CONCEPT

Teamwork and Patient Safety Culture: Huddles, SBAR Handover and Speaking Up

31 May – 4 June 2027
London - Central London four-star



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Introduction:

Teamwork and patient safety culture decide whether a ward, theatre or clinic catches a wrong-site risk, a deteriorating patient or a missed medication before harm occurs. Communication breakdown within care teams and silence in the face of concern remain leading contributors to avoidable harm, yet many units run no briefs, no huddles and no shared handover structure. This Core Concept course equips nurses, physicians, allied health staff and unit leaders with team structures, structured communication and speaking-up tools, and ends with a Unit Teamwork Improvement Plan with safety culture measures.

Course Objectives:

- Diagnose human factors and teamwork failure patterns on a care unit using a team behaviour observation baseline
- Organise unit team structures and run briefs, safety huddles and debriefs with defined roles and escalation routes
- Use SBAR, call-outs, check-backs and structured handover tools for escalation, critical orders and transfers of care
- Raise safety concerns with graded assertiveness and resolve interprofessional disagreement without delaying care
- Interpret safety culture survey results and lead safety walkrounds that link findings to just culture responses
- Build a Unit Teamwork Improvement Plan that involves patients and families and sustains team training with measures

Target Audience:

- Frontline nursing staff responsible for bedside care, shift coordination and patient handover
- Physicians and medical trainees responsible for orders, procedures and responses to escalation calls
- Allied health practitioners responsible for pharmacy, therapy, imaging and laboratory input to shared patient care
- Unit and shift leads responsible for staffing decisions, daily huddles and team performance on the ward
- Clinical educators and simulation staff responsible for team training and competence refreshers
- Patient safety coordinators responsible for safety culture surveys and unit safety programmes

Course Outline:

Day 1: Human Factors and Teamwork Failures in Patient Care

- Human Factors in Clinical Work: Fatigue, Interruptions, Workload and Cognitive Limits
- Teamwork Failure Patterns: Silence, Steep Hierarchy, Assumed Information and Role Confusion
- Clinical Team Structures: Core Unit Team, Rapid Response Team, Coordinating Team and Contingency Team
- Shared Mental Model, Mutual Trust and Adaptability in High-Performing Care Teams
- Unit Teamwork Baseline Using a Team Behaviour Observation Tool

Day 2: Safety Culture Models and Healthcare Teamwork Frameworks

- Reason Model of Informed, Reporting, Learning, Just and Flexible Culture
- Safety Culture Survey Dimensions: Teamwork Climate, Leadership Support, Reporting and Staffing
- Evidence-Based Healthcare Teamwork Systems Adapted from Crew Resource Management
- Team Competency Domains: Leadership, Communication, Situation Monitoring and Mutual Support
- Unit Team Charter: Roles, Escalation Routes and Meeting Rhythm

Day 3: Briefs, Huddles, Debriefs and Structured Clinical Communication

- Start-of-Shift and Pre-Procedure Brief Checklist
- Daily Safety Huddle Format: Watch-List Patients, Staffing Risks and Open Issues Board
- SBAR Escalation Calls to Senior Clinicians and Rapid Response Teams
- Closed-Loop Call-Outs and Check-Backs for Critical Orders and Results
- Post-Event Debrief Guide and Structured Handover Tools for Transfers of Care

Day 4: Speaking Up, Mutual Support, Conflict and Safety Leadership

- Graded Assertiveness Ladder and the Two-Challenge Rule
- Situation Monitoring Scan and Cross-Monitoring: Patient, Team, Environment and Progress
- Mutual Support and Interprofessional Conflict Resolution with the DESC Script
- Leadership Safety Walkrounds and Just Culture Responses to Unsafe Acts
- Patient and Family Engagement: Speak-Up Invitations, Family Escalation Lines and Bedside Handover

Day 5: Team Simulation and the Unit Teamwork Improvement Plan

- Simulated Deteriorating Patient Scenario: Huddle, SBAR Escalation and Call-Outs
- Simulated Speaking-Up Scenario: Challenging a Senior Clinician Before a Procedure
- Scenario Debrief Scoring with Team Behaviour Markers and Peer Feedback
- Plan Sustainment Section: Unit Coaches, Refresher Drills and Survey Remeasurement Cycle
- Unit Teamwork Improvement Plan Presentation with Safety Culture Measures

Skills You Will Gain:

- Team Structure Design
- Safety Huddle Facilitation
- SBAR Escalation
- Closed-Loop Communication
- Graded Assertiveness
- Interprofessional Conflict Resolution
- Safety Culture Survey Interpretation
- Leadership Walkround Practice

Why Attend This Course:

- Leave with a Unit Teamwork Improvement Plan, rehearsed in simulated scenarios and tied to safety culture measures
- Practise speaking up to senior colleagues in realistic scenarios and receive observer feedback on the wording used
- Replace informal handovers and corridor escalations with brief, huddle and SBAR routines the whole unit can adopt
- Compare teamwork practice with nurses, physicians and allied staff from hospitals, clinics and long-term care services

Conclusion:

Safe care depends on teams that share one picture of the patient, speak up early and support each other under pressure. The course moves from human factors, teamwork failures and clinical team structures, through safety culture models, survey dimensions and team competency domains, to briefs, huddles, SBAR, call-outs and handover tools, then to graded assertiveness, situation monitoring, conflict resolution, safety walkrounds and patient and family engagement. The final day runs simulated care scenarios and produces a Unit Teamwork Improvement Plan with safety culture measures.