Enhancing Team
Dynamics in the
Operating Room:
Collaborative
Strategies for
Success

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#### **Objective**

THE PURPOSE OF THIS SESSION IS TO INCREASE YOUR AWARENESS ON MASTERING TEAM DYNAMICS IN THE OPERATING ROOM AND PROVIDE SOME STRATEGIES FOR SUCCESS.

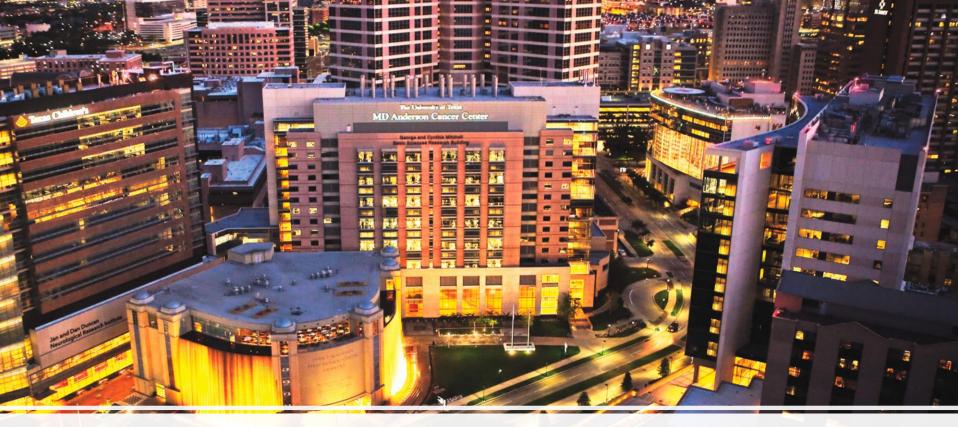




Memorial Hermann-TMC Trauma Team



Memorial Hermann Hospital in the Texas Medical Center (TMC) Level I Trauma Center



Texas Medical Center, USA, is the World's Largest Medical Complex



# One of the Busiest Level I in the Nation

- Magnet Recognized
- Teaching Facility
- 1082 Patient Beds
- 200 Trauma Beds
- 54 Operating Rooms
- Fleet of 6 helicopters
- Only Verified Burn
- Center in Houston
- Over 9000 trauma patients yearly
- Lowest mortality index

