Healthcare Team Training LLC

Implementing TeamSTEPPS™ in the Operating Room

Briefs + Debriefs + Checklists = Glitch Capture, Good Catches & Patient Safety

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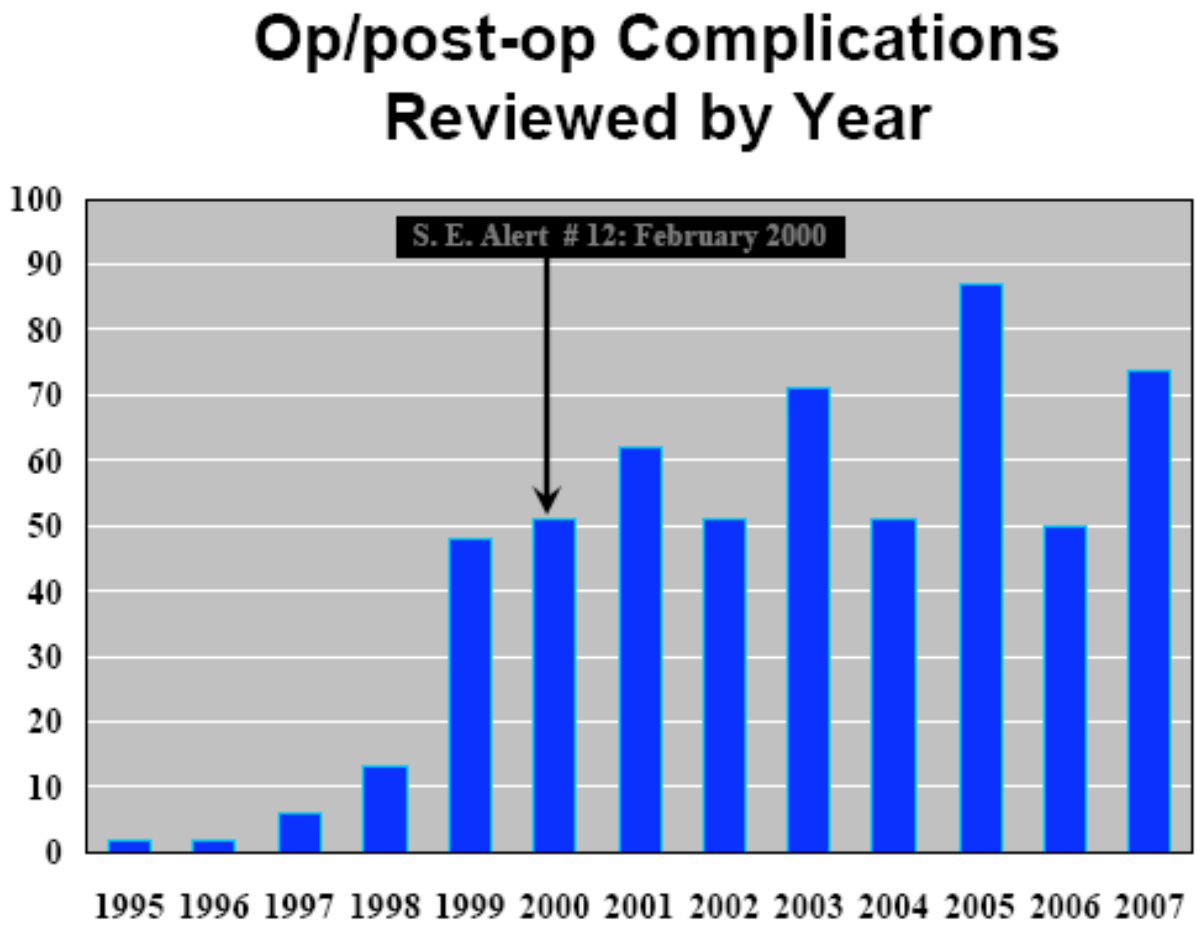
Principal, Managing Partner

Objectives

- Assess the need for improved teamwork in the OR
- Define the outcomes of high performing teamwork
- Integrate TeamSTEPPS tools into the OR
- Develop a measurement plan for OR teamwork
- Analyze and report meaningful improvement
- Celebrate the “good catches” and fix the “glitches”

Why Teamwork?



