This is side A of the observer checklist. General instructions for completing this section are included at the top of the page. You begin by inserting the names of each team member participating in the exercise across the top of the columns. You are assessing individual performance in this section of the checklist. The instructions also include the rating scale you will use as you assess the team’s collaboration skills. You’ll notice the 9-point scale at the top of this page. At the end of the scenario we would like each one of the members you have observed to be assigned a number on the nine point scale for each of the 6 collaboration competencies. I’ll speak in detail about this scale shortly.

First I would like to review the 6 core collaboration competencies that you will be assessing. These competencies are listed in the first column.

Communication is the first one. There are sub-category examples of what is included in the communication competency. These include active listening, the ability to attend to the other person on the team when they are speaking, being able to have a positive body language and demeanor that reflects that they are respectfully listening to what is being said. These would include behaviours such as not interrupting the other person, or looking distracted or flipping through notes. You will also be assessing how well each team member is able to communicate in an articulate, clear way that conveys their message well to the other team members.
Collaboration is the second competency. This is the ability to demonstrate by word and deed that you are able to take what you have heard from other team members in terms of their skills or their input and being able to frame back those ideas. Included here is demonstrating the recognition that there is some value to other ideas that you can show by thinking out loud, by talking out loud and generally, engaging in this conversation of changing and multiple ideas to effectively manage the patient. Therefore, collaboration is that idea of respectfully receiving the input of others and demonstrating that you can go forward with both your own ideas and other team member’s ideas for a better patient outcome.

Roles and responsibilities is the third category and this is where we are looking for the team members to demonstrate their scope of practice and how well they articulate a sense of scope of practice of the other people on the team. As opposed to collaboration where you might observe them saying “that is a really good idea, I hadn’t thought about that. Why don’t we think about putting that forward in this kind of way?”; in this competency you are looking for team members to be saying something like, “Well if someone were coming to see you in your role would you be doing this or this?” You are also looking for people to be clarifying their role and probing other people’s roles. Again, discussing the roles and responsibilities and how they differ or overlap with one’s own roles and responsibilities is the focus of this competency.

Collaborative patient-centred or patient family-centred approach is the forth competency. This is a catch all where we are hoping the observers will take a look at how the individuals on the team use, question and discuss patient-specific life circumstances, cultures, values, beliefs that they may feel are important from that scenario. They should be asking other team members their opinions around those ideas and be taking a patient and family centred approach in ways that incorporate the patient and potentially their family into the decision making and care plan.

Conflict management resolution is the fifth competency. As it says, you are looking for people to demonstrate respect toward other professionals and work with them to prevent and minimize or resolve conflict. Inevitably in a team that is trying to come together to solve a difficult clinical dilemma there will be differences of opinion, and perhaps differences in terms of approaches. There may be more assertive and less assertive team members and you should look at how those normal features of having individual thoughts and feelings and ideas are managed and dealt with by the individual.

Team functioning is the sixth competency. This is more a catchall that takes a look at how the team members divide up things like leading the conversation, coming to a resolution, pointing a direction for the team, using the time of the team meeting well, was it focused on task, was there a lot of chit chat. The general coming together as a team, ideas around leadership, using the time well, with a focus on a quality of care is what is being assessed here.

Those are the six core collaboration competencies you, as an observer, are assessing for each team participant. We suggest you make little notes in the boxes as the scenario is unfolding that are prompting reminders of what someone said or what you thought about that. You may want to refer back to that at the end when you are making your final decision regarding each score. Once the scenario is over the observer takes a moment or two to look at the grid, the nine point scale and then assign to each person in each of those six categories a number on that scale so at the end each person has six different numbers in their boxes and that whole grid is filled out.

Now let’s take a closer look at the rating scale.

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Many people ask us about what we mean by “well below expected”, “below expected”, “expected”, “above expected”, well above expected” on this grid and what we are asking is for discernment to be done according to the individual team. This can be the norm to which you are comparing it. For example, is this a new team, have they just come together, are we expecting them to be in those early stages of a team where you don’t all necessarily know each other’s roles and maybe don’t even really know how to function in a team setting well? Therefore, “expected” would be according to the developmental timeline of the team. If this was a well-oiled team that had been together for many, many years then you might be saying that expectations would be compared to a team that has been together for many, many years and should have a good understanding of what each other does and how they work together in a team meeting. The norm for this thing called “expected” has to be customized to the genesis of the team and how long they have been together and how experienced they are.

One last point about scoring individual team participants: In our recent evaluation project, observers sometimes struggled with how to score a particular team member if they didn’t have much of a role in that particular clinical case (i.e. a dietician participating in a patient case discussion around mental health issues). Participating in a team meeting isn’t always about speaking up or having equitable amount of air time. Therefore, even team members who feel this problem doesn’t have a lot to do with their particular clinical area have an opportunity to demonstrate a greater understanding of what the roles are of the rest of the team. They can always be a sounding board. They can be the kind of person at team meetings who helps facilitate how the team meeting unrolls, and provide some leadership and structure to it. There is more to coming together as a team than just being able to equally participate in the clinical scenario that is unfolding and that is what we are looking for.

That is a fairly detailed description of how to complete page one (scoring the individual competencies) of the checklist. Now let’s move on to the second page.
This second part of the observer sheet is an assessment of the global rating scores and again in our research we found that coming up with a global rating score for the team, an overall gestalt of how well did the team do, was itself a highly valuable score. The reason we looked at this was because we wanted to know which seemed to be a better assessment of team competencies, those six areas and all the individual things we just spoke about or the overall gestalt of the individual based on observing teams working together. We think that teams can pick and choose once they are using a TOSCE whether they prefer to complete the individual assessments and the global assessments or just one or the other. The first part on the back is just to give an overall rating and we would encourage the observers not to flip back to the first page. The previous section (side A) is a drill down based on exactly what was said. This second part is an overall summary opinion in a way. You should complete the global scores using the same 9-point scale as previously used on side A. Assign a global score to each team member as well as an overall team score (how well did the team perform as a whole).

And then the very last part of this sheet is an area we call “red flags”. We included this because we didn’t want the observers to be distracted by something that is said in a TOSCE related to a clinical comment, whether, it may be that you hear something that you disagree with in terms of how you might clinically manage this patient. Or you may think an error was made on a bit of clinical knowledge, a wrong medication chosen, wrong dose, anything that you would consider to be something clinically relevant. If you feel something is significant enough you should note it here to discuss later with the team during the debriefing session.
That is basically what is involved in assessing primary care team collaboration competencies within the TOSCE.