Johns Hopkins started using preoperative briefings and postoperative debriefings in its inpatient ORs in May to help improve communication and the culture of safety. 

“We have been promoting the briefings for the past year, and a lot of surgeons are doing it. Hopefully, it will become a routine practice like the time-out,” says Martin A. Makary, MD, MPH, assistant professor of surgery.

The goal of the briefings “is to promote a team discussion,” says Lisa Rowen, DNSc, RN, director of nursing for the Department of Surgery. Johns Hopkins has 39 inpatient ORs.

The preop briefing takes 1 to 2 minutes and is an expanded version of the time-out for surgical site verification. The purpose is to check critical information and promote open communication.

The debriefing is a short discussion that takes place in the OR immediately after surgery, particularly after difficult cases or a case where something unexpected happened.

**Preoperative briefing**

Preoperative briefing steps include:

1. Introduce team members by first and last names and roles. Names are written on a whiteboard in the OR. “One thing we have learned is that a lot of people don’t know each other’s names in the OR even as they are operating on humans in these important cases,” Dr Makary says.

2. Conduct time-out for surgical site verification to meet the requirement of the Joint Commission on Accreditation of Healthcare Organizations.

3. Discuss goals for the case and any issues that should be anticipated.

4. Discuss issues by discipline: surgeon, anesthesia provider, nurse, surgical technologist, and any other team member.

   The briefing is performed in the OR before the incision, though there is still discussion about whether it should be done while the patient is awake or asleep.

   The briefing generally is guided by a comprehensive checklist developed with input from each discipline as well as by lessons learned from near misses and sentinel events.

   An example of an item discussed is the anticipated blood loss. Is an appropriate amount of blood available? The anesthesiologist may be anticipating a routine amount of blood loss, but the surgeon may be aware there will be more. If they discuss this during the briefing, more blood can be ordered. (An example of a briefing is on p 13.)

   If the surgeon doesn’t start the briefing, the circulating nurse does. The circulating nurse also is responsible for filling out the briefing checklist, and the anesthesia provider is responsible for filling out the debriefing checklist.

   “A great thing about the briefing is that it allows issues to surface,” Rowen says. In one case that involved 2 surgeons of different specialties, they discovered during the briefing that they had different thoughts about the goal of the procedure. They decided to cancel the case until they worked out their differences.
“Would it have been better for them to have had that conversation earlier? Yes,” Rowen says. “But it would have been worse to have it after the incision was made.”

Johns Hopkins’s detailed briefing tool will be described in a paper to be published in the *Archives of Surgery*.

**First-name project**

One of the first steps in implementing the briefings was to encourage team members to call each other by their first names once the patient is asleep. The rationale is that team members will feel more comfortable speaking up if they know one another’s names, and first names help put the team on a more equal footing. It’s more likely to encourage teamwork than calling out, “Hey, Anesthesia.”

Though getting the staff comfortable with first names sounds simple, it wasn’t easy, Rowen notes. “Some nurses said, ‘I can’t do that. It’s disrespectful.’ What we didn’t realize is how deeply embedded the hierarchy is,” she says.

After much discussion and many meetings, the first breakthrough came when the previous chair of surgery told a large group of nurses and surgical techs to call him by his first name, John.

Over several years, the culture has changed. “The nursing staff recognizes that calling all team members by their first names establishes an equitable environment, and familiarity promotes a level of comfort to share concerns,” Rowen says.

**Postoperative debriefing**

The postop debriefing includes these steps:

1. Verify the specimen. “We have learned specimen errors and labeling errors are common,” Dr Makary says.
2. Ask if anything could have been done better.
3. Ask if anything could have been done more safely and efficiently. If so, a team member is appointed to address the issue.
4. Discuss plans for postop care, such as pain control and prophylaxis for deep-vein thrombosis.

Timing is a challenge because the debriefing is supposed to take place before the attending surgeon leaves the room, usually when the team is ready to close the incision. But that can be a busy time for anesthesia providers and nursing.

“It’s a big culture change. It’s new, and we’re still working out the kinks,” Rowen says.

**Training for OR teams**

Teamwork training laid the groundwork for the briefings. The ORs were closed for 4 hours, and about 700 personnel received training, including circulating nurses, surgical technologists, surgeons, anesthesiologists, physician assistants, perfusionists, and residents.