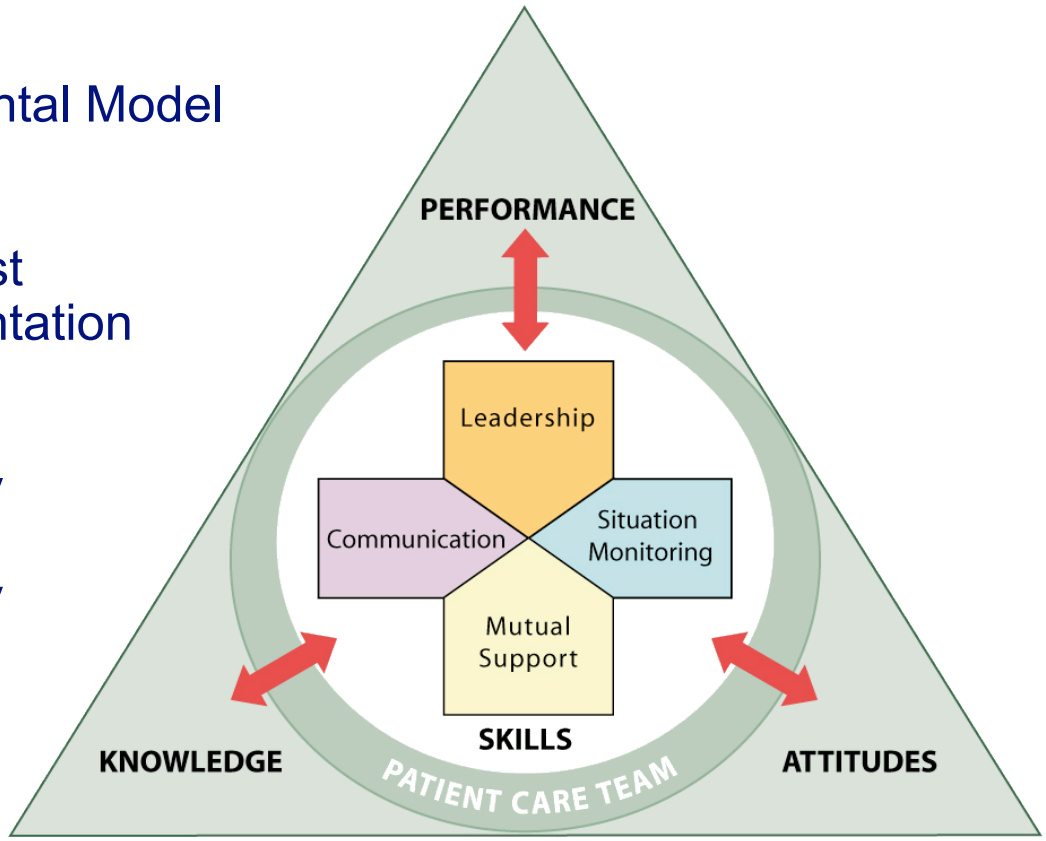
Source: The Joint Commission

Why Teamwork?

- “If everyone just knew their jobs,….”
- “The same ‘glitches’ happen every day…”
- “It’s hard to know all surgeon preferences…”
- “Staff is inexperienced, …always someone new”
- “Equipment issues are our #1 concern…”
- “Pre-op delays keep us from starting on time”
- “I don’t feel valued or respected by the Team”
- “Our patients suffer when we’re not coordinated”

