The Elements of an Effective Safety Team

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Problem/Challenges

Harm to patients in peri-op period
Lack of robust systems-based approach
Standardized approaches lacking
Denial
Culture
Teamwork
What are the characteristics of a TEAM?
Characteristics of a Powerful Team

- Common Purpose
- Clear Roles
- Accepted Leadership
- Effective Processes
- Solid Relationships
- Excellent Communications
- Exceptional Results
~70% to 80% of RCAs cited **COMMUNICATION FAILURE** as, at least one of the root causes/contributing factors for an adverse event or close call report.

*SPOT Database:  VA National Center for Patient Safety, April, 2008 Completed RCAs, Number = 8661.*
Root Causes of Sentinel Events

(All categories; 2005)

- Communication
- Orientation/training
- Patient assessment
- Staffing
- Availability of info
- Competency/credentialing
- Procedural compliance
- Environ. safety / security
- Leadership
- Continuum of care
- Care planning
- Organization culture
Communication - The Problem

Reliability In Healthcare Is Poor
  – Not Individually Acknowledged
Basic Problems Are Same World Over
  – Property of Being Human
Organizationally Ignored Compared To Other High Hazard Industries
Association Between Handover of Anesthesia Care and Adverse Postoperative Outcomes Among Patients Undergoing Major Surgery

Philip M. Jones, MD, MSc; Richard A. Cherry, MD; Britney N. Allen, MSc; Krista M. Bray Jenkyn, PhD; Salimah Z. Shariff, PhD; Suzanne Flier, MD, MSc; Kelly N. Vogt, MD, MSc; Duminda N. Wijeysundera, MD, PhD

**IMPORTANCE**  Handing over the care of a patient from one anesthesiologist to another occurs during some surgeries and might increase the risk of adverse outcomes.

**OBJECTIVE**  To assess whether complete handover of intraoperative anesthesia care is associated with higher likelihood of mortality or major complications compared with no handover of care.

**DESIGN, SETTING, AND PARTICIPANTS**  A retrospective population-based cohort study (April 1, 2009-March 31, 2015 set in the Canadian province of Ontario) of adult patients aged 18 years and older undergoing major surgeries expected to last at least 2 hours and requiring a hospital stay of at least 1 night.

**EXPOSURE**  Complete intraoperative handover of anesthesia care from one physician anesthesiologist to another compared with no handover of anesthesia care.

**MAIN OUTCOMES AND MEASURES**  The primary outcome was a composite of all-cause death, hospital readmission, or major postoperative complications, all within 30 postoperative days. Secondary outcomes were the individual components of the primary outcome. Inverse probability of exposure weighting based on the propensity score was used to estimate adjusted exposure effects.
Handovers During Anesthesia Care
Patient Safety Risk or Opportunity for Improvement?

James P. Bagian, MD, PE; Douglas E. Pauill, MD, MS

Optimal patient care and clinical outcomes depend not only on technical knowledge and skill but, even more importantly, on ready access to critical information on which to base patient care decisions. Access to needed information at the appropriate time is a crucial form of communication.

Numerous studies have shown that inadequate communication is the leading cause of harm to patients. It is estimated that the majority of serious adverse events in healthcare involve miscommunication during the handoff between physicians and perhaps between other healthcare practitioners.\(^1\)\(^2\) Contributing factors to inadequate communication during handoffs include insufficient or misleading information, absence of safety culture, ineffective communication methods, lack of time, poor timing, inadequate feedback between sender and receiver, interruptions or distractions, lack of standardized procedures, and insufficient staffing.\(^3\)

In this issue of JAMA, Jones et al\(^4\) describe the association between “complete handovers” among anesthesiologists and deleterious patient outcomes. A complete handover was defined as one in which the initial anesthesiologist handed over care of a patient to another anesthesiologist but then was no longer available.\(^4\) The complete handover described in this study is more commonly classified as a transition in care. The critical importance of well-executed transitions in care was identified and specifically targeted by the Accreditation Council for Graduate Medical Education (ACGME) Clinical Learning Environment Review initiative as one of the foundational areas where improvement in patient care was needed by residents and the institutions in which they practice.\(^5\) This retrospective cohort study, based on administrative databases, included more than 313,000 adult patients across the province of Ontario, Canada, from April 2009 through March 2015, who underwent major surgical procedures that were expected to last at least 2 hours. The exposure of interest was the complete handover of anesthetic care from one anesthesiologist to another and the primary outcomes were death, hospital readmission, and major complications within 30 days of surgery.

