

## FACILITATOR RESOURCE

### INTRODUCTION

The 2007 Operations Team Coordination Training Refresher features two important changes:

First, this Team Coordination Training (TCT) Update reflects an emphasis on the 7 components of Team Coordination that you have previously been introduced to: *Leadership, Mission Analysis, Adaptability, Situational Awareness, Decision Making, Communication and Assertiveness*. This training is now part of the annual currency maintenance requirements for the USCG Auxiliary Boat Crew program.

Second, the format has been changed to a group problem solving session, rather than facilitated discussion. This new approach will emphasize your role as a facilitator and, hopefully, make the training interesting for both you and your participants. This training session should be limited to approximately one hour in duration.

### FACILITATOR'S ROLE

As the facilitator, your role is to help participants discover new knowledge or discover new applications for knowledge you may already have. This is not accomplished by lecturing. Lecturing is one of the least effective ways to promote learning that can be utilized. Trust that the participants have the answers, and you are there to help them discover new relevance for a familiar concept.

A facilitator creates a positive, interesting and challenging environment for the participants in the classroom so that **they, as a crew**, can learn to solve problems and make better decisions that will keep the crew safe, the public safe, and accomplish the mission.

A facilitator leads the learning, but allows the participants to go their own way... *to a point*, always gently steering the process so that learning objectives are met...but also insuring that participants learn to make decisions in a "team format", similar to the "crew" that exists onboard our air and surface facilities.

*The patrol story presents a scenario with several sub-plots that describe problems, incidents or situations. This scenario paints a picture that, with some analysis, will lead the team to recognize core problems or issues among the crews in the scenario. The process is similar to what a physician goes through who must diagnose the disease in a patient from a list of specific "symptoms." In this case we want the participant groups to identify the symptoms (incidents or situations) that point to the underlying TCT component that is missing or dysfunctional and therefore threatens the success of the patrol. In addition we want participants to suggest a course of action for the scenario group to take to correct this deficiency.*

### **FACILITATOR RESPONSIBILITIES**

1. (10 min) At the outset of the session, organize the participants into "crews" of 3-5 members that will work together on the patrol story (case study). Tell them to appoint a recorder/reporter.
2. (5 min) Provide each group with one piece of paper and pencil. Tell them that the group is to:
  - o **Describe the elements in the story where you feel that the principles of TCT were not followed.**
  - o **Suggest a course of action or change in behavior that might correct the problem or align this crew's activity with TCT principles.**
3. (10 min) Present the patrol story (see page 7). Be sure that everyone is clear on the scenario but don't give away any answers. If possible hand out a copy of the story to each group.
4. (15 min) Redirect the session into small groups. During the small group work, circulate among the crews and listen. Make notes, if needed. Allow the groups to struggle (discuss/disagree) a little in making their lists. They are developing a problem solving relationship with their fellow crew members. Leaders may emerge in the groups (they usually do). Your job is to keep the groups focused on their question list and determination of dysfunctional TCT components, and to assist them by asking questions if and when they get off track or bogged down. Use the definitions of the TCT components below, your knowledge of the boat crew program and the targeted questions that

accompany the scenario (see page 9) to refocus groups that have gone astray. Try to insure that everyone participates, and that no one “hijacks” the process because they are more experienced, or louder, or because others seem willing to just go along. If you hear something that is inappropriate or not consistent with good practice, intervene with a gentle comment so that the group recognizes the problem. Try not to take control of the session away from the crew but get them “back on course,” then let them continue.

5. (15 min) Lead a focus session during which participant group reporters present their group solutions to the other participants. Don’t try to discriminate between solutions! Simply be a clerk and record, in brief, the reports. When all groups have reported, ask the group, at large, to choose the best three solutions (there’s rarely one “right” answer) or to rank order the best solutions. Use the last 2-3 minutes to summarize the group results (groups almost always find good answers, as a group) and, if necessary, interject one or two considerations that might have been missed.
6. (5 min) Thank the participants for their participation and assist with any final questions or concerns.

### REVIEW OF TCT BASICS

A short summary of the key points of Team Coordination Training is provided to assist the facilitator in presenting the material in the refresher. This information is accessible to all members on the Coast Guard’s TCT website: <http://www.uscg.mil/hq/g-w/g-wk/wks/TCT.htm>.

