OR debriefings put the safety checklist ‘on steroids’

See it, say it, fix it. That saying by a former FedEx pilot set the stage for a major quality improvement effort in surgical services at a South Carolina medical center.

A key QI tool is debriefings performed at the end of every case. These quick exchanges help to bring defects to the surface and get them addressed quickly.

Debriefings highlight a variety of defects from patient safety risks to minor annoyances. Payoffs from fixing them are safer care with fewer delays, with better surgeon and staff satisfaction and labor productivity.

The debriefings data has put the OR’s surgical safety checklist “on steroids,” says Michael Rose, MD, anesthesiologist and vice president of surgical services at McLeod Health based in Florence, South Carolina. McLeod is one of the original designers of Premier’s QUEST High Performing Hospitals program, a voluntary inpatient QI project sponsored by the 2,500-member health care alliance.

McLeod Regional Hospital, the system’s 450-bed flagship, has a surgical volume of about 19,000 cases a year.

QI from the top

QI at McLeod is led from the top. Senior executives gather each morning to review quality metrics on a whiteboard. Were there any codes in the past 24 hours? How are patient experience scores? What new best practices are being introduced?

Since joining the Premier program 3 years ago, McLeod’s mortality index improved from 1.02 to 0.799 for 2011, compared to 0.6 to 0.7 for peer hospitals, with 19 fewer deaths than expected. The 30-day all-cause readmission rate, 6.2%, is below the 8.0% QUEST average.

McLeod’s core measures for 2011 averaged:

- 97.51% for on-time antibiotic administration
- 97.31% for antibiotic selection.

McLeod is also a low-cost provider for its market, having reduced its case-mix adjusted cost per discharge by 22% for the baseline through 2010, notes Donna Isgett, MSN, RN, senior vice president of corporate quality and safety.

Resolve to ‘fix it’

To lay the foundation for QI in surgical services, McLeod brought in FedEx pilot Michael Farnsworth, a commanding presence and expert in crew resource management, now deceased.

One of his key points was, “See it, say it, fix it—with an emphasis on fix it,” Dr Rose recalls.

The idea is, “If you are going to ask people to identify risks and defects, you need to create a time in each operation for people to be heard.” Then you need to fix it.

OR leaders seized on the World Health Organization Surgical Safety Checklist as a
tool not only to make care safer but also to improve operational performance.

A group from surgical services, including medical staff, anesthesia providers, nurses, and technicians, decided they needed to create an opportunity for any team member to tell management what it needed to focus on.

Management “committed to them we were going to come back and do it,” says Dr Rose.

The group decided that the WHO checklist, including the debriefing, would be completed for every case. The checklist, launched in 2008, identifies safety measures to check during 3 phases of the operation:

- before anesthesia induction (brief)
- before the skin incision (time-out)
- before the patient leaves the OR (debrief).

Studies have found use of the checklist significantly reduces surgical morbidity and mortality.

Though many ORs have embraced checklists, debriefings have been slower to catch on than the briefing and time-out. In the 2011 OR Manager Salary/Career Survey, only 37% of respondents were using debriefings, whereas 55% of respondents had implemented briefings.

**Debriefings a focus**

At McLeod, the debriefings have become a focus. Some 2,000 debriefings have been analyzed and the data used to set priorities for improvement.

Debriefings “allow us to see where there are risks, vulnerabilities, and system defects,” says Dr Rose.

As fixes were made, surgeon satisfaction rose because they saw their cases being completed with fewer delays.

“We have learned that this kind of communication dramatically alters the day for surgeons,” he says.

The OR’s labor productivity is also up. Labor has been reduced by 3 to 4 minutes per case on average as delays have decreased, says April Howell, RN, CNOR, assistant director of surgical services.

“If you have 4 to 6 people in a case, and there is a 15-minute delay, that is a lot of time. The connection between the debriefing information and operational effectiveness has been very direct.”

**How debriefings are conducted**

The debriefing is performed at the end of each case as the surgeon closes the incision. The circulating nurse asks the team for information such as:

- where the patient is going from the OR
- the patient’s specific needs
- blood loss
- review of specimens and labeling.

