momentum is gathering to extend preoperative briefings. OR teams already must pause before the incision to verify the surgical site. Now some experts would like to see these briefings expanded to include other critical aspects of the procedure.

A new study from Johns Hopkins Medicine published in February found OR teams who participated in 2-minute briefings before the surgical incision said teamwork had improved. They also perceived the risk of wrong-site surgery to be lower.

The study’s results provide scientific evidence for briefings as a method to improve the coordination of care and patient safety in the OR, the lead author, Martin Makary, MD, MPH, a surgeon at Johns Hopkins, told OR Manager.

With these scientific underpinnings, briefings are creating a buzz. Dr. Makary said the Joint Commission is talking about the possibility of expanded briefings, and the American College of Surgeons and Association of periOperative Registered Nurses are showing interest.

He also said he is partnering with a leading patient safety researcher, Atul Gawande, MD, MPH, FACS, of Harvard and Brigham & Women’s Hospital, Boston, to have preop checklists more widely adopted. Use of preop checklists is one approach being considered by the World Health Organization as part of a 2-year campaign for safer surgery.

Dr. Gawande told OR Manager he sees briefings as “an extremely promising approach. It gets the whole team involved in thinking how to make sure safety is a priority. “I do think it’s potentially a very important patient safety strategy. But this is still a new area and an opportunity for innovations to help show us new ideas.”

How briefings are conducted
Preoperative and postoperative briefings became policy at Johns Hopkins Hospital in June 2006. The policy requires a briefing before and after every surgery and is audited. The 2-minute preop briefing has 3 critical components:
• Each team member states his or her name and role, which are written on a whiteboard.
• The surgeon leads the timeout for surgical site verification.
• Each discipline—surgery, anesthesia, and nursing—discusses relevant issues for the procedure.

For nursing, the issues discussed are:
• Are all necessary instruments available?
• Will any special equipment be considered?
• The plan for breaks (relieving staff are to introduce themselves when switching).

The checklist for the briefing is in the article in the Journal of the American College of Surgeons. For more, see the July 2006 OR Manager.

The study and results
The aim of the Johns Hopkins study was to measure the association between OR briefings and clinicians’ perceptions of collaboration and the risk for wrong-site surgery.
There were 422 participants (147 surgeons, 59 anesthesia providers, 187 nurses, and 29 other staff) who were surveyed twice, before implementing the briefing policy and after the policy had been in effect for 3 months. All OR staff and physicians were trained to use a standard format for the preop briefings. Dr Makary also met with each surgeon in the program.

The survey included 6 items. The results showed clinicians’ perceptions improved on 5 of the 6 items:
• “A preoperative discussion increased my awareness of the surgical site and side being operated on.”
• “The surgical site of the operation was clear to me before the incision.”
• “Surgery and anesthesia worked together as a well-coordinated team.”
• “Decision making utilized input from relevant personnel.”
• “Team discussions are common in the ORs here.”

The only item that did not improve was: “A team discussion before a surgical procedure is important for patient safety.” Responses to that were already favorable before the study (94% after versus 93.3% before).

The survey was adapted from the Safety Attitude Questionnaire, originally from aviation, which has been validated for assessing team collaboration, safety climate, and related issues in health care.

The study follows 2 previous studies from Johns Hopkins published last year. One study, which focused on teamwork ratings OR caregivers give one another, found important differences in the way nurses rate physicians and physicians (surgeons and anesthesiologists) rate one another. The second study described how OR personnel rated their hospital’s safety climate. The studies were based on a survey of more than 2,700 OR personnel in 60 hospitals.

Said Dr Makary about the briefings, “It’s striking to me how surgeons can operate without knowing the names of the members of their team.” Though medical schools and surgical training stress the importance of teamwork, he said there is little formal training on communication, and barriers are established.

He said the new research is helping to apply scientific rigor to patient safety practices, which so far have little data to support them.

Dr Gawande has conducted research on adverse events in hospitals, risk factors for retained foreign bodies, and the role of human factors in surgical error. He is the winner of a 2006 MacArthur Foundation Award.

Reference