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THE ESSENTIAL ***CRUX*** OF EACH TCT MODULE  
*Jeanette Wells, M.Ed*

Communication

1. Communication is a loop – it’s not done until it has come back correctly, full circle.
2. The sender is responsible for making the message understood.
3. The receiver controls what happens to the message.

4. Both have a responsibility to overcome the barriers in sending and/or receiving messages to insure accurate and effective communication.
5. The biggest error people make is taking the attitude...."I told them – now it's up to them" ....and walk away thinking the communication and their responsibility with it is over.

#### Decision Making

1. Decision strategies, (minimize, scan, muddle, moralize and deny), when used alone are recipes for disaster.
2. When they are used in concert, they help prioritize and order tasks.
3. Each decision we make creates the playing field we enter into next.
4. Making good decisions instinctively encourages the continuation of making good decisions.
5. Making bad decisions instinctively encourages the continuation of bad decisions.
6. It is critical to be able to discern between *symptoms* and *root causes*.
7. Deciding to address the root causes will facilitate the elimination of the symptoms.
8. Time analysis studies of mishaps show that in critical moments, there was actually time to consider other options for action.
  - Our instinct: There isn't time to consider any other options.
  - Fact: There IS time.
  - Therefore: TAKE TIME TO DO IT

#### Leadership

1. Leadership is not just about commanding and controlling. Leadership is about creating and maintaining an environment where everyone can thrive and do their best.
2. Leaders need to know when to give orders and when to strive for collaboration and consensus and how to achieve it.
3. Leaders need to know how to recognize, develop and utilize knowledge, talent and abilities in their folks.
4. Leaders' behavior, policy and actions need to manifest the Coast Guard's core values so that others can see those values in their leaders.

#### Mission Analysis

1. Always go through a risk assessment process even if you go anyway under high risk conditions. This process will show where your hot spots are so everyone can be exceedingly vigilant with regard to those areas.

2. Examine every category to reduce risk.
3. Develop contingency plans.
4. Continually reassess risk through out the mission.

### Adaptability & Flexibility

#### *Stress:*

1. Stress is created by various categories of events:
  - Bad things
  - Good things
  - Fearful things
  - Exciting things
  - Change in things
2. Using a stress survey/inventory with your folks will let them know how much stress they are actually dealing with.
3. If you do the above, follow up with a coping with stress inventory so they can see how much durability they have to withstand the stress they can't eliminate or reduce any further.
4. Stress creates fatigue and effects individual and team performance.
5. Complex tasks are better done under lower stress. Simple tasks can be done effectively when people are under greater stress.
6. Work in teams to come up with a variety of ways to:
  - improve tasking and performance for individuals and teams
  - adapt size, structure and cohesion factors to improve team performance
  - develop ways to fight, control and predict fatigue

#### *Hazardous Thought Patterns*

1. Anti-Authority, Impulsiveness, Invulnerability, Macho and Resignation all distort judgment, decision-making and good outcomes.
2. Each person has a tendency to fall in one of these categories. Most of the time people keep themselves under check, operating in a thoughtful mid range.
3. Under extreme stress and/or fatigue, people will default to their natural thought pattern tendency and that is where mishaps are more likely to occur.
4. Each person should know their default thought pattern tendency.
5. Everyone should know some effective ways to pull their team members out of a hazardous thought pattern when they fall into that rut.

Assertiveness

1. The Coast Guard wants assertive people, not passive or aggressive behavior.
2. It is imperative that people know where the dividing line is between assertive and aggressive behavior. (Because these terms are used interchangeably in our culture, this water is very muddy for our folks.)\*

Situational Awareness

1. Definition: KNOW WHAT IS GOING ON AROUND YOU
2. Two Challenge Rule: This is an optional tool to use if a team wants to take advantage of it.
3. Three Levels of Human Error:
  - Slips.....Miss Speak
  - Mistakes.....Bad Plan
  - Errors.....Flawed Execution
4. The earlier an error is caught, the less damage is done. Better to catch a slip before it becomes a mistake. Better to catch a mistake before it becomes an error.