Nearly 6000 of the 313,000 cases involved a complete handover, and complete handovers were associated with significantly poorer patient outcomes. In the unweighted sample, the primary outcome (ie, all-cause death, hospital readmission, or major postoperative complications all within 30 postoperative days) occurred in 44% of the complete handover group compared with 29% of the no (complete) handover group. After adjustment, complete handovers were associated with an increased risk of death (adjusted risk difference [ARD], 1.2% [95% CI, 0.5% to 2.0%]; \(P = .002\)) and major complications (ARD, 5.8% [95% CI, 3.6% to 7.9%]; \(P < .001\)) but not with hospital readmission (ARD, 1.2% [95% CI, −0.3% to 2.7%]; \(P = .11\)) within 30 days of surgery.\(^4\) As estimated by the authors, “On average, for every 15 patients exposed to a complete anesthesia handover, 1 additional patient would be expected to experience the primary outcome.”
Assumption...

Higher levels of coordination and collaboration create an environment for more effective communication.
Institute of Medicine (2000)

“…establish team training programs for personnel in critical care areas using proven methods such as the crew resource management training techniques employed in aviation.”

Aviation Safety & Crew Resource Management (CRM)
Crew Resource Management (CRM)*

**Origin:** 1979-80 NASA workshops examining the role of human error in airline crashes
- Research into aviation accidents in 1970s

**Definition:** “Using all available sources – information, equipment, and people – to achieve safe and efficient operations.”

**Focus:** safety, efficiency, and morale of humans working together

**LOFT:** “Line Oriented Flight Training”
- Work in flight simulators and measurement of airline crew performance

**Briefings and Debriefings**

Tenerife – March 1977
Fatalities - 583
CRM Training*

Required by FAA and worldwide – “the way of doing business”

Aircrew performance measured by materials, organization, individual, and group variables

Expanded aviation training from technical focus to human factors dimensions – stress, fatigue, communication, shared awareness, and teamwork

Outcomes: efficiency, safety, customer satisfaction

Airline crew surveys: CRM relevant, useful, and effective in changing attitudes and behavior to improve safety

CRM accepted by industry on face validity

Highest Performing Surgeons and Teams

**Few uncompensated MAJOR events:**
- Highly adaptive surgeons working within teams who respond quickly to the onset of a major event
- Willing to step back and change approach based on accruing data

**Few uncompensated minor events:**
- Adaptive behavior in the OR
  - Increase in verbal and non-verbal communication with an inexperienced assistant
- Interdisciplinary Teamwork & Planning
  - Check that ICU bed is available before starting case; communication with blood bank; control of distractions in OR suite (meetings, pagers, phone calls, etc.)

**Ability to Compensate = Adaptive Capacity for Change**

Collaboration & Teamwork in ICU = Lower Morbidity & Mortality + Increased RN Retention

Evidence from ICUs
Knaus – 5030 ICU pts in 13 hospitals
  – M&M risk improved with collaboration
Baggs – 286 consecutive Med ICU pts transferred
  – M&M risk decreased from 16% to 5%
Shortell – 17440 pts from 42 ICU
  – Teamwork across disciplines improved outcomes & RN retention
Pronovost – Daily briefings in ICU with RNs and Residents
  – Improved quality of care
Technical skill is not the only factor contributing to excellence

“Surgical excellence is the ability to anticipate and respond to future changes in patient status.”

-Dunphy (1974)
Communication

Definition: The exchange of thoughts, messages, or information.*

A dynamic process between people:

- Sender (talks/writes/signals) & Receiver (listens/reads/signals)
- Roles alternate back & forth
- Verbal vs. non-verbal

Feedback:

- Sending a message is not sufficient
- Was it received...understood?

