Facilitator Resource Guide

Introduction

The 2012 Operations Team Coordination Training Refresher follows the normal workshop format. It focuses on group, or "crew" problem solving activities rather than a lecture presentation format. The 7 components of TCT are the guiding principle to emphasize as you lead this problem solving session. The facilitator should be a trained instructor, someone familiar with the operations program and familiar with the TCT program (but does NOT have to be a TCT Facilitator).

Note: This TCT refresher session should last about one hour.

This Team Coordination Training (TCT) Refresher reflects an emphasis on the 7 components of Team Coordination you have previously been introduced to:

- **Leadership**
- **Mission Analysis**
- **Adaptability**
- **Situational Awareness**
- **Decision Making**
- **Communication**
- **Assertiveness.**

This training is part of the mandatory annual currency maintenance requirements for the USCG Auxiliary Boat Crew program, and must be completed by 31 Dec 2012 to avoid going into REYR status.

The format, as in prior years, takes the form of a group problem solving session. This approach will emphasize your role as a facilitator and, hopefully, make the training more interesting for both you and your participants.

IMPORTANT: Do not deliver this as a straight lecture, the key learning objective includes the interaction of small 'crews' (3-5 members) solving the problem presented.

Facilitator's Role

As facilitator, your role is to help participants discover new knowledge or discover new applications for knowledge you already have. This is not accomplished by lecturing. Lecturing is one of the least effective ways to promote learning. If you find yourself talking a lot and teaching numerous techniques and required actions in detail, you are probably talking too much. 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 **they, as a crew**, can learn to solve problems and make better decisions to 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 learning objectives are met…but also insuring that participants learn to make decisions in a "team format", similar to the "crew" onboard our air and surface facilities. Let the discussions happen, but do not hesitate to step if they get "off topic".

Note:

The patrol story presents a scenario with several sub-plots describing 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) pointing to the underlying TCT missing or dysfunctional components that threaten the success of the patrol. In addition participants are to suggest a course of action for the scenario group to take to correct this deficiency.

The crew has intentionally been made less efficient and effective than normal to help stimulate the discussion.

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 to take notes.

2. (5 min) Provide each group with one piece of paper, pencil, and 2 blank GAR forms. Tell them that the group is to:
   - **Describe the elements in the story where they feel the principles of TCT were not followed.**

- **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 be careful not to give away answers. If possible hand a copy of the story to each group. Be sure to have them complete the GAR form, before discussing the scenario.

4. (15 min) Redirect the session into small groups. During the small group work, **circulate among the crews** and **listen**. Make notes for yourself 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 crewmembers. Leaders may emerge in the groups (they usually do). Your job is to **keep the groups focused on their question list and the 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 pages 9 & 10) 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. Now have them complete the second GAR form as a group and review any differences in scoring.

5. (15 min) Lead a focus session during which the participant group reporters present their group solutions to the other participants. Don't try to discriminate between solutions! Only be a clerk and record, in brief, the reports. When all groups have reported, ask the group, at large, to choose the better 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 may have been missed.

6. (5 min) Thank the participants for their participation and assist with any final questions or concerns. If there are suggestions from the group on how to improve the course, jot those down as well and forward them to the **DVC_OE, email** address found at the end of this guide.

Review of TCT Basics

A Team Coordination Training student guide is available on the Coast Guard site at http://www.uscg.mil/hq/cg3/cg3pcx/training/tct/intro.pdf. Facilitators can also get additional information from the Coast Guard TCT web site at http://www.uscg.mil/hq/cg3/cg3pcx/training/tct/default.asp.

Mission Analysis

1. Always conduct a risk assessment prior to a patrol, no matter how routine you believe the mission to be. Every mission is unique, contingency planning based on experience should include complexity of mission, environmental factors, crew fitness factors and any other circumstance which could impact the mission & your safety
2. Develop escape/contingency plans for potential risk scenarios
3. Reassess risk when conditions change

Situational Awareness

1. To make good decisions we must **know what is going on around us**. Plans are critical to success, that is for sure…but we must be ready, based on what we encounter during the mission, to change those plans, and/or use contingency plans as necessary.
2. Stressful situations, complacency and boredom will inhibit our situational awareness and increase the likelihood of poor decision making. Remember the 3 levels of human error:
    a. Slips ….. Misspeak
    b. Mistakes ….. Bad Plan
    c. Errors …. Flawed execution
3. Catch the slip before it becomes a mistake. Catch the mistake before it becomes an error.

