Ensuring a Positive Surgical Experience via Optimal Communication

December 12, 2012
D20: 9:30 – 10:45
E20: 11:15 – 12:30

These presenters have nothing to disclose

Presenters

Gerald B. Healy, MD, FACS*
- Past President, American College of Surgeons
- Professor, Harvard University Medical School

Brian J. Cammarata, MD
- Clinical Assistant Professor, Anesthesiology, University of Arizona
- CMIO, Tucson Medical Center

Charlotte L. Guglielmi, MA, BSN, RN,CNOR
- Past President, Association of periOperative Registered Nurses
- Perioperative Nurse Specialist, Beth Israel Deaconess Med Ctr

Margaret Rodriguez, CST, CFA, BS, FAST
- President, Association of Surgical Technologists
- Associate Professor of Surg Technology, El Paso Comm College

* Session Moderator
Disclosures

Gerald Healy
  ● None

Brian Cammarata
  ● None

Charlotte Guglielmi
  ● Patient Safety Consultant, Sedgwick CMS

Margaret Rodriguez
  ● None

Session Objectives

- Identify best ways to guide surgical team members towards optimal communication with patients and their families
- Develop ways to change patient education from disease centered to patient centered
Session Format

Over the course of the next 75 minutes we will dialogue about the continuum of care through the surgical experience by:

- Describing recent studies focused on surgical team communication
- Using the case presentation model to demonstrate how communication failures can result in a “never event”
- Collecting the feedback from the dialogue to:
  - Share with our societies
  - Contribute to “Safe Transfer of Care” project
  - Provide a summary that will be made available to you

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The Council on Surgical and Perioperative Safety (CSPS) is a non-profit, incorporated (501(c)3), multidisciplinary coalition of professional organizations whose members are involved in the care of surgical patients.

- We represent 250,000 health professionals caring for surgical patients every day.
Mission
- The CSPS promotes excellence in patient safety in the surgical and perioperative environment

Vision
- The CSPS envisions a world in which all patients receive the safest surgical care provided by an integrated team of dedicated professionals

Seven (7) society component members
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of PeriAnesthesia Nurses
- Association of periOperative Registered Nurses
- American Association of Nurse Anesthetists
- Association of Surgical Technologists
- American Association of Surgical Physician Assistants
Each of the seven organizations has two voting members on the CSPS that constitutes the Board of Directors.
A Three-Pronged Approach to Teamwork

- Communication
  - Efforts to maintain accurate and precise information exchange
  - Use of closed-loop protocols
  - Effective interaction between teams
  - Leadership promotion of free discussion without fear of reprisal
- Coordination
  - Use of effective behavior mechanisms
  - Mutual performance monitoring
  - Team learning of back-up behaviors
- Cooperation
  - Motivation to hold team together – Inspiration to achieve more
  - Promotion of role understanding between team members
  - Use of CRM and cross-training


A System for Safer Surgery

- Communication in surgery
  - Highly identified as contributory factor in patient harm during the surgical continuum of care
- Application of reliable, systematic approaches to surgical care delivery is relatively new
- Reliable systems should include:
  - Team analysis of workflow
  - Identification of practice variations
  - Understanding of systems failures
  - Redefinition of practice workflows
  - Testing of interventions prior to implementation

Little work in the published literature that addresses communication across the entire surgical continuum
This study is limited and serves as the basis for further work
Analysis of the full care pathway is critical
Communication failures are not discrete events
- A single failure can spark several subsequent failures
- Problems identified in pre-op phase often are lost and lead to failures of patient optimization for surgery
- Problems in post-op phase are generally due to incomplete hand-offs, missing information or information overload
- There is a strong need for tools to enhance information transfer and communication

Case Study to Answer Two Questions

- Are the perceptions of what your providers believe that patients and their families need to know during the surgical experience valid?
- Is the type and quality of information that is shared through the process relevant, timely and clearly communicated

Swiss Cheese Model

1. Surgeon sees patient with multiple dx. Patient is unable to participate in care process
2. Surgeon completes booking request; scheduling changes surgeon; incorrect resident documentation in EMR
3. Discrepancy between EMR & Booking not reconciled with surgeon
4. Aide not familiar with pt.; Holding Area busy; Surgeon marks but does not examine pt.
5. Anesthesia Provider & RN check in patient by protocol unaware of discrepancy
6. Surgeon not a good citizen; Work around to standard protocols; production pressure from surgeon; usual scrub not available
7. Wrong side surgery discovered

Reason (1990): Human Error
A Model for Improvement

“In order to play a leadership role in health care improvement, surgeons need to bust out of the silos that have bound them to an ideology driven by a narrow focus on their own practices and open their minds to a more collective way of thinking.”

Thomas R. Russell, MD, FACS
(www.facs.org/fellows_info/bulletin/2007/aug07russell.pdf)

Questions