\* It is helpful to distinguish between those behaviors which are **respectful** of the other member’s position or point of view (assertive), as opposed to behaviors that are demeaning, sarcastic or dismissive (aggressive). The volume of the voice may be loud or soft; it is the *tone* of the voice or temperament of the individual that distinguishes between the aggressive behavior and the assertive behavior.

**LEARNING OBJECTIVES**

- **Describe** how stress, fatigue and hazardous thought processes can affect judgment and mission performance.
- **Review** the decision making strategies and **illustrate** these styles using the case study.
- **Discuss** the importance of risk assessment and management in the preparation and execution of a patrol.

**Review the tasking on page 2.  
Then, say or read the following to all of the participants.**

## THE PATROL

This Auxiliary Operational Facility (OPFAC) in question is a 24 foot center console I/O, equipped with radar and GPS.

The crew consists of the following members:

- A coxswain with 15 years experience in surface operations, the last 11 years as a Coxswain who is very familiar with local waters and conditions. He also serves as the FSO-OP.
- The crewmember has 2 years of experience in surface operations and about 5 years experience in the local waters.

The weather today:

- Air temperature: 79 ° F with 91 % humidity,
- Water temperature: 71° F, seas 1 to 2 feet. The winds are calm, 3 to 7 mph out of the southwest
- Coastal fog is approaching from the southwest, but the visibility at launch is 5 miles.

One of the purposes of this multi-mission patrol was to run two boat training evolutions to complete currency maintenance requirements. Two Auxiliary OPFACs were practicing evolutions of man overboard drills, side tows and stern tows in the relative safety of a protected harbor. The OPFAC coxswain (who, as noted, was the FSO-OP) was not happy with the forecast that predicted thick fog was approaching. However, it was already mid June and some of the crewmembers needed to get their yearly currency maintenance completed, so they were anxious to practice their skills.

The coxswain completed the Risk Assessment portion of the Boat Movement Record (BMR), used the "marginal" score of "5" for the environment factor, and decided to continue with the training despite concerns about the weather. He faxed the BMR to the station officer of the day and they were underway by 0800. The two boats completed the training exercises by about 0930 and return to their respective areas to complete the multi-mission patrol.

At 0945 hours, a distress call was received by the Coast Guard station. A collision had occurred between a party boat (for

hire) and a small pleasure craft some 10 miles from the mouth of an inlet leading to the Atlantic Ocean. A Coast Guard 41foot utility boat (UTB) was dispatched and, once on scene, found a 23 foot cuddy cabin vessel had collided with a party boat in the fog. There were some serious injuries to passengers onboard the 23 foot pleasure boat. The officer of the day considered a medivac via CG helicopter, but the ceiling and visibility precluded launch. The UTB coxswain decided to transport the injured to the town dock for medical treatment and transport to the local hospital.

Given the deteriorating weather conditions and poor visibility the CG UTB coxswain radioed the remaining Auxiliary OPFAC. She asked if the Auxiliary vessel could precede the UTB through the inlet to clear the way. This area is known as a high traffic corridor for both pleasure and commercial vessels. There were also anchored small boats fishing in the harbor area which is a regular occurrence, especially in bad weather.

The Auxiliary coxswain immediately responded to the call, agreeing to proceed to the ocean to await the UTB at the mouth of the inlet. His plan was to lead/escort the UTB through the waterways to clear a path. The UTB was spotted within 10 minutes. The Auxiliary OPFAC took the lead and quickly achieved a speed in excess of 15 kts as he re-entered the inlet towards the harbor, the CG UTB on a course set to follow. The OPFAC struggled to maintain its position, trying to navigate by RADAR as they headed for the town dock. The Auxiliary boat was thrown to and fro from the confused seas created by the confined area and vessel traffic. The lone crewman was doing double duty, acting as forward lookout while attempting to alert boaters in their path with the handheld loud hailer. The crewman finally entered the cockpit after nearly falling overboard from a sudden change in vessel position.

Eventually the CG UTB passed the OPFAC and moored at the town dock, where an ambulance was standing by to transport the injured to a medical facility. The Auxiliary coxswain moored behind the UTB. He loosened his "death grip" on the helm, gathered himself, and began working on the SAR Incident Report while the crewman secured the vessel at the pier.

