Targeted Solutions Tool helps banish communication barriers during surgery

Process and communication concerns led OR management at the University of Florida Health Shands Hospital, Gainesville, to implement a Surgical Safety Process using the Joint Commission Center for Transforming Healthcare’s Targeted Solutions Tool (TST) for Wrong Site Surgery.

“When we reviewed our patient safety reports, what came to the surface loud and clear was that we could be communicating better,” Diane Skorupski, MS, RN, CNOR, NE-BC, told OR Manager.

“The reports showed us there were opportunities for improvement in our process, and we chose the TST to help identify those opportunities,” says Skorupski, associate vice president for perioperative services at Shands.

Even though the TST is labeled Wrong Site Surgery, notes Skorupski, “it’s more than that—it’s really a Robust Process Improvement method to reduce process errors across the system, including scheduling, preoperative, intraoperative, and post-procedure.”

Identify problems
To identify process problems, leadership and staff trained on the TST performed 100 audits in each area—scheduling, preoperative, and intraoperative. The audits took about 3 weeks to complete.

Sifting through the information gleaned by the audits was “exciting,” says Skorupski. “The TST easily identified where we were hitting the mark and where we needed to address process issues.”

Like the patient safety reports, the TST found communication to be a problem.

Skorupski, the chairman of surgery, and the medical director—who is an anesthesiologist—presented the findings of the TST, opportunities for improvement, and the new Surgical Safety Process during a multidisciplinary grand rounds. The safety process includes a briefing, time-out, and debriefing. No surgery was scheduled during this time, and 800 people attended, including nurses, surgical technologists, surgeons, residents, and anesthesia providers.

The attendees were told they would be coached on how to do the briefing, time-out, and debriefing, and their practice would be audited.

Currently the auditors document their findings on paper, but soon they will do the audits on an iPad and download the findings onto a Pareto chart.

Use team approach
Before implementation of the Surgical Safety Process, the circulating nurse and the anesthesiologist performed a time-out when the patient was brought into the OR. This consisted of patient identification and anything pertinent to the patient’s anesthesia.

A second time-out was done when the surgeon arrived. A third time-out was performed after the patient was anesthetized and before the incision was made.

Now a briefing is done in the OR before induction with all parties present.

“What we clearly identified was that we wanted more of a team approach, and we wanted everyone to come together—the surgical technologist, surgeon, RN, and anesthesiologist—and have a discussion about the plan of care with the patient before induction,” says Skorupski.
The briefing is started by the surgeon or anesthesiologist, who asks, “Is everyone ready for our briefing?” Team members introduce themselves and discuss the points in the briefing. The patient also participates in the discussion.

“We have found that patients love being involved in the process, especially the introductions,” notes Skorupski.

At first, some team members objected to introducing themselves to each other because they work together all the time. But the chairman of surgery pointed out that they were not introducing themselves to each other but to the patient.

“Once they started thinking of it that way, there was no longer a problem,” she says.
During their postoperative rounds, the surgeons say, patients tell them how wonderful it was to be introduced to the people who would be taking care of them while they were under anesthesia.

**Customize briefing to the patient**

Skorupski says they tried very hard to keep the number of discussion points to a minimum and told team members to customize the briefing to each patient. For example, a pediatric hernia patient would not be on beta blockers, so that type of discussion would not be necessary. “This was a new thought to them because most were used to a checklist where they had to go through each bullet,” she says.

Specialty teams known as colleges (see OR Manager, July 2013, pp 1, 6-9) were consulted about which discussion points they wanted in the briefing, and a staff-driven committee decided which points to include. “Now, if a situation comes up, the first thing people say is, ‘Let’s add it to the briefing points,’ so we have to be careful we don’t keep adding to the list to the point that it becomes unwieldy,” says Skorupski.

After team members introduce themselves, they check the patient’s identification (ID). The surgeon confirms the patient’s name and ID number on the wristband, and the anesthesiologist checks the name and ID number on the computer to make sure the correct patient record is pulled up. The circulating nurse reads the patient’s name, ID number, and procedure from the consent form.

