# Teaching Tool 3 – Small Group Teaching

CanMEDS Leader

## **Leading and managing in everyday practice**

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Completed by:

### Instructions for Learner

Draw from ***your clinical practice over the past four weeks*** to answer the following questions. Be sure to use specific details.

1. Describe a situation where you were a leader and you were pleased with the process and outcomes. Include details about clinical location/setting (patient types, type of service, your role in this location and situation). What, if any impact did the location/setting and your role in that location have on the outcomes?
2. Describe a situation where you were a leader and you were NOT pleased with the process and outcomes. Include details about clinical location (patient types, type of service, your role in this location and situation). What, if any impact did the location and your role in that location have on the outcomes?
3. Based on ONE of the situations from above answer the following questions.
	1. What aspects of leadership (e.g. goal setting, accepting responsibility, delegation) did you do well in that situation?
	2. What could you have done differently to achieve better outcome(s)?
4. Review the tables below. Select and complete the tables below that apply to this situation

**🞎 Leadership process applies to this situation**

**🞎 Leadership process does not apply to this situation**

**🞎 Done**

**🞎 Not Done**

**🞎 N/A**

|  |  |  |  |
| --- | --- | --- | --- |
| Leadership processIN THIS SITUATION | Rating | Comments | Areas or ideas for improvement? |
| Done | Not done | Not applicable |
| I asked what needed to be done |  |  |  |  |  |
| I explicitly determined what was right for the patient(s), problem, organization etc.  |  |  |  |  |  |
| I developed and documented action plans |  |  |  |  |  |
| I took responsibility for decisions |  |  |  |  |  |
| I took responsibility for effective communications |  |  |  |  |  |
| I found solutions and focused on opportunities rather than problems  |  |  |  |  |  |
| I lead productive meetings |  |  |  |  |  |
| I demonstrated teamwork by thinking and saying “we” rather than “I” |  |  |  |  |  |

Other notes/reflections:

**🞎 Managing people and resources applies to this situation**

**🞎 Managing people and resources does not apply to this situation**

|  |  |  |  |
| --- | --- | --- | --- |
| Managing people and resourcesIN THIS SITUATION | Rating | Comments | Areas or ideas for improvement? |
| Done | Not done | Not applicable |
| I ensured understanding of work and timelines |  |  |  |  |  |
| I identified the priority tasks and timelines |  |  |  |  |  |
| I established steps and sequence to deliver outcomes on time |  |  |  |  |  |
| I shared the work through effective delegation |  |  |  |  |  |
| I assigned people important activities |  |  |  |  |  |
| I assigned tasks based on match/fit of competencies and strength |  |  |  |  |  |
| I assigned tasks based on learning needs |  |  |  |  |  |
| I monitored people’s progress |  |  |  |  |  |
| I communicated and clarified with people |  |  |  |  |  |
| I supported peoples’ progress and success |  |  |  |  |  |
| I flexibly modified plans with new, emerging situations |  |  |  |  |  |
| I deployed or redeployed people with new, emerging situations |  |  |  |  |  |
| I integrated personal and professional priorities |  |  |  |  |  |
| I used tools and resources effectively to achieve outcomes |  |  |  |  |  |

Other notes/reflections:

**🞎 Stewardship process applies to this situation**

**🞎 Stewardship process does not apply to this situation**

|  |  |  |  |
| --- | --- | --- | --- |
| StewardshipIN THIS SITUATION | Rating | Comments | Areas or ideas for improvement? |
| Done | Not done | Not applicable |
| I demonstrated careful consideration of the appropriate use of finite health care resources |  |  |  |  |  |
| I demonstrated consideration of benefits and costs to the individual and the system |  |  |  |  |  |
| I engaged patients in making informed decisions that reflect appropriate use of tests and treatments |  |  |  |  |  |
| I applied evidence and processes to achieve high value care |  |  |  |  |  |
| I supported others to make decisions that promote the appropriate use of finite health care resources |  |  |  |  |  |

Other notes/reflections:

**🞎 Quality improvement applies to this situation**

**🞎 Quality improvement does not apply to this situation**

|  |  |  |  |
| --- | --- | --- | --- |
| Quality improvement IN THIS SITUATION | Rating | Comments | Areas or ideas for improvement? |
| Done | Not done | Not applicable |
| I identified an aspect of my practice or care setting that needed improvement, described as one or more of the six domains of quality (i.e. Safe, Effective, Patient-centred, Timely, Efficient, Equitable) |  |  |  |  |  |
| I clarified what needed to be accomplished from an improvement standpoint |  |  |  |  |  |
| I reviewed quality improvement measures (i.e. outcome, process, balancing measures) that help to determine 1) the extent of the quality problem; or 2) whether a change resulted in an improvement |  |  |  |  |  |
| I used process tools (i.e. process mapping, Cause and Effect analysis, 5 Whys) to better understand what changes need to be made (or where opportunities for improvement exist) |  |  |  |  |  |
| I identified the changes that could be implemented to result in improvement? |  |  |  |  |  |
| I used rapid-cycle change methods, such as a PDSA cycle, to carry out a small test of change |  |  |  |  |  |

Other notes/reflections:

**🞎 Patient safety applies to this situation**

**🞎 Patient safety does not apply to this situation**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Safety IN THIS SITUATION | Rating | Comments | Areas or ideas for improvement? |
| Done | Not done | Not applicable |
| I recognized the patient safety incident, and was able to classify it as: 1) A **harmful incident** results in harm to the patient, Harm occurred due to medical care as opposed to underlying medical condition.2) A **no harm incident** reaches a patient but does not result in any discernible harm, 3) A **near miss** does not reach the patient |  |  |  |  |  |
| I contributed to a safety culture including demonstrating commitment to openness, honesty, fairness, and accountability. Include examples of how. |  |  |  |  |  |
| I reported the incident(s) and safety hazard(s) and/or notified my supervisor. Include who, how and when.  |  |  |  |  |  |
| I met the immediate and ongoing care needs of the patient, limited further harm, and provided ongoing monitoring and care. |  |  |  |  |  |
| I explained to the patient what unexpected event or change happened. Include who, how and when. |  |  |  |  |  |
| I apologized that it happened. Include who, how and when. |  |  |  |  |  |
| I explained what would happen next including explicitly discussing prevention with future patients. Include who, how and when. |  |  |  |  |  |
| I/we analyzed the patient safety incident(s) to enhance systems of care. Include who, how and when. |  |  |  |  |  |
| I/we planned a debriefing to manage the emotional impact. Include who, how and when. |  |  |  |  |  |
| OTHER: |  |  |  |  |  |

Other notes/reflections:

1. Summarize your TOP two or three areas of strength?
2. Planning for improvement

|  |  |  |  |
| --- | --- | --- | --- |
| # | Summarize your TOP two or three personal areas for improvement over the next four to eight weeks? | How are you going to work on your personal improvement priorities over the next four to eight weeks? | How will you know that you have achieved the needed improvement in your personal priority areas? |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |