Enhancing Perioperative Teamwork to Improve Patient Safety

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Perioperative Services - Lehigh Valley Hospital-Cedar Crest

Lehigh Valley Health Network, Allentown, Pennsylvania

Abstract:

Problem Statement:

A “Culture of Patient Safety” survey conducted in 2008, revealed a lack of patient centered focus, teamwork, and positive communication amongst the majority of perioperative staff members at a Pennsylvania multi-campus health network. Only 43% were willing to challenge or question authority. Likewise, 53% were afraid to ask questions when something did not seem right.

Rationale:

Communication, a core component of teamwork, was cited by the Joint Commission as root cause is nearly 70% of sentinel events. Weaver, et al, performed a multi-level evaluation of the TeamSTEPPS training program. This evaluation demonstrated positive results as evidenced by significant increases in quality and quantity of pre-surgical procedure debriefings and the use of quality teamwork behaviors during the case. Leadership members from departments of Surgery, Anesthesiology, Nursing and the Divison of Education created a multi-disciplinary team focused to look at the issue and develop countermeasures to the survey results. Multimedia services were also included in the group.

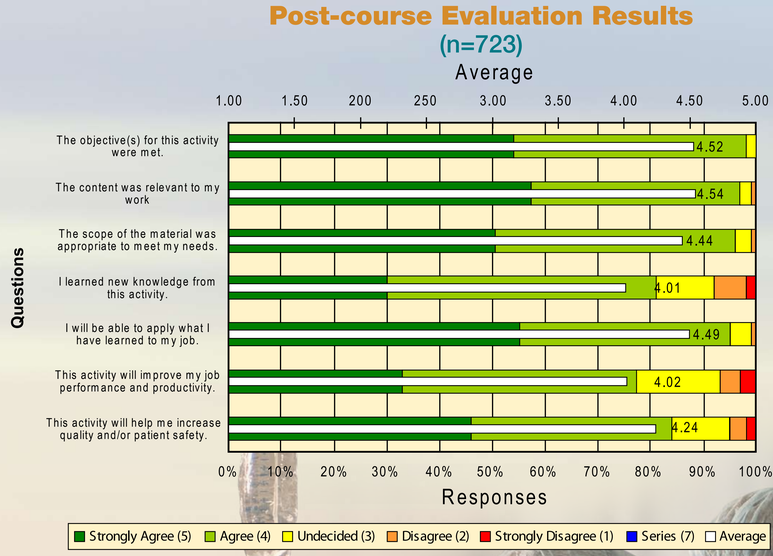
Methodology:

Countermeasures:

Utilizing principles taught in Crew Resource Management, Team STEPPS, and Crucial Conversations, the team developed a multidisciplinary course emphasizing techniques for improved teamwork. The course included video vignettes depicting pre- and intra-operative experiences. Course attendance was mandatory for all members of the Departments of Anesthesiology, Surgery, Ob/GYN, and Perioperative Nursing. Leadership from all areas participated as presenters for the course.

Results:

Over 6 months, over 809 staff members attended the training course. Throughout post-course surveys, participants repeatedly stated they felt more able to question the decisions or actions of those with more authority. After reviewing root cause analyses (RCA) completed for sentinel events, a marked decrease was seen post-course implementation. The number of RCAs went from 12 to 1 during the one year timeframe the course was given.



Reference: 1. Weaver, S.L, et al (2010). Does teamwork improve performance in the operating room? A multilevel evaluation. Joint Commission Journal on Quality and Patient Safety, 36(3), 133-142.