“All 3 are involved in the identification of the patient at the start,” notes Skorupski.

Once the patient identification process is completed and the team is assured of the correct patient and procedure, the surgeon scans the briefing discussion points, which are posted on a 3- by 5-foot laminated poster in each OR, and discusses any pertinent information with the other team members (sidebar).

In a typical discussion, the surgeon might ask if there are any unusual medications the patient might be taking or other special concerns to discuss. The anesthesiologist might say, “We are concerned about the potential of a difficult airway and will be taking the following special precautions.”

The surgical technologist might ask if there needs to be antibiotics in the irrigating fluid on the sterile field.

The circulating nurse might show the surgeon an implant to make sure it is the correct one.

After the team discusses all the relevant points, the surgeon asks, “Are we ready to begin?” This question is important, Skorupski says, because it invites team members to acknowledge whether they are ready.

If the surgeon instead said, “Let’s get started,” the discussion would be cut off, she says.

**Shorten the time-out**

After the briefing, the patient is anesthetized, prepped, and draped. Before the knife is passed, the surgeon or resident initiates the time-out.

“The time-out is crisp,” says Skorupski, “because we covered all of our bases in the briefing.”

The surgeon asks if everyone can see the site marking and if the antibiotic is in. The anesthesiologist says the patient has been induced, vital signs are stable, and the antibiotic is in.

Then the surgeon asks, “Are we ready to go?” All team members verbally respond to the question.
Check on any concerns

“The debriefing is supposed to start as the wound closure is beginning or near completion, but we are still struggling with the best time to start the debriefing,” notes Skorupski. Sometimes the surgeon leaves and the resident closes. “We are trying to define a point in time that will trigger the debriefing,” she says.

A month ago, Skorupski says, they decided to put stop signs on the doors of each OR to remind surgeons to debrief. The sign asks, “Did you debrief?”

The circulating nurse calls a stop as the wound closure begins and says, “It’s time to debrief.”

The circulator reviews the discussion points, saying, for example, “All specimens are off the field and labeled, and pathology slips are made out.”

If unused blood is going with the patient to the ICU, that is acknowledged.

The surgeon might say the Potts scissors seemed dull and need to be sharpened.

The surgeon contacts the family, and the circulating nurse calls the report to the postanesthesia care unit or ICU.

To end the debriefing, the surgeon or circulating nurse asks, “Are there any concerns?”

When the OR goes live on Epic in May 2014, Skorupski says she wants to make the debriefing electronic so there is an automatic feed to other departments. This way, for example, the sterile processing department will be notified if scissors need to be sharpened.

If a scheduling problem with the case surfaces during the debriefing, that information will go right to the scheduler, so there will be real-time feedback.

The debriefing is a way to empower the staff, and Skorupski hopes they will come to appreciate what an important part of the process it is.

Pause for change

A pause is required for a change in the surgeon performing the procedure, change in patient position, or before a second procedure on the same patient is started.

During the pause, for example, the circulating nurse will read from the consent if it is a second procedure and say, “Yes, that is the procedure we are doing.”

Promote communication

To promote communication, the RNs are participating in simulation training.

“We want them to speak up—to say ‘No, we can’t start this case’ or ‘No, we can’t go any further until blood has been drawn,’” says Skorupski.

“The training is going over well,” she adds.

Skorupski says she is seeing an improvement in communication when she rounds.

The surgeons tell her it is good to get everyone together at the beginning of the case and have a conversation.

The circulating nurses and surgical technologists say they are more prepared for the procedure because they learn at the beginning of the case the supplies that might be needed even if they are not listed on the preference card.

“What I am seeing is more of an esprit de corps in the OR since kicking off the Surgical Safety Process last May,” says Skorupski. “There is more [a spirit] of ‘Yes, we are all on the same page,’ and we are all taking care of our patient and recognizing our patient as an important person who we have to communicate with.”

—Judith M. Mathias, MA, RN

Reference