The nurse then asks if there were any issues that could have made the case go better and then completes a paper debriefing form (illustration). In lieu of detailed comments, the nurse might simply write, “See me,” or “Call me about this.”

Howell collects the forms and compiles the information daily in an Excel spreadsheet, which is sent to the management team and a few others.

“We know within 24 hours if there has been a problem with a case,” she says. If necessary, she can go back to the staff member in the room and ask about the situation.

Examples are a wrong patient sticker on a chart, a wrong consent filled out, or a
supply not available. An attempt is made to address each defect.

‘People are listening’
The benefit of tracking and fixing defects, she says, is that the surgeons and staff realize “people are listening.”
Since data collection on debriefings began in November 2010, the percent of cases with defects has declined from 17.5% to about 8%.
“What I hear from staff is that we’re identifying problems and fixing them so they’re not repeating as much,” Howell says.
Compiling the debriefings takes about 1 hour a day, she estimates.
“It’s a little time-consuming. But we’ve seen a huge return on investment both in patient safety and staff and surgeon satisfaction.”

Learning from a fall
From one debriefing, the management team learned what went wrong in a case where a patient fell from an OR table. Fortunately, the patient was not significantly injured.
A team member had raised concern about the patient’s positioning, but others had brushed off the concern.
Instead of being hushed up, the incident was shared and discussed with the staff. “We took a look at all of our positioning, brought in educators, and got different tools for our staff,” Howell says.

They also discussed the need for each team member to have a voice and to listen to others.

Catching a near miss
A wrong-site surgery averted got the attention of a surgeon who had not fully bought in to briefings and debriefings. A laterality discrepancy was caught during the briefing.

From then on, says Howell, he had buy-in.

Other near misses identified have been patients with allergies and patients who are Jehovah’s Witnesses and won’t accept blood transfusions.

Events where harm actually reached the patient or got close “have fallen dramatically,” Dr Rose says.

In a complex system like an OR, “it’s not necessarily possible to get defect rates to zero,” he says. “But the team’s capability through collaboration can substantially mitigate the actual harm that results when something has gone awry. We think we’re seeing that in our data.”

Staff voice support
McLeod’s staff voiced their support for briefings and debriefings in a 2011 safety culture survey.

One staff member responded: “I strongly believe the checklist encourages conversation among members of the staff. It helps the team discuss every aspect of the patient’s condition and focus on the critical abnormal points.

“The surgical arena can be both a stressful and demanding area to work in, but with effectively implementing the checklist, the process has slowed enough for us to focus on the important point, the patient.”

The survey was conducted by the Harvard School of Public Health and the South Carolina Hospital Association.

Safety and quality structure
McLeod has reached out to learn about performance improvement, Dr Rose notes.

Every employee and a number of physicians have received PI training, working with a team led by Atul Gawande, MD, and his group from Harvard as part of the South Carolina Hospital Association’s Safe Surgery 2015 initiative (www.safesurgery.org). The initiative’s goal is for the WHO checklist to be used in every OR in the state by the end of 2013.

McLeod’s managers and a group of physicians were also part of a distance learning group led by Marshall Ganz, PhD, of Harvard, an expert on community organizing and organizational behavior.

“We learned a lot about the theory and method of interacting with people,” says Dr Rose.

One lesson was the benefit of interacting peer to peer when introducing a change such as the checklist, particularly for the physicians.

“Our strongest physician users are now using the peer-to-peer connection to take the idea to each of their peers,” he says, adding, “It’s painstaking work over a long time.”
**Sustainability**

To sustain the effort, the management team audits briefings, time-outs, and debriefings, giving immediate feedback to the teams.

Support comes from the top, Dr Rose observes, with senior execs and board members regularly coming to the OR.

The chairman of the board, a realtor, visits the OR, dresses in scrubs, and talks with team members.

Isgett says McLeod’s participation in the Premier QUEST project creates “constant movement” to improve. Hospitals pledge to be transparent in sharing data and best practices.

In turn, she says, “We feed that back into other QUEST hospitals. That is the secret to the work—flowing it through.”

——Pat Patterson

For more about the WHO Surgical Safety Checklist, visit [www.who.int/patientsafety/safesurgery/en/index.html](http://www.who.int/patientsafety/safesurgery/en/index.html)