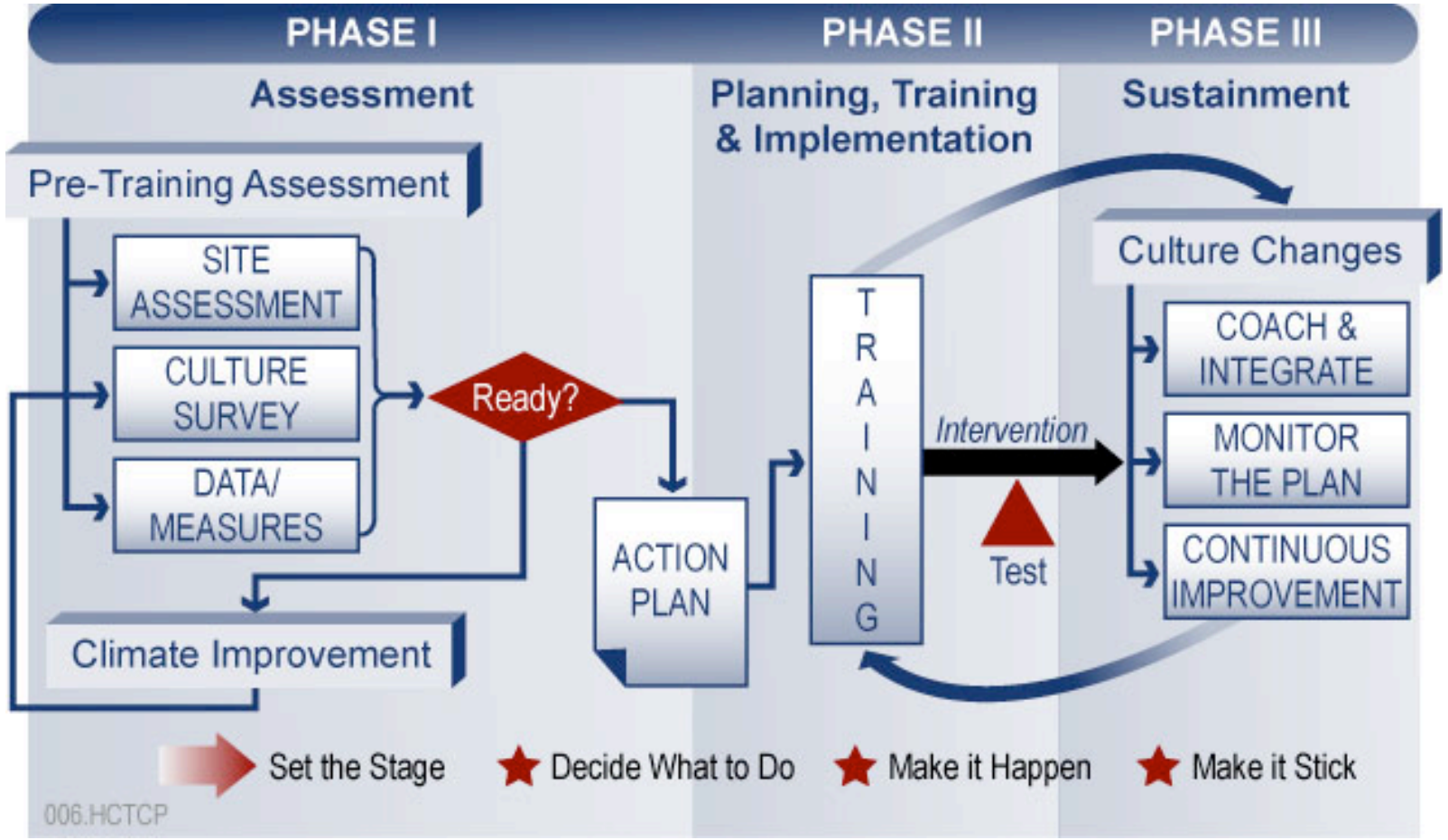
TeamSTEPPS™ Outcomes

- **Knowledge**
  - Shared Mental Model
- **Attitudes**
  - Mutual Trust
  - Team Orientation
- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety



Source: AHRQ Team Strategies and Tools to Enhance Performance and Patient Safety

Model for Change



Source: AHRQ Team Strategies and Tools to Enhance Performance and Patient Safety

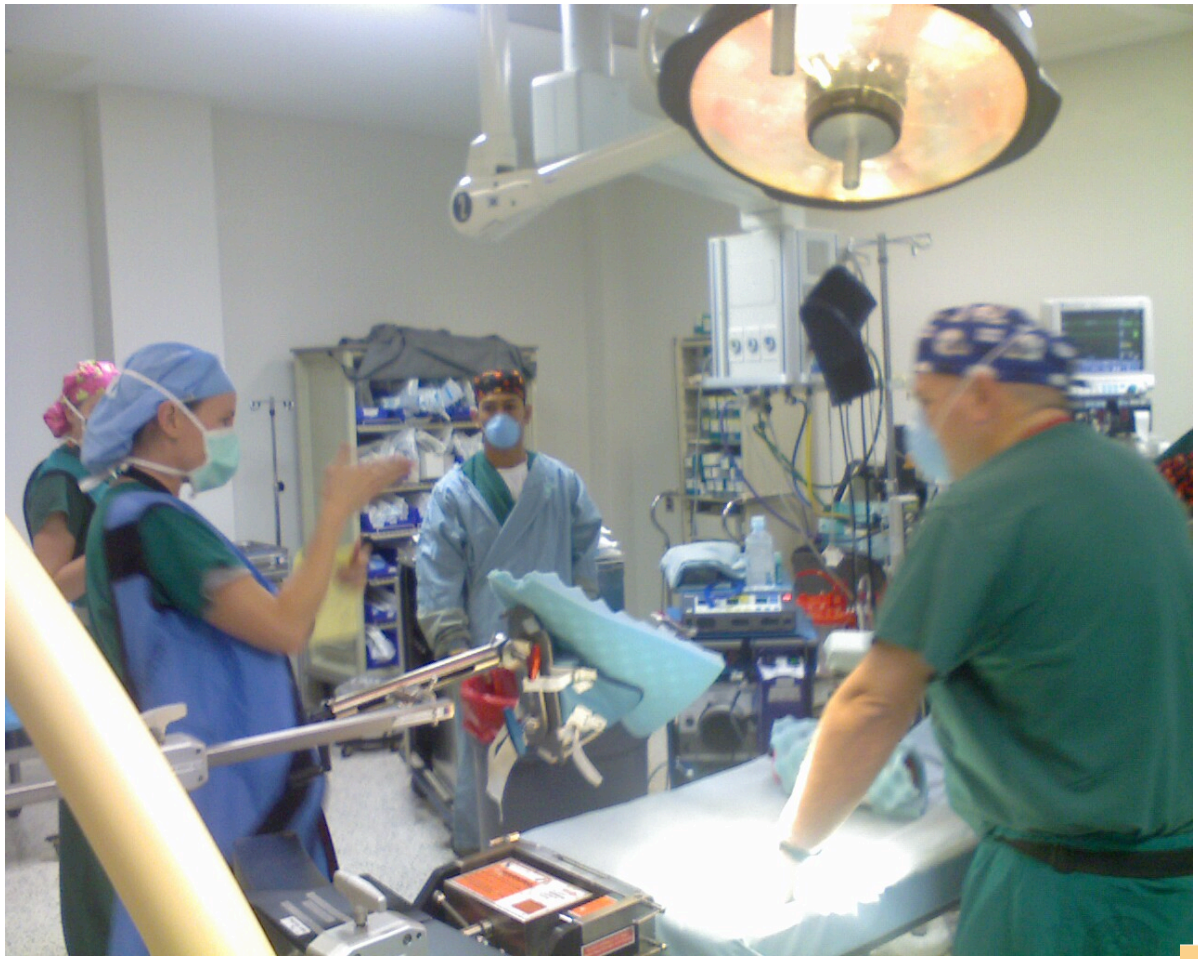
Develop a Measurement Plan

- Culture/Attitudes Surveys (AHRQ HSOPS)
- Team Satisfaction
- Direct Observations- “Surgical Disruptions”
- Efficiency Measures
  - First Case Start Time
  - Improved Equipment Utilization
  - Case length
- Good Catches/Glitch Capture

Multi-disciplinary Training Plan

- Change Team (Care Improvement Team)
- Trainers/Coaches (Promote & Model Teamwork)
- Providers and Staff (Knowledge-Practice-Experience)
- Newcomers (Orientation)
- Refres

Implementing Briefs and Debriefs



Brief Checklist

During the brief, the team should address the following questions:

- ☐ Who is on the team?
- ☐ All members understand and agree upon goals?
- ☐ Roles and responsibilities are understood?
- ☐ What is our plan of care?
- ☐ Staff and provider's availability throughout the shift?
- ☐ Workload among team members?
- ☐ Availability of resources?