**PARTICIPANT CHALLENGE QUESTIONS** – use these questions to help stimulate discussion in the small groups.

1. What elements should have been in the coxswain's risk assessment before accepting this mission? Should the mission have been undertaken? What pre-mission preparations should have taken place for a safe patrol?

*Skills to discuss: leadership, situational awareness, decision making and mission analysis.*

*The conditions were deteriorating yet this coxswain accepted a mission with relatively high risk. Was a risk assessment done before accepting the mission? What elements of the assessment (planning, mission complexity, asset selection, communications and environment) might have precluded accepting this tasking? What elements could be modified to lower the risk? Did the benefit justify the risk?*

*The coxswain is both responsible and accountable for these decisions. This is a principle of leadership. Did this coxswain demonstrate leadership during this mission?*

2. Were the capabilities of this Auxiliary crew and facility equal to this tasking? How would the situation been different if there had been 2 crewmembers?

*Skills to discuss: adaptability and flexibility, mission analysis*

*The mission analysis must always include an assessment of the crew capability. This includes such elements as the amount and type of training accomplished, physical capabilities of the crew, fatigue, stress and the numbers of crewmembers. Limited to one crewman, this coxswain had no flexibility in assigning critical tasks. In fact, he was reliant on one person to do the work of 2-3 people, especially under adverse weather conditions.*

3. What is a safe speed under these conditions? How would you categorize the decision making strategy of the coxswain in proceeding to the dock at 15 kts?

*Skills to discuss: decision making, adaptability and flexibility*

*The coxswain is responsible for the safe conduct of business with the facility. At question is the ability to carry out the mission safely at this rate of speed. RADAR cannot be used effectively at this speed, this was a high traffic area, the forward lookout was pre-occupied with giving instructions to vessels in the area, the visibility was poor, and much more. What, then, caused a reasonably competent coxswain to conduct the mission in this fashion? Was a hazardous thought process at work? Was the coxswain using a "moralizing" decision making strategy or another? What factors should have been considered in the conduct of the mission?*

4. What is your assessment of the communication and leadership demonstrated on this mission? Who is responsible for speaking up about safety concerns?

*Skills to discuss: communication, assertiveness, leadership*

*Although the case does not contain a lot of detail, one is struck by a lack of communication between the crew members and between the Auxiliary and active duty coxswain. Was there discussion about undertaking this high risk mission? Did the crewman have an opportunity to contribute to the decision? Did the coxswain discuss possible strategies for achieving the objective with the active duty coxswain (i.e. staying in the harbor and notifying boaters rather than trying to "escort" the UTB)? Did the crewman speak up as the situation became treacherous with high rates of speed? How could the weather and environmental factors have affected communication?*

*The coxswain clearly had concerns...we note his stress after the vessel is moored. He needed to voice his concerns and develop an alternate strategy. The crewman needed to voice concerns about the unsafe conditions faced with trying to maintain a lookout while using a load hailer for crowd control.*

*Communication walks hand in hand with assertiveness. Both are critical building blocks of a good plan and mission execution. Leadership depends on clear, assertive and timely communication. We are lacking evidence for good communication in this mission.*

5. Where there other tools available to these crews to mitigate the risks associated with entering the harbor at a relatively high rate of speed?

*Skills to discuss: communication, mission analysis*

*There are always alternatives. Some alternatives are good, others are not as good. In this case, using the radio (i.e. issue an Urgent Marine Broadcast), ask for assistance from harbor pilots or other professional mariners or use of the "danger signal" (5 short blasts) might have avoided a potentially or actually dangerous situation. When we do mission analysis, we identify risk, use all of our tools to **lower the risk** and then determine if we can accept the remaining risk. The coxswain could have done some quick brainstorming with both the active duty coxswain and his crewman to search for safer solutions.*

Thank you for your participation as a facilitator for the 2007 Team Coordination Training Refresher. Please share your thoughts about this training and the format with us!

***Bruce Pugh, DVC-OE***  
*Division Chief Operations Projects and Educational Outreach*  
*US Coast Guard Auxiliary*  
[DVC\\_OE@yahoo.com](mailto:DVC_OE@yahoo.com)