-utilised mechanics of course, is that we do now actually have very good video telecommunication links, particularly in remote areas,
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<td>It was interesting in WA when allied health assistant pilots were conducted, that that was one of the techniques that wasn't used as much as maybe it could have been, even when video link was in place. I find that fascinating in the light of the fact that the observational visits were the ones that were challenging for the supervisors and assistants to find the time to do, and yet the video conferencing wasn't used as much.</td>
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<td>I think we have an obligation as supervisors of assistants working remotely from us, to actually become skillful in the use of some of the more modern technologies that actually allow us to get the quality of clinical supervision in place that's required.</td>
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<td>The greater the challenge, the more effort we need to put into the supervisory relationship, because of course there are these circumstances where it can come unstuck, when it's remote.</td>
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<td>But there are many, many examples of good clinical supervision and very</td>
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Estimate: 15 minutes
### Effective Teamwork Happening Across Distances

Effective teamwork happening across distances, and I think we are in a position now to be much more innovative and to use technology more effectively.

### Challenges to Team Dynamics

- **Cultural dynamics**

- ‘Junior’ - ‘Senior’ dynamics

Another challenge can be the challenges to team dynamics. In some instances, for example, part of the reason for working in teams is that we actually have team members who have explicit cultural connections to the clients or patients whom we look after.

An example of that would be where you have indigenous health workers, or people who have been employed in rural communities because of their cultural or community links, and they may have clinical supervisors who have not had that cultural experience or background.

So it’s important to be aware of those issues if you’re working in a team where there’s been a deliberate mix of backgrounds and cultures, in order to better service the clients, that that can put additional stresses on the communication.

And I’d encourage everyone to actually...
undertake specific cultural awareness training, not just for our own indigenous communities, but also in many clinically or medically under-served areas where multicultural communities are the target of our services.

And quite commonly one of the advantages of working with assistants is that it’s much easier to find somebody from that community background who’s trained as an assistant, than possibly to get a medical practitioner or a pharmacist or allied health professional who’s actually got that background.

So just embrace the challenges, be aware of them, if you do have a multicultural team working with that multicultural or a culturally sensitive environment, to make time in your teamwork to establish the proper level of skills and competence culturally.

One of the really interesting challenges for working with clinical assistants is that as a registered health professional, you may in fact be the youngest members of the team in some instances. So we have, particularly in rural and regional areas, quite junior registered health
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<td>professionals, say the second year out physiotherapist, as supervisor for a rehab assistant say where the rehab assistant may have been doing this job for 10 or 15 years and be extremely clinically able. Often these people are also very keen and effective patient or community advocates within the health service itself. And this poses particular challenges, I think, for both sides of the relationship. It’s worth exploring that a little bit further, and you can do that in your activities.</td>
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Another challenge that's been alluded to in other places is where you have assistants, for example, who are working across multiple care plans, or maybe have multiple clinical supervisors.

Often in these circumstances there's a different line manager, who's the line manager for the whole health service delivery. Particularly, say, in rural areas. So you may have a rehab manager, and you might then have community rehab assistants, who actually take briefs from a range of allied health therapists for different patients that they may be looking after in any one week. And this puts a significantly larger burden on communication, and on balancing resources, and can be quite challenging, I think, for the assistants involved.

And again, the only way you can tackle this is to actually be aware of it and sit down and work your way through these issues as teams, and go over your checklist that we alluded to earlier, in terms of the structure and functioning of your team and the lines of communication, and work your way through the issues and be willing and

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<td>Another challenge that's been alluded to in other places is where you have assistants, for example, who are working across multiple care plans, or maybe have multiple clinical supervisors. Often in these circumstances there's a different line manager, who's the line manager for the whole health service delivery. Particularly, say, in rural areas. So you may have a rehab manager, and you might then have community rehab assistants, who actually take briefs from a range of allied health therapists for different patients that they may be looking after in any one week. And this puts a significantly larger burden on communication, and on balancing resources, and can be quite challenging, I think, for the assistants involved. And again, the only way you can tackle this is to actually be aware of it and sit down and work your way through these issues as teams, and go over your checklist that we alluded to earlier, in terms of the structure and functioning of your team and the lines of communication, and work your way through the issues and be willing and</td>
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So these are some of the special issues that we'll look at in some of our activities as well, and you might like to reflect on whether any of those special issues apply to you and your assistants.

