Briefings, debriefings: Path to safer care

A circulating nurse reports she called 3 times, asking a technical support assistant to bring a piece of equipment to the OR, but the equipment never arrived. Later, it’s learned the assistant didn’t know what the equipment was and was afraid to ask.

A nephrectomy case continues past 3:30 pm. The change of shift occurs before the count is completed. The situation is brought to the attention of the manager, who reviews with the staff their professional responsibility for counts and the importance of continuity of counts for patient safety.

These examples, recorded in OR debriefings, have helped a large Michigan hospital identify and resolve issues, both big and small, that arise during surgery. They’re part of a database of more than 6,000 defects identified over nearly 4 years at Beaumont Royal Oak Hospital, a 1,061 hospital with 58 ORs in Royal Oak, Michigan.

Briefings and debriefings have proven to be a practical way to catch problems from daily annoyances to potentially catastrophic events like wrong-site surgery before they can cause patient harm.

Briefings and debriefings are one safety strategy Beaumont has adopted from Keystone Surgery, a project of the Michigan Health & Hospital Association. Keystone Surgery, in partnership with Johns Hopkins, is a statewide collaborative of 100 hospitals seeking to improve safety for surgical patients.

Beaumont Royal Oak adopted briefings and debriefings in 2006 and expanded them to a total of 8 OR teams in 2007. All 58 ORs are now participating.

There’s evidence briefings and debriefings have made a difference. After briefings were rolled out on new services, surgical site infections (SSIs) on those services declined, as measured by the American College of Surgeons National Surgical Quality Improvement Program (NSQIP).

How the process works
Here’s how briefings and debriefings are conducted:

- The briefing is performed before each case after the patient is positioned and before the incision, taking an average of 2.9 minutes. The attending surgeon is encouraged to start the briefing and debriefing, though any team member is empowered to do so if necessary.
- The debriefing is completed after the first counts and before the attending surgeon leaves the room. Average time for a debriefing is 2.5 minutes.
- The circulating nurse completes the one-page briefing and debriefing form. The form is stapled to the OR record and given to the OR clerk, who places the forms in a designated tray. Each day, data from the forms is entered in an Excel spreadsheet by a clinical outcomes nurse.

Sharing results
Every 2 weeks, the updated spreadsheet is sent to 30 surgical services leaders and administrators, including the OR managers, senior administrators, and physician leaders.

Each service manager reviews the defects for his or her own service and either re-
solves the defects or assigns responsibility for resolving them, which has led to a number of unit-based QI projects.

“It is an expectation of management to follow up on each of the issues, to close the loop, and to report back to the surgeons and staff,” says Amanda Nash, MSA, RN, an OR nursing director.

Useful management tool
Data from the briefings and debriefings is a useful management tool, Nash says.

For equipment-related issues—the most common defect identified—she has used the data to justify new purchases.

Briefings and debriefings are also a way for nurses to speak up about concerns they might not mention otherwise, such as interpersonal issues that contribute to communication breakdowns.

“They feel more comfortable because it’s a more anonymous approach,” Nash says, and they know leaders at all levels will see the information.

She has also used information from briefings and debriefings to counsel individual staff about their performance.

Nash and other managers make sure to share the defect data with the staff and surgeons so they know how issues are being resolved. That, in turn, reinforces the value of briefings and debriefings.

A way of life
Briefings and debriefings are a way of life at Beaumont. A study published in 2009 found overall compliance ranged from 76% to 95%.

In a 2008 survey of 40 clinicians (10 surgeons, 10 anesthesiologists, 10 nurse anesthetists, and 10 circulating nurses):

• 83% agreed the briefing was an effective method to identify defects
• 74% agreed the debriefing was an effective strategy to identify defects.

Beaumont’s patient safety efforts have strong leadership through Robert J. Welsh, MD, vice chief of surgical services and chief of thoracic surgery, who also serves as the statewide physician lead for Keystone Surgery.

“It’s all about the level of commitment of your surgical leadership,” says Kathy Schumacher, MSA, CPHQ, system director of quality and patient safety initiatives.

Nash acknowledges that surgeons’ participation varies. “Some really drive this bus,” while others are not as engaged.

Briefings and debriefings have brought forward “a lot of informal leaders from the OR staff,” Schumacher notes.

“There are staff who have taken this on. They provide full-blown descriptions of cases. They don’t leave out details because they believe in the process.”

Foundation for safety
Schumacher says Beaumont’s wide adoption of briefings and debriefings has created a foundation for other Keystone Surgery projects, including introducing bundles of

Making the most of briefings/debriefings
Tips from the team at Beaumont Royal Oak on spotting and resolving defects in your OR.

Keep it simple
Use a simple Excel spreadsheet to compile data on defects from briefings and debriefings. Beaumont’s spreadsheet has:

• a tab for each service
• categories for defects
• a rolling calendar to identify issues from week to week
• space to record how the defect was resolved or to whom it was assigned.

Create the team
• Make it a team effort. Involve the OR leadership team, staff, quality specialist, and educator.
• Assign responsibility. Designate someone, such as the quality specialist or a staff nurse who is seeking an expanded role, to enter the data. The person should have strong interpersonal skills for communicating with the staff and surgeons.

Relate debriefings to real life
• Report to staff and surgeons regularly on defects and how they are resolved.
• Give examples of how they are addressing annoying problems and preventing patient harm.
interventions for preventing SSIs and specimen defects.

“We looked at the specimen defects and saw a good number could be resolved with a good debriefing,” she says.

“We were able to go back to the staff, help them see the value in the debriefing, and hold them accountable for that.”

Briefings and debriefings also help level the playing field among the disciplines.

“It can give even the most junior nurse a voice that is on a level playing field with the most senior physicians,” says Sean Berenholtz, MD, an associate professor at Johns Hopkins, who is advising Keystone Surgery.

“We say that until a junior nurse can correct a senior physician, and that conversation goes really well, patients will continue to be harmed. Briefings and debriefings provide a forum for that.”

Underlying the surgical safety culture at Beaumont is CUSP—the Comprehensive Unit-based Safety Program. Developed at Johns Hopkins, CUSP empowers front-line clinicians in improving patient safety, Dr Berenholtz explains.

CUSP teams, which involve all disciplines, identify safety concerns, learn about successful approaches and tools, initiate solutions, and perform regular safety assessments.

CUSP is the model behind the CUSP-Stop BSI, a national project by 700 hospitals to eliminate central-line associated bloodstream infections. An interim report shows a 35% reduction in ICU bloodstream infections in 350 hospitals (www.onthecuspsstophai.org/)

Worth the work
Tracking and resolving defects is a lot of work, Schumacher acknowledges. “But a lot of good things have come out of it. I think a lot of harm has been avoided. There have also been process changes because of this.”

She adds: “I think our nurse managers have done an excellent job of filtering information back to our staff and surgeons.

“Now it’s embedded in our culture.”

—Pat Patterson

For more on CUSP, go to www.innovations.ahrq.gov/content.aspx?id=1769

References