Adaptability & Flexibility

1. Adaptability is the ability to react to changes in conditions, crew fitness, equipment failures, etc. and is based on the "situational awareness" we mentioned above. How flexible are we? How receptive are we to differing opinions? Leaders do not necessarily have "all the answers". Leaders do take advantage of everyone's ideas and experience and they remain adaptable to new conditions and challenges.

Communication

1. Communication takes many forms. There are verbal and non-verbal (facial expressions, etc.) communication everyone uses to convey thoughts and ideas.
2. The key is to ensure that the person or persons we communicate with have a **clear** understanding of what we wish to convey. This is the 'senders' responsibility.

3. Good communication involves closing the "feedback" loop. We can ask for feedback, or we can observe behavior to be sure the message was received.
4. This is a two-way expression, either verbally or non-verbally, which confirms the communication process was completed. Both parties are responsible for insuring the message received is accurate, understood, and effective.

Leadership

1. Leadership is not about giving orders. Leaders do find ways to obtain the willing participation of others towards accomplishing a goal. That goal, in this case, must be consistent with the Coast Guard's core values as well as consistent with the mission at hand.
2. Since we cannot "order" anyone to do anything, we must strive to achieve the respect, confidence, collaboration and loyalty of those entrusted to our care.
3. Remember all Auxiliarists have the opportunity to lead, regardless of their position.

Assertiveness

1. The Coast Guard values people who are assertive, but not aggressive.
2. Know where the dividing line is. The difference between these two characteristics is sometimes hard to see. The aggressive person seeks to bully his/her way though situations for their own ego or self image…. while an assertive person cares about the "mission" more than themselves and their ego.
3. The assertive person will always communicate their concerns but they also, try to get a reasonable resolution when ideas are in conflict without stepping on top of those who may disagree.

Decision Making

1. Making good decisions is really at the heart of TCT. How do we ensure that we act or perform in a manner that maximizes mission success and minimizes risk to ourselves, our crew, the public, etc?
2. The other elements of TCT all play a role in improving those decisions. We define a problem or condition, seek information about that problem, analyze that information, identify alternatives and select one or a range of alternatives.
3. Then we measure our success or failure in order to adjust our course of action. This process can take us 20 seconds in the case of routine decisions, or 20 months in the case of large complex problems. The process is the same; …the depth of analysis and level of importance is always changing.
4. There is always time to consider other actions, use that time before you act.

Learning Objectives

Participants will learn to identify key risk factors and decision points that may impact judgment and crew safety.

- **Identify the special challenges this mission presented.**
- **Identify and discuss the key issues that created a hazardous condition on this patrol.**
- **Understand how crew selection, condition or fitness, and experience issues impacted the outcome of this situation.**
- **Define the leadership and decision making issues that arose when the so-called "routine" mission became dangerous to the crew and public.**

Participants will identify at least three examples of good decision making by this crew and others.
Participants will identify at least 3 examples of poor decision making by this crew & others.
Participants will be able to suggest alternative actions to avoid high risk situations.
Discuss at least 3 errors, and 3 good decisions made by this crew during the mission.

The Patrol

Mission: A "routine" MOM patrol in Monterey Bay, California

Facility:
1963 Chris Craft cabin cruiser, 36 foot LOA, twin screw inboard, wood construction.