Source: AHRQ Team Strategies and Tools to Enhance Performance and Patient Safety

Debriefs

Self-Learning, Reporting, Feedback, Coaching

Team Debriefing

Please complete the debrief form with team input.

Level of team satisfaction with procedure.

Surgeon	◯ Very Satisfied	◯ Satisfied	◯ Neutral	◯ Needs Improvement	◯ Unsatisfactory
Anesthesia	◯ Very Satisfied	◯ Satisfied	◯ Neutral	◯ Needs Improvement	◯ Unsatisfactory
Nurse	◯ Very Satisfied	◯ Satisfied	◯ Neutral	◯ Needs Improvement	◯ Unsatisfactory
Surgical Tech	◯ Very Satisfied	◯ Satisfied	◯ Neutral	◯ Needs Improvement	◯ Unsatisfactory

What went well?

☐ Pre-case planning ☐ Effective Communication ☐ Task Assistance ☐ Shared Workload ☐ Effective Use of Resources

Other (please specify)

Room for Improvement?

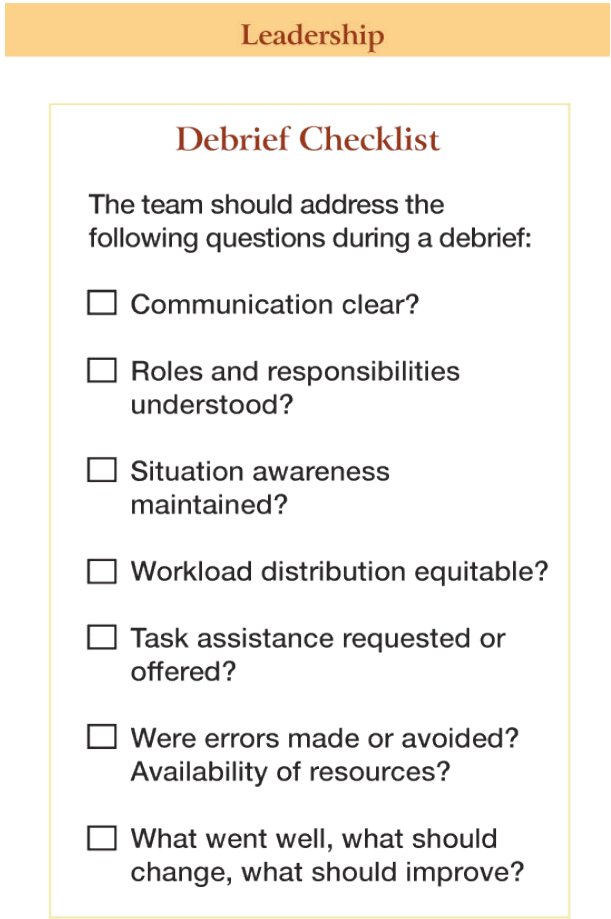
☐ Pre-Op ☐ Case Scheduling ☐ On-time Performance ☐ Team Communication ☐ Equipment and Supplies

Reason for "glitch" (please specify)

Any good catches by team?

What's in it for me/us/patients?