Now, ultimately this environment is about health care delivery, and delegated models of care are one of the models for delivering health services, now and into the future. And it's important that we think about the way we manage these models using a quality framework, as we do with everything else clinically.

So what are the elements of quality systems that apply to the clinical supervisory assistant relationship in teams now? We've alluded to a number of them before. It's very important to make explicit standards, and to have documentation about standards, which we can use as benchmarks to measure ourselves against. But it's key to the actual implementation of those standards, that teams develop tools for their implementation.
For example, I alluded earlier to the Western Australian pilot for allied health assistants in rural and remote communities, and one of the things that was found by both supervisors and assistants there to be extremely beneficial, was a logbook. And it was a logbook not just of the care of the patients, but explicitly about the nature of the supervisory relationship. So how often had there been communication between the assistant and the therapist, what was the nature of that, were the observational visits conducted on time, and so on. And this record of the process of implementing assistant care within rural communities, was actually the subject of the monitoring through the logbook system.

Now that's one tool. I'm sure you can use your local teams and your quality training to actually think of a range of suitable tools that you can build into your quality systems so that you can actually see where you're getting the results and you're implementing the processes and getting the results that you think you are within your team. It's important that there be data created, that you can use for monitoring so that...
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<td>you can track on to the standards that you’ve set yourselves, and that you have a regular review process to actually have a look at the results of that monitoring.</td>
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<td>And within a team culture that we described earlier of no blame and shame, but everybody working together to actually improve the delivery of care and the performance and the job satisfaction of all members of the team, you can actually close the loop and be on a continuous improvement cycle.</td>
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<td>And I hope that you will do that, and that in the process of doing that, you also share those experiences with other teams. Can you contribute to the development of, say, a peer support, or a culture of borrowing other peoples' quality solutions to implement in your own environment as appropriate? Perhaps you might establish some networks from this course.</td>
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<td>So let’s sum up. Teamwork needs work. Respect and communication are fundamental to teamwork. But the work of teams is to actually identify systems and processes that are agreed by the team to optimise the teamwork. Distance, team differences and organisational structures are all challenges but ones that you can overcome by working through with your teams to how you’re going to address them. And the work of the team also includes monitoring its own performance and addressing issues to be on a continuous improvement cycle.</td>
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References

Learning Goals
Have you met these Learning Goals?

- Describe the elements of effective teamwork as they apply in delegated practice
Teamwork challenges

Group learning

Table of contents

1.0 Your team situation
2.0 Improving your teamwork for delegated practice

Learning Goals

- Describe the elements of effective teamwork as they apply in delegated practice

Reflection

If your team is working progressively through the materials in this workshop over a period of weeks, take a moment to quickly refresh your memory of what you have previously covered in this workshop before continuing on with this new topic.
1.0 Your team situation

**Group discussion questions**

1. List the roles that exist in your clinical team.

2. What challenges are inherent in your situation?
   - Role relationships complicated? For example, many health professionals giving work to a single assistant? Or manager not the supervisor?
   - Inexperienced health professional or inexperienced assistant?
   - Remote supervision required?

3. What strategies do you currently have in place to assist the team to be effective in response to these challenges?

4. Are there any adaptations that you would like to apply to existing strategies or processes? Alternatively, are there any new strategies or processes that you would like to implement to develop your teamwork in relation to delegated practice?
2.0 Improving your teamwork for delegated practice

Instructions

Use the space provided below to note down:

(a) steps that you have identified for yourself within your role in the team

(b) agreed actions amongst your team for how you can improve your teamwork within a delegated practice model of care.

Steps for your own skills:

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Agreed steps for your team:

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Learning Goals

Have you met these Learning Goals?

- Describe the elements of effective teamwork as they apply in delegated practice

Authority

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