Weather: 91°F and hazy …wind: W at 10 mph…Humidity: 72%...Low tide 1432 hrs

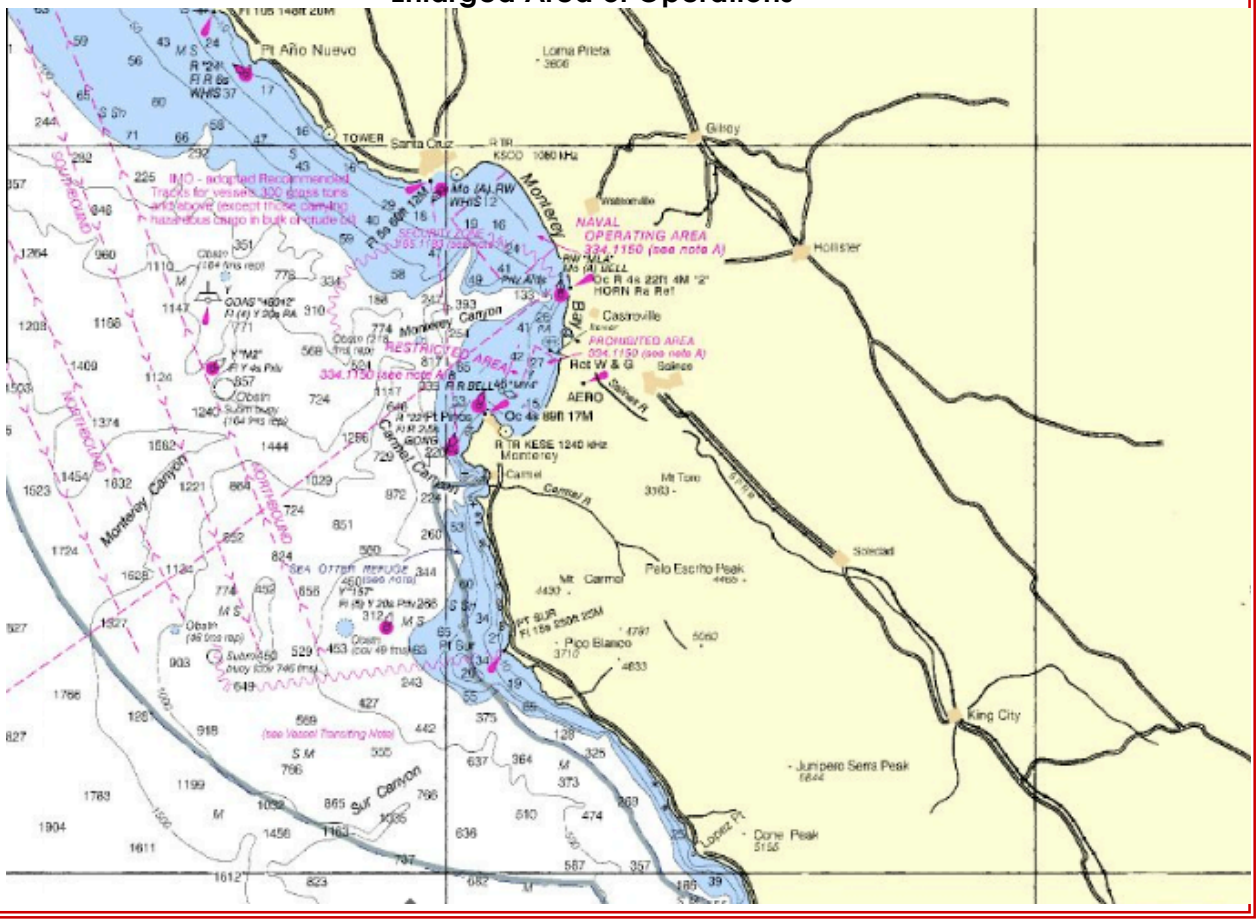
CREW
Coxswain: Jack, 55 year old with 12years experience with his own 20 foot center console, no experience with the facility used in this patrol.

Crewmember: Joe, 82 year old "retired cox'n" who offered his 36 footer for use since a heart ailment forced him to drop back to "crew" status earlier this year.

Crewmember: Ed, 64 year old with 3 years experience as crewmember

Venue:

Enlarged Area of Operations



Scenario:

Facility owner Joe is a 20 year veteran; 17 years as coxswain of his own 36 foot Chris Craft. Joe now takes heart medicine that causes an occasional dizzy spell in hot weather. That has caused him to give up his coxswain qualification, but he still offers his boat for use as a facility, as long as he can continue to crew.