- "more coordinated"
- "less frustration"
- "on the same page"
- "better prepared"
- "have more information"
- "feel more valued"
- "easier to speak up"
- "more willing to ask questions"
- "patients see us as a team"
- "don't repeat the same mistakes"



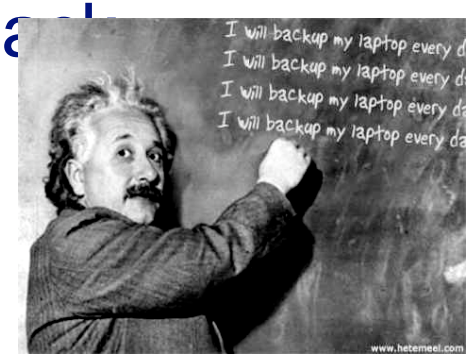
Actual OR “Good Catches”

- “Case was scheduled as left arm which was incorrect. Surgery was right arm. Caught during brief.”
- “Wrong arm written on schedule.”
- “Discovered expired medication on back table through the check-back process.”
- “Nurse noted discolored limb during briefi
- “Cancelled case following brief due to contraindication.”
- “Case cancelled prior to intubation due to missing/required equipment.”

AP / Jeff Chiu

Lessons Learned

- Training alone does not change behaviors
- Customize/integrate with local processes
- Connect data collection to team behaviors
- Coach & practice behaviors regularly
- Include simulation if possible
- Build “just enough” consensus/buy-in to begin
- Repeat, reinforce and seek feedba



Questions/Comments/Feedback

Frequently Asked Questions

http://dodpatientsafety.usuhs.mil/index.php?name=News&file=article&sid=43

Reduction of Communication Errors

Table 2. Number of Communication Failures With and Without at Least 1 Visible Consequence in the Preintervention and Postintervention Phases

	Preintervention	Postintervention	Total
Failures with no visible consequence	133	38	**171**
Failures with at least 1 visible consequence	207	75	**282**
Total	**340**	**113**	**453**

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Decrease in Surgical "Disruptions"

	Pre-Implementation Group	Post-Implementation Group	Percent (%) Decrease	P Value
Total Surgical Disruptions per case	9.5	5	47	.0002
Procedural Knowledge Disruptions per case	4.1	2.17	46	.007
Miscommunication events per case	2.5	1.2	53	.03

Table 5: Per case average of total surgical disruptions, procedural knowledge disruptions, and miscommunication events for pre-implementation and post-implementation groups.

Mayo CT OR, Henrickson, et al., 2008

Circulator leaving the room…

	Pre-Implementation Group	Post-Implementation Group	Percent (%) Decrease	P Value
Trips to core (per case)	10	4.7	53	.008
Time spent in core per case (min)	6.6	2.9	56	.01

Table 4: Average number of trips to the core per surgical case by circulating nurse in pre-implementation vs. post-implementation group.

Mayo CT OR, Henrickson, et al., 2008

Positive Attitudes toward Briefings

Table 3. Number of Survey Respondents by Profession and Status Who Agreed With Selected Survey Items Relating to Safety, Education, Collaboration, and Overall Value of the Team Checklist Briefings

Survey Item	"Agree" Responses, No. (%)[a]					
	Surgery Staff (n = 9)	Surgery Trainees (n = 13)	Anesthesia Staff (n = 20)	Anesthesia Trainees (n = 12)	Nurses (n = 23)	Total (n = 77)
The checklist gives me information about the patient and/or procedure that would otherwise not have been available to me.	4 (44)	7 (54)	15 (75)	11 (92)	16 (70)	53 (69)
The checklist provides an opportunity for the team to identify and resolve problems and ambiguities.	9 (100)	12 (92)	18 (90)	10 (83)	22 (96)	71 (92)
The checklist provides an educational opportunity for students and residents.	7 (78)	11 (85)	16 (80)	6 (50)	20 (87)	60 (78)
The checklist has the potential to guard against mistakes in the operating room.	7 (78)	11 (85)	20 (100)	10 (83)	20 (87)	68 (88)
The checklist strengthens the operating room team.	6 (67)	10 (77)	14 (70)	9 (75)	17 (74)	56 (73)
Considering all of the positive and negative aspects of the checklist, are routine checklist discussions worthwhile?	7 (78)	11 (85)	16 (80)	9 (75)	19 (83)	62 (81)

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