Communication Skills

In medical school and nursing school, the focus is on successful communication with the patient.
Communication - The Problem

Reliability in healthcare is poor
– Not individually acknowledged
Basic problems are same world over
– Property of being human
Organizationally ignored compared to other high hazard industries
Successful Communication

Many communication improvements focus on improving accuracy and availability of content, e.g. CPOE, CPRS, “Hand-Off” templates.

Poor communication results from context. Context is vulnerable to culture, gender, education, experience, time pressure, stress, mood, etc.
Culture of Safety

“Learns” from adverse events
People report things
Non punitive
Flatten hierarchies – promotes teamwork and open feedback (CRM)
Safety examined retrospectively and prospectively
Intensive training of personnel and teams
Systems thinking
Build fault tolerance into the system
Fault Tolerance

“Fault tolerant system - system tolerates errors but still functions successfully...."

Zero error is NOT realistic.
VHA NCPS Medical Team Training Program

Pilot 2003  Rollout 2005 -2010

170 Facilities

193 Learning Sessions

13,882 VHA Staff

Mean = 74 Attendees Per Learning Session
Largest One Day Session = 208 (Baltimore, MD Jan 14, 2010)
Largest Facility Attendance = 356 (Dallas, TX December 9-11, 2008)
Operating Room Challenges: Vertical Hierarchy

“Silence Kills”. Team members uncomfortable “speaking up” when something does not seem right in a patient’s care, leading to patient harm.

Poor communication between team members leading to a lack of situational awareness and a poor clinical decision resulting in patient harm.
Supporting Long Term Memory

Checklists

- Put knowledge in the world vs. in the head
- Recognition is better than recall

- Tool to Guide and Improve Communication
## Checklist-Driven Preoperative Briefing

**VETERANS HEALTH ADMINISTRATION**

**Preoperative Briefing Guide for Use in the Operating Room**

- Read and Verify Checklist, Local Facilities Decide When Checklist Completed.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Pertinent Lab Results</th>
<th>Risk of &gt;500 ml Blood Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #, Birthdate, or Other VA-Approved Identifier</td>
<td>No</td>
<td>Yes, and adequate IV access and fluids planned, and blood availability confirmed</td>
</tr>
<tr>
<td>Names &amp; Roles of Team Members</td>
<td></td>
<td>If Yes,</td>
</tr>
<tr>
<td>Procedure</td>
<td>Type &amp; Screen</td>
<td>Type &amp; Cross</td>
</tr>
<tr>
<td>Surgical Site</td>
<td>Prophylactic Antibiotics Given Within 60 Minutes of Incision</td>
<td>DVT Prophylaxis</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>If Yes, Equipment &amp; Assistance Available</td>
<td>Anticipated Critical Events</td>
</tr>
<tr>
<td>Laterality/Side</td>
<td></td>
<td>Surgeon</td>
</tr>
<tr>
<td>Known Allergy</td>
<td></td>
<td>Anesthesia</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td></td>
<td>Implant(s)</td>
</tr>
<tr>
<td></td>
<td>Difficult Airway, Aspiration Risk?</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>If Yes, Specifics</td>
</tr>
</tbody>
</table>

### Time Out!

<table>
<thead>
<tr>
<th>Name of Patient &amp; SS# or birthdate</th>
<th>Procedure to be performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Consent form checked (patient, procedure, site/side, reason)</td>
</tr>
<tr>
<td>Check that surgical site marked (and visible after draping) and/or wristband confirmed</td>
<td>Implant to be used (if applicable)</td>
</tr>
<tr>
<td>Two members confirm imaging studies available, correct, properly labeled, presented</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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*This checklist contains the elements of the WHO checklist and also includes a sampling of the majority of elements as suggested by frontline OR teams from the VHA. The WHO Surgical Safety Checklist is available at [https://www.safesurg.org/uploads/1/0/9/0/1090835/ssa1_checklist_finalium08.pdf](https://www.safesurg.org/uploads/1/0/9/0/1090835/ssa1_checklist_finalium08.pdf)

VHA Policy/Directive, 'WHO Checklist', Joint Commission, 'Medical Team Training'
Association Between Implementation of a Medical Team Training Program and Surgical Mortality

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Peter D. Mills, PhD, MS
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Adverse events related to surgery continue to occur despite the best efforts of clinicians.\(^1\) Teamwork and effective communication are known determinates of surgical safety.\(^2,4\) Previous efforts at demonstrating the efficacy of patient safety initiatives have been limited because of the inability to study a control group.\(^5\) For example, the use of the World Health Organization Safe Surgery checklist has been evaluated, but its overall efficacy remains uncertain because no control group was studied to clearly demonstrate this instrument's effectiveness.\(^6\)

The Veterans Health Administration (VHA) is the largest national integrated health care system in the United States, with 133 hospitals, 130 of which provide surgical services. The VHA implemented a national team

Context There is insufficient information about the effectiveness of medical team training on surgical outcomes. The Veterans Health Administration (VHA) implemented a formalized medical team training program for operating room personnel on a national level.

Objective To determine whether an association existed between the VHA Medical Team Training program and surgical outcomes.

Design, Setting, and Participants A retrospective health services study with a contemporary control group was conducted. Outcome data were obtained from the VHA Surgical Quality Improvement Program (VASQIP) and from structured interviews in fiscal years 2006 to 2008. The analysis included 182 409 sampled procedures from 108 VHA facilities that provided care to veterans. The VHA's nationwide training program required briefings and debriefings in the operating room and included checklists as an integral part of this process. The training included 2 months of preparation, a 1-day conference, and 1 year of quarterly coaching interviews.

Main Outcome Measure The rate of change in the mortality rate 1 year after facilities enrolled in the training program compared with the year before and with nontraining sites.

Results The 74 facilities in the training program experienced an 18% reduction in annual mortality (rate ratio [RR], 0.82; 95% confidence interval [CI], 0.76-0.91; \(P = .01\)) compared with a 7% decrease among the 34 facilities that had not yet undergone training (RR, 0.93; 95% CI, 0.80-1.06; \(P = .59\)). The risk-adjusted mortality rates at baseline were 17 per 1000 procedures per year for the trained facilities and 15 per 1000 procedures per year for the untrained facilities. At the end of the study, the rates were 14 per 1000 procedures per year for both groups. Propensity matching of the trained and untrained groups demonstrated that the decline in the risk-adjusted surgical mortality rate was about 50% greater in the training group (RR, 1.49; 95% CI, 1.10-2.07; \(P = .01\)) than in the untrained group. A dose-response relationship for additional quarters of the training program was also demonstrated: for every quarter of the training program, a reduction of 0.5 deaths per 1000 procedures occurred (95% CI, 0.2-1.0; \(P = .001\)).

Conclusion Participation in the VHA Medical Team Training program was associated with lower surgical mortality.

Incorrect Surgical Procedures Within and Outside of the Operating Room

A Follow-up Report

Julia Neily, RN, MS, MPH; Peter D. Mills, PhD, MS; Noel Eldridge, MS; Brian T. Carney, MD; Debora Pfeffer, RN, MBA; James R. Turner, BS; Yinong Young-Xu, ScD, MA, MS; William Gunnar, MD, JD; James P. Bagian, MD, PE

Objective: To describe incorrect surgical procedures reported from mid-2006 to 2009 from Veterans Health Administration medical centers and build on previously reported events from 2001 to mid-2006.

Design: Retrospective database review.

Setting: Veterans Health Administration medical centers.

Interventions: The Veterans Health Administration implemented Medical Team Training and continues to support their directive for ensuring correct surgery to improve surgical patient safety.

Main Outcome Measures: The categories were incorrect procedure types (wrong patient, side, site, procedure, or implant), major or minor surgery, in or out of the operating room (OR), adverse event or close call, specialty, and harm.

Results: Our review produced 237 reports (101 adverse events, 136 close calls) and found decreased harm compared with the previous report. The rate of reported adverse events decreased from 3.21 to 2.4 per month (P = .02). Reported close calls increased from 1.97 to 3.24 per month (P = .001). Adverse events were evenly split between OR (50) and non-OR (51). When in-OR events were examined as a rate, Neurosurgery had 1.56 and Ophthalmology had 1.06 reported adverse events per 10,000 cases. The most common root cause for adverse events was a lack of standardization of clinical processes (18%).

Conclusions: The rate of reported adverse events and harm decreased, while reported close calls increased. Despite improvements, we aim to achieve further gains. Current plans and actions include sharing lessons learned from root cause analyses, policy changes based on root cause analysis review, and additional focused Medical Team Training as needed.


Increasing the incidence of wrong-site surgery and invasive procedures is a challenge both in and outside of the operating room (OR).

Wrong-site surgery is the reviewable sentinel event most frequently reported to the Joint Commission.1,2 Improperly performed surgery is a major cause of patient harm and potentially preventable events.2 This study provides a follow-up report and an update on recent system-wide interventions.

OBJECTIVE

We analyzed surgical adverse events and close calls reported in the VHA system to describe the rate of incorrect surgical procedures reported from mid-2006 to 2009.
Association Between Implementation of a Medical Team Training Program and Surgical Morbidity

Yinong Young-Xu, ScD, MA, MS; Julia Neily, RN, MS, MPH; Peter D. Mills, PhD, MS; Brian T. Carney, MD; Priscilla West, MPH; David H. Berger, MD, MHCM; Lisa M. Mazzia, MD; Douglas E. Paull, MD; James P. Bagian, MD

**Objective:** To determine whether there is an association between the Veterans Health Administration Medical Team Training (MTT) program and surgical morbidity.

**Design, Setting, and Participants:** A retrospective health services study was conducted with a contemporaneous control group. Outcome data were obtained from the Veterans Health Administration Surgical Quality Improvement Program. The analysis included aggregated measures representing 119,383 sampled procedures from 74 Veterans Health Administration facilities that provide care to veterans.

**Main Outcome Measures:** The primary outcome measure was the rate of change in annual surgical morbidity rate 1 year after facilities enrolled in the MTT program as compared with 1 year before and compared with the non-MTT program sites.

**Results:** Facilities in the MTT program (n=42) had a significant decrease of 17% in observed annual surgical morbidity rate (rate ratio, 0.83; 95% CI, 0.79-0.88; P = .01). Facilities not trained (n=32) had an insignificant decrease of 6% in observed morbidity (rate ratio, 0.94; 95% CI, 0.86-1.05; P = .11). After adjusting for surgical risk, we found a decrease of 15% in morbidity rate for facilities in the MTT program and a decrease of 10% for those not yet in the program. The risk-adjusted annual surgical morbidity rate declined in both groups, and the decline was 20% steeper in the MTT program group (P = .001) after propensity-score matching. The steeper decline in annual surgical morbidity rates was also observed in specific morbidity outcomes, such as surgical infection.

**Conclusion:** The Veterans Health Administration MTT program is associated with decreased surgical morbidity.

*Arch Surg. 2011;146(12):1368-1373*
MTT Impact - VA

N=108; 74 MTT, 34 Control
MTT 50% greater decrease in mortality & morbidity than Control, 18% & 17% respectively

Dose-response –
  – 0.5 deaths/1000 procedures less per quarter p=0.001
  – 0.6 deaths/1000 procedures per increase in briefing/debriefing p=0.001

70% reduction in reported OR related harm
What Have We Learned?

Actions needed well before entering the OR

- Timeout period is too late in many cases
- Systems-based approaches beyond individual

Involvement of all disciplines

Structured communication that drives discussion

- Briefings & debriefings, Medical Team Training essential
How do you build teamwork?

CRM - Team Building Skills

1. Interpersonal skills (NASA, 1990)
1. Interpersonal skills
   - Greet Team
     - Shift
     - Case
     - RRT for example
   - Practice Civility – Be Polite
   - Set Tone
     - “The Leader sets the Tone”
   - Make Eye contact (5-10 seconds)
   - Use appropriate Body language (Non-Verbal)

Tony Kern, Controlling Pilot Error, 2001
Gaffney, Hardin & Seddon, 2005, FAA, 2004
Directed Communication

Communicate to someone
  – Use person’s name
  – Use eye-contact

Confirm that message was received
2. Briefings to establish positive team climate
   – Must occur early
   – Initiated by leader
   – Structured via checklist
   – Encourages team to ask questions
   – Creates Shared Mental Model
Asking The Right Question

“Any questions?” 😞

VS

“What is(are) your biggest concern(s) for today?” 😊
3. Invite and Expect Participation
   - “Please speak up”
   - “I expect you to speak up”
   - Receive it well
   - Humble yourself – the “3Ds”
4. Engage with Questions
5. Acknowledge all communications
   – Set acknowledgement expectation
   – Close the loop on all communication
   – NASA Research

How Do You Build Teamwork?
CRM - Team Building Skills

Gaffney, Hardin & Seddon, 2005
Closing the Loop

Repeat Back
- Reflect back what you hear
- Confirm with sender

Read Back
- Write down what you heard
- Read back what you wrote
- Confirm with the sender
How Do You Build Teamwork?

CRM - Team Building Skills

6. Debriefing

Debriefing Checklist

- What went well?
- What did not go well?
- Did we have what we needed?
- Did Equipment function properly?
- What could we do better?
- Other
Followership

Critical to Safety
Followership

Engaged and active in decision making
Critical thinkers
Assume ownership and responsibility for team decisions
Provide honest, timely feedback
Practice inquiry and assertive advocacy
“Speak up” regardless of situation or rank
Assertive but Respectful
Dynamic Skepticism

Attitude of constantly questioning and evaluating the patient care environment

- Avoid trusting what appears to be obvious
- Do not assume!
- Seek facts
- Verification is NOT a mistrust of others
- Questioning and verifying is safe practice
Feedback

Communication should be

- Specific
- Direct
- Concise

DO NOT

- “Hint and Hope”
3 “W”s

1. What I see

2. What I’m concerned about

3. What I want
“3Ws” Case Study

A case is about to begin on a patient having several laryngeal polyps removed. The circulating nurse notices that the fires risk assessment section of the briefing was skipped and the surgeon wants to start the case.

**Hint and Hope:**

“Isn’t this an ENT case?”

**“3Ws”**

What I see
What I’m concerned about
What I want

This is an ENT case. I’m concerned about the risk of an airway fire. We need to briefly complete the fire risk assessment.
**SBARR**

**Situation**
What is the problem?

**Background**
Brief background information

**Assessment**
What is your assessment of the patient?

**Recommendations**
What do you recommend?

**Response**
Close the loop
4 Step Assertive Communication Tool

1. Get Attention - State name or position - Strip away title as option
2. State concern ..... “I’m uncomfortable”
3. Offer Alternative
4. Pose question to get resolution
4 Step Communication Tool

1. State name or position to get attention.

   Dr. Jones

2. State concern.

   I am concerned. We’re missing a sponge and it could be in the patient.

3. Offer alternative.

   We need to stop and explore the wound.

4. Pose question to get resolution.

   Would you like me to call for the X-Ray?
“Feel the Pinch”

Visceral sensation that
“all is not right”
“Pause in the Action”

- Reassessing a situation that does not appear to be working
- Other team members should become involved
- Last chance
When all else fails?

Chain of Command
Escalation Protocol

• 3W’s
• 4 Step Tool - Assertive Statement
• Step Back - “Feel The Pinch”
• Chain of Command
• Take Action is always an option
Avoid Hint and Hope

1. Specific
2. Direct
3. Concise

3 W’s
1. What I see
2. What I’m concerned about
3. What I want

4 Step Assertive Tool
1. Get Attention
2. State Concern (‘Feel The Pinch’)
   “I’m uncomfortable with…”
   “I’m concerned about…”
3. Offer Solution
4. Pose Question

Use Chain of Command

TAKE ACTION OR STEP BACK

SBAR
General Points
Call Out

• Communicate to all what you see and know
• If you “feel the pinch” that trouble is brewing, communicate that to everyone
• If you keep it to yourself, the patient may suffer
Assertive Statements

Direct and clearly communicated statements that facilitate patient advocacy in decision-making.

• Not a license to be rude

• Remember:
  “Assertiveness with Respect”
Words to Avoid

“You” - blame/shame, elicits defenses

“Should” – judgmental, value statement

Hyperbole – “never,” “always,” “nothing,” “everything”

– Not fact

– Not credible

– Inflates correctable problem into impossible challenge
Words to Use

“The” statements (policy) – stick to the facts
  – Avoiding conflating person with behavior
  – Attack the problem, not the person

“I” statements – identify your concern, confusion, difficulty and ask for assistance

“We” statements – shared responsibility and shared interests
  – Invoke common principle, accepted standard
Assume Nothing!

Communicate what you see and know!
What Have We Learned?

Actions needed well before entering the OR

- Timeout period is too late in many cases
- Systems-based approaches beyond individual involvement of all disciplines

Structured communication that drives discussion

- Briefings & debriefings, Medical Team Training essential
The Challenge of Staying Focused

or

The Danger of Being Focused
Situational Awareness

Definition: The **continuous perception of self and team** in relation to the dynamic environment and the **ability to make adjustments**.

*The one most important aid in maintaining Situational Awareness is a common understanding of the briefed plan.*
Briefings

Dialogue among principals using concise, relevant information to promote clear and effective communication

- Real time
- Face-to-face
- All team members present
- All team members participate
Why Do a Briefing?

Establish a platform for common understanding
- Gives people permission to be frank & honest
- Gets everyone on the same page

Provides a structure for collaborative planning

Creates a shared mental model
Pre-Op Briefing

Entire Surgical Team
- Attending surgeon
- Anesthesiologist/CRNA
- Circulator
- Scrub nurse/tech
- Resident, PA, perfusionist, others

Guided by checklist guide (specialty specific)

OR suite prior to anesthetic induction

Does not replace pre-op planning

Complements the TIMEOUT
Supporting Long Term Memory

Checklists

- Put knowledge in the world vs. in the head
- Recognition is better than recall
- Tool to Guide and Improve Communication

Checklist Philosophy

- “Read and Verify” checklists
- “Read and Do” checklists
Post-op Debriefing

- Entire Surgical Team
  - Attending surgeon
  - Anesthesiologist/CRNA
  - Circulator
  - Scrub nurse/tech
  - Resident, PA, perfusionist, others
- Guided by checklist (specialty specific)
- What went well? What did not go well? What can we do to improve our processes? What did we learn?
- Timing – when patient is stable before attending leaves (update prior to patient leaving OR)
- Method to track debrief items and follow-up: Leadership Group
Post-Op Debriefing

What it is NOT:
- Chance to whine about people
- Chance to collect statistics for statistics sake

What it IS:
- Tool to identify problems that impact patient care
- Tool to solve problems as a team
VETERANS HEALTH ADMINISTRATION
Postoperative Briefing Guide for Use in the Operating Room
✓ Provide Comments as Appropriate

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>1</th>
<th>Unsatisfactory</th>
<th>2</th>
<th>Satisfactory</th>
<th>3</th>
<th>Excellent</th>
</tr>
</thead>
</table>

Comments:

<table>
<thead>
<tr>
<th>Anesthesiologist/CRNA</th>
<th>1</th>
<th>Unsatisfactory</th>
<th>2</th>
<th>Satisfactory</th>
<th>3</th>
<th>Excellent</th>
</tr>
</thead>
</table>

Comments:

<table>
<thead>
<tr>
<th>Nurse(s)</th>
<th>1</th>
<th>Unsatisfactory</th>
<th>2</th>
<th>Satisfactory</th>
<th>3</th>
<th>Excellent</th>
</tr>
</thead>
</table>

Comments:

☐ Areas for Improvement/Safety Issues/Action Items

☐ Instruments, Sponge, Needle Count Correct
  ☐ Yes
  ☐ No
  ☐ If No, Explain

☐ Delays
  ☐ No
  ☐ Yes
  ☐ If Yes, Specify

☐ Equipment Issues
  ☐ No
  ☐ Yes
  ☐ If Yes, Specify

☐ Name of Procedure Recorded

☐ Specimen Labeled Properly

☐ Concerns for Postoperative Course [Surgeon, Anesthesiologist/CRNA, Nurse(s)]

☐ Comments

*This checklist contains the elements of the WHO checklist and also includes a sampling of the majority of elements as suggested by frontline OR teams from the VHA. The WHO Surgical Safety Checklist is available at http://www.safeurg.org/uploads/1/0/9/0/1090835/ssl_checklist_finaljun08.pdf

VHA Policy/Directive, WHO Checklist, Joint Commission, Medical Team Training
OR 23
DOB: 11/21/1975 (36y)

XORMIS, FIVE
060000645
2349

# Allergy Info

In 13:07 ETO 14:07 Pt: 0.0°C
ISO: Latex Allergy
BP:
H: cm; W: kg; BMI:

(1) APPENDECTOMY - OPEN

Sign Out:
- Specimens labeled and sent?
- Sponge/Needle/Instrument Count Correct (if complete)?
- Airway, extubation, EBL, Post Op concerns?
- Admit, Discharge instructions, antibiotics?
- Pain control (PCA/epidural)?
- Debriefing: What could have been done differently?
- Prebriefing: Next case plan? Next patient on call?

Counts:

<table>
<thead>
<tr>
<th>#</th>
<th>Count Class</th>
<th>Count Types</th>
<th>Status</th>
</tr>
</thead>
</table>

Blood Information:
- Target HCT: Not available
- Actual HCT: Not available
- Type/RH: No order placed in UMCL
- Antibody Screen: No order placed in UMCL
- PRBC: No order placed in UMCL

EBL: 0 CC PACU Bed Req.: N/A

Next case information not available
### OR Debriefing Form

**Patient:**
- [ ] Name
- [ ] CPT
- [ ] Room
- [ ] Case Date

**Surgeon:**
- [ ] Name
- [ ] Surgical Resident
- [ ] Nurse
- [ ] Scrub Tech / RN

**Anes Attending:**
- [ ] Name
- [ ] Anes Resident
- [ ] CRNA

<table>
<thead>
<tr>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgeon:</strong> Overall case assessment.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The team worked together in a safe and respectful manner.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>Anesthesiologist / CRNA:</strong> Overall case assessment.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The team worked together in a safe and respectful manner.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>Nurse(s) / Surgical Tech:</strong> Overall case assessment.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The team worked together in a safe and respectful manner.</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**Please indicate areas for improvement / safety issues / action items**

- Insufficient time to count: (click to select) [ ]
- [ ] Explain
- Delays: (click to select) [ ]
- [ ] Explain
- Antibiotic delay: (click to select) [ ]
- [ ] Explain
- Instrument issues: (click to select) [ ]
- [ ] Explain
- Equipment issues: (click to select) [ ]
- [ ] Explain
- Specimen labeling / handling issue [ ]
- [ ] Explain
- Procedure NOT performed as booked / consented [ ]
- [ ] Explain

**Additional Comments**

**Followup needed by**
- [ ] Anesthesia QA
- [ ] Nursing
- [ ] Surgical Chair
- [ ] Instrument Processing

*This is a QA Document, not part of the medical record*
Obstacles to Performing the Debrief

- Processed Viewed as a Nursing Function
- Some Personnel Don’t See Value
  - Limited cross functional participation in solving problems
  - Don’t see action taken – both communication and capacity issue
  - Staff don’t see themselves as able to make change happen, waiting for management
    - Greater clarity of structure and process
  - Some people use debrief as an opportunity to whine
- Debrief not being facilitated as designed
- Some staff receive negative response when surfacing issues
Evaluating Progress
Trust But Verify
Observational Data
Barriers to Communication

- Leadership
- Communication Techniques
- Communication Expectations
WE ARE ALL LEADERS!

If you see it and say nothing, you are responsible
Team Responsibility in the Operative Arena –

**Final summary:**

1. *We are **ALL** responsible, all the time:*
   - Pre-induction
   - Pre-incision
   - Debriefing
2. *Speak-up! (it’s impossible to over-communicate)*