William Taggart, a human factors expert formerly with Southwest Airlines now with the University of Texas and SaferHealthcare, Denver, who led the training, explains that it covers the culture of medicine, why change is difficult, and teamwork strategies that have helped aviation improve its safety record.

The training introduces practical tools like briefings, assertion skills, and the SBAR model for improving handoffs. (SBAR stands for situation, background, assessment, recommendation.)

Rowen says the training conveyed the message, “We are a team. The team may have an individual leader, but the surgeon is dependent on the team. The team needs to be able to communicate and raise safety issues.”

As a “magnet hospital” for nurses, Johns Hopkins has also invested in development for the nursing staff, including training in communication and assertiveness, Rowen says. Conferred by the American Nurses Credentialing Center, magnet status recognizes organizations that have achieved excellence in nursing and adopted practices that attract and retain nurses.

**Getting briefings off the ground**

OR leadership stands behind the briefings, says Rowen, including the chief of
surgery, chief of anesthesia, and director of critical care medicine. Letters were sent to all nursing and medical staff saying briefings would begin on May 1.

The chief of surgery, Julie Freischlag, MD, FACS, believes so strongly in briefings that she has told the OR Executive Committee that surgeons who resist performing them should lose their block time, Rowen notes.

The ORs geared up for briefings by discussing them at grand rounds for nurses, anesthesia personnel, and surgeons, as well as combined grand rounds.

Preparation has to go beyond training, Taggart adds. “It can’t just be a seminar—there has to be followup.” There needs to be a group guiding the application. Johns Hopkins has a “teamwork team” that fostered briefings and keeps the momentum up.

Will the briefings make a difference?

To find out, Johns Hopkins is measuring perceptions of safety before and after implementing briefings, using the Safety Attitudes Questionnaire developed by J. Bryan Sexton and colleagues. (See p 11.)

Suggestions for leaders

OR briefings can be a great way to prompt discussion of important issues, “but you need to lay groundwork,” Rowen advises. Her suggestions for OR leaders who want to introduce briefings:

• Get buy-in from OR leadership.
• Provide training for all disciplines.
• Have honest conversations about sentinel events and near misses to see how briefings could help prevent them.

“A lot of hospitals keep these issues hush-hush,” Rowen says. “Here we have developed a transparent culture. When you can say to one another, ‘This almost happened,’ you can understand and address issues that protect patients.”

References


Sample preoperative briefing

This is how an OR team might conduct a briefing:

Richard Davis (surgeon): This is Mr Robert Jones. He is a 62-year-old male with cancer of the head of the pancreas. We are proposing to do a Whipple and put in a feeding jejunostomy. Julie, please read the consent.

Julie (circulating nurse): Mr Robert Jones, ID 237789, scheduled for a Whipple and a feeding jejunostomy with surgeon Dr Richard Davis.

Dr Davis: Thanks. He has been cleared by cardiology. He is not taking any medications that will affect the case. The patient has a latex allergy.

Julie: We have been through the latex-free setup checklist.

Dr Davis: Right. He had a previous bowel resection in 2003. I envision the case will take about 4 hours. Bill [anesthesiologist], I would just as soon that you not give a lot of fluid; 1,200 to 1,600 cc is OK during the case. If you need to give more, let me know. I am going to explore the patient first. If by 8:45, I haven’t said that I am going ahead, please ask me. Antibiotics were started at 6:45. Right, Julie?

Julie: That’s correct.

Dr Davis: Blood is available. If anyone sees anything they are uncomfortable
with or is having any difficulties, please say so. Bill, if you are having trouble with blood pressure, pulse, urine output, or oxygenation, please say something. And if I run into something I don’t expect or get into any bleeding or anything that affects the operation, I’ll let you know. Does anyone have any questions or concerns? We will need an ICU bed. So if we go ahead, by 10, you should count on that bed. Bill, any concerns?

Bill: Everything is looking good. Blood pressure 120/80.

Dr Davis: John [scrub person], any concerns?

John: None here.

Dr Davis: Julie, any nursing concerns?

Julie: Just a reminder that the patient is allergic to latex.

Dr Davis: Let’s go.

Source: William Taggart, University of Texas and SaferHealthcare. SaferHealthcare can be reached at 866/398-8083 or www.saferhealthcare.com.