Brief Encounters of the 5th Kind

5 Steps to Safer Surgical Care - Putting Quality into Operating Team Briefs

Project Team: Suzi Lomax, Nicola Davey, Jenny Sutcliffe, Dovlar Cinco, Nazima Hoque, Daniel Yeow

SCReaM Surrey Crisis Resource Management

NHS Royal Surrey NHS Foundation Trust

1 What are we trying to accomplish?

Background

- Different team compositions occur daily within operating theatres. We perform complex surgery, under time pressure. We use high-risk medication, have high patient turnover and make rapid intervention during emergencies.
- **However, adverse events are more commonly caused by communication and teamwork problems**, not technical or medical problems.
- The operating team brief improves the climate within the surgical team & efficiency. It is the first step of the **5 steps to safer surgery**, and an important trust governance target.

Challenge

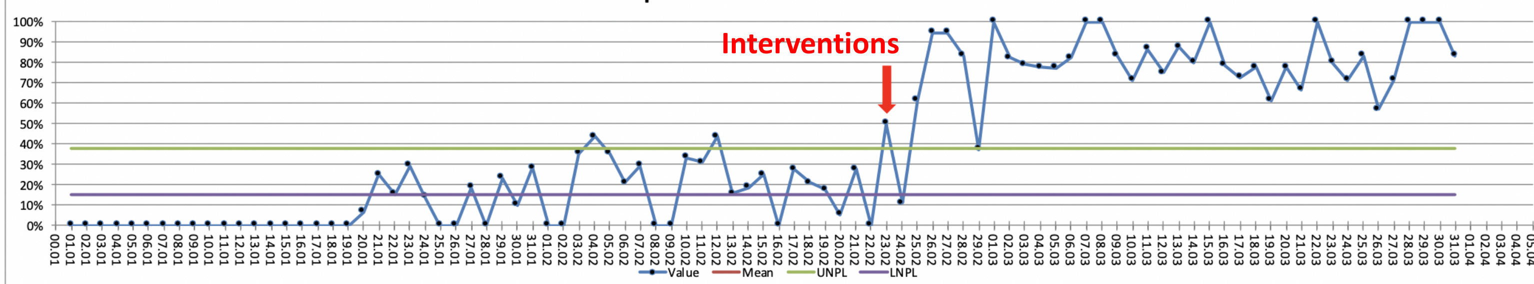
Our quality and documentation of theatre team brief is variable, risking poor shared mental models and unclear communication

Aim

Reduce variability in quality and documentation of operating theatre team briefs as part of a wider QI project. Initial focus: Improving the rate of team brief documentation.

2 What did we achieve?

Outcome Measure



SPC chart

Team brief documentation (template return) ***significantly improved*** *and* ***sustained*** *following interventions*

Average rate of return ***increased from 11% to 79%***

3 How did we do it?

Baseline data

- "Go and See" - Observation of current theatre team briefs , method of documentation & storage of data
- Current rate of return of documented team briefs

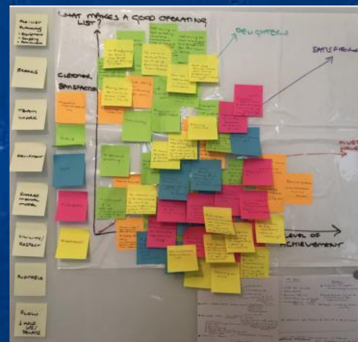
Observation of team briefs

Aspect and Problem	
Team brief paper template	Not used during actual brief, many staff unaware of its existence; if filled out, done so retrospectively by scrub staff. Template stored centrally in transfer and not immediately available where team briefs take place. Lack of process for how the template should be used.
Staff knowledge of importance of team brief	Unaware of step 1 (brief) and 5 (debrief) of 5 steps to safer surgery – only aware of WHO paper checklist (steps 2,3,4). Variable buy into value of brief and that, in fact, many of the primary drivers which staff had identified in the kano diagram were driven by a high-quality team briefs. i.e. quality of the team brief directly related to the quality of the operating list.
Process for collation/ filing of completed templates	No clear process: scattered filing and forms, no review of data, no feedback to frontline staff completing them

Engagement of stakeholders

- Kano principle – "what makes a good operating list for you?"

- Minimal unexpected steps / boxing and coxing
- Equipment requirements known by team
- Civility / respect / rapport
- Good team work
- Shared mental model
- Auditable safety checks
- Better flow
- Breaks
- Well planned list



- Completed by surgeons, anaesthetists, APs, PACU, managers, clinical governance stakeholders
- Primary drivers for most of the themes dependent on the quality of the team brief

ID barriers and enablers to target interventions

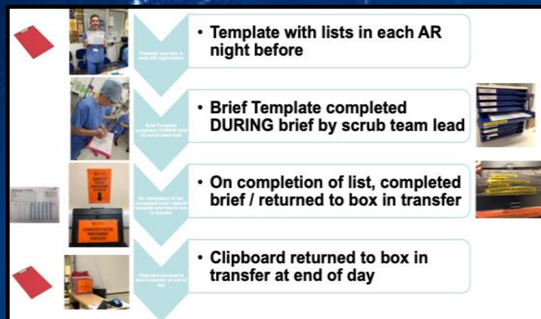
- Process map 'work done' vs 'work as imagined'
- Root Cause Analyses to ID reasons for variation
- PDSA methodology to test interventions to improve brief documentation rates

Process Mapping and Root Cause Analysis Results

Reasons why the Brief Template wasn't being used	
PEOPLE	Not valued by staff/not aware of template/lack knowledge/ little feedback
PROCESS	No monitoring or set process. Unclear about what a good brief looks like,
EQUIPMENT	Template not easily available. 'Tick-box' exercise too long or not relevant

PDSAs

Intervention 1:
New process to return and distribute brief templates



Intervention 2:
Staff engagement via educational event and champions

Team Briefs – Why bother?

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4 What have we learned?

- **Challenges** engaging >400 staff from multiple theatre specialties to follow the briefing documentation process correctly. Changing culture and beliefs
- **Champions** -Helped facilitate and streamline new process
- **Change improvement**-Required active listening, careful planning, stakeholder engagement, closed loop communication and presence of key leads to make implementation less challenging and achievable.

5 What Next?

- This is start of a larger project to increase the **quality** of operating theatre briefs undertaken
- We are continuing to analyse brief return rates during the COVID pandemic to assess impact on process and return rate

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