Coxswain Jack is an experienced coxswain but, until now, has exclusively used his own 20 foot center console for patrols. Crewmember Ed, a 64 year old with 3 years' experience as crewmember, rounds out the crew.

The patrol is a Maritime Observation Mission (MOM) conducted in the Monterey Bay AOR just off the coast of California; the facility is under orders, and communications maintained by the local CG boat station. The coxswain considered this to be a routine patrol that posed no special problems and advised his crew of that finding.

During the patrol, a passing boater hails the facility. The boater informs the crew that, moments earlier, he saw a lone fisherman fall off a small skiff after a large wake, caused by a passing party fishing boat, violently rocked his boat.

Jack is at the helm and proceeds to the location reported by the passing boater, approximately 500 yards away. He plans to assess the situation before notifying the Coast Guard duty officer. About 100 yards from the scene, they see a male struggling in the water some 20 yards from a small skiff with no one aboard. Ed immediately yells "Man Overboard", points to the port side and yells again, "Man overboard… 100 yards at 270 degrees relative".

Jack immediately powers down and begins approaching the man in the water. Joe goes below and begins rummaging through his cabin, looking for his throwable life ring. Several minutes pass while Jack tries to maneuver the 36 footer in closer to the struggling man.

As the facility arrives next to the man in the water, Joe finally emerges from the cabin, but seems unsteady and a little pale as he tries to untangle the line attached to the life ring. Jack sees Joe's difficulty and realizes that Joe cannot heave the ring, nor will he be able to assist retrieving the man from the water due to his weakness and instability on deck.

Scenario Continued:

Jack has been having trouble maneuvering the twin-screw vessel close in without losing sight of the man in the water, due to the size and configuration of the large cabin cruiser, as well as his inexperience with this vessel. He feels helpless to assist with the retrieval. Jack then realizes that Joe must take the helm while he heaves the life ring and Ed prepares to help him (Jack) lift the exhausted man from the water.

Jack reluctantly orders Joe to the helm and throws the ring. As the man in the water grabs onto the ring, Jack notices the facility, still under power, moving further away from the man. As he hauls in on the life ring line with the man hanging on, they begin to inadvertently tow the man through the water, which causes the man to lose his grasp on the ring. Jack retrieves the ring and throws it again to the man, then quickly takes the helm, places the facility in reverse to stop its forward motion and begins to again close the gap between the man in water and the facility. As the facility comes up to the man again, he places both engines into neutral and then leaves the helm to assist Ed in retrieving the man according to proper procedure.

They then notify CG communications and request immediate assistance, unsure of the medical condition of the man just retrieved. Meanwhile Joe sits in the mate's chair and searches for his heart medication. The Coast Guard dispatches a patrol boat, which takes charge of the recovered man and takes the skiff in tow.

End of Story

What did the crew do correctly during this mission?

1. **Coxswain approached the scene & assessed the situation before taking action. SITUATIONAL AWARENESS**

2. **Ed correctly initiated the required MOB protocol by giving the alarm ASSERTIVENESS, DECISION MAKING**

3. **Ed correctly assumed role of pointer & correctly gave relative position of the "man overboard" DECISION MAKING**

4. **Joe immediately went below to retrieve throwable life ring DECISION MAKING**

5. **Coxswain recognized the problem with crewmember and switched roles at the helm to address the problem he saw LEADERSHIP**

What did this crew do incorrectly during this mission?

1. ***Jack failed to conduct a GAR risk assessment with his crew LEADERSHIP***

2. ***Jack begins a patrol in a vessel that he has never operated and knows little about PLANNING, LEADERSHIP***

3. **Jack failed to assign watches. LEADERSHIP**

4. ***Potential medical issues were unresolved, or ignored before getting underway PLANNING, DECISION MAKING***

5. ***Joe failed to raise the issue of his own medical condition as a potential issue ASSERTIVENESS, DECISION MAKING***

Anything else missing?

Should the team have informed *the OIA of the changed mission before, or while, proceeding to the scene; or is waiting to assess the situation first the better choice? What are the risks/benefits to either?*

How about a follow-up formal debriefing of the mission?