#### Life Flight to OR Protocol Video



SAFE SURGERY TOGETHER AORN



#### The Dynamic OR Environment





#### **Case Scenario**

65-year-old male

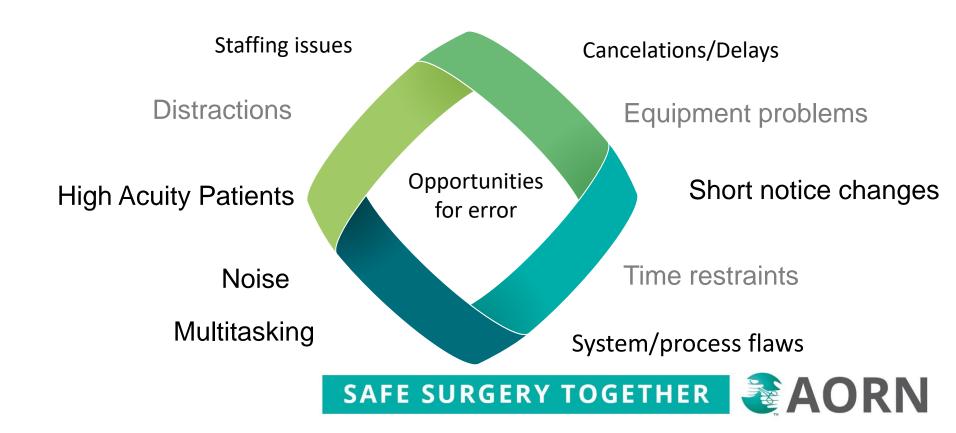
Emergent bowel resection

ASA 4E

Receiving blood products

Running the bowel

#### The Dynamic OR Environment



#### The OR Team Core Members

#### **Interprofessional Team**

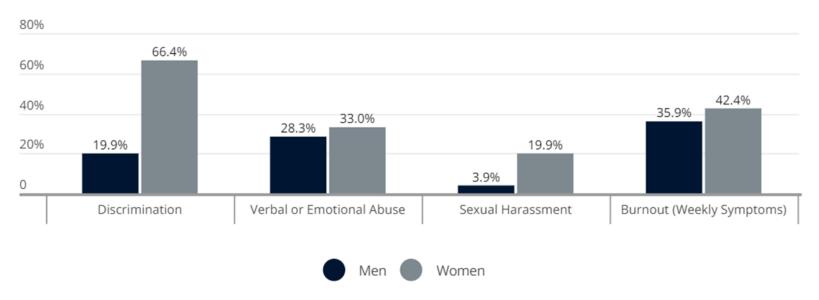


## **Team Member Dynamics**

- Perceived hierarchy
- Perceived socioeconomic status
- Unfamiliar team members
- Skill and experience level
- Proximity
- Gender
- Generation
- Language barriers
- Mask wearing
- Human



#### Frequency of Mistreatment and Burnout Among Surgery Residents (n = 7409)



Source: Hu et al., New England Journal of Medicine (2019)



# Unfamiliar TeamMembers



# Team Members Familiarity Affects



Fewer surgical delays



Reduced mean total anesthesia time



Decreased surgical costs

# One solution: Pod System



# Polling Question

How many of you utilize a pod system at your facility?

#### Top 10 Frequently Reviewed Sentinel Events, 202

Patient falls were the most prevalent sentinel event type reviewed in 2022 (n=611) – an increase from 483 reviewed falls in 2021.

Top 10 Leading Reviewed Sentinel Event Types (CY2022)		
Event Types	N	% of Total
Fall	611	42%
Delay in treatment	89	6%
Unintended retention of a foreign object	88	6%
Wrong surgery*	85	6%
Suicide	73	5%
Assault/rape/sexual assault/homicide	60	4%
Fire/burns	49	3%
Perinatal event	33	2%
Self-harm	30	2%
Medication management	30	2%
*Wrong surgery includes wrong site, wrong procedure, wrong patient, and wrong implant.		

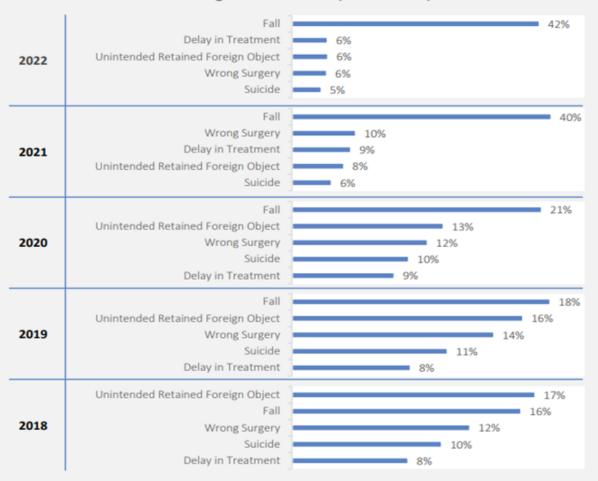
The Joint Commission Sentinel Event Data 2022 Annual Review

#### **Polling Question**

How does your country rank with wrongsite surgery and unintentional retained foreign objects?

#### Leading Sentinel Events Trends

#### Leading Sentinel Events (2018 – 2022)





Accurate Clear Communication is Crucial Concise Complete

DRN

#### Techniques to Improve Communication



**CHECKLISTS** 



**SAFETY BRIEFINGS** 



TEAMWORK/COMMUNICATION TRAINING



Does checklists alone improve team communication?

#### **Checklists & Briefings**

Structure

Standardization

Increases quality and quantity of communication

Improves perceptions of communication and teamwork

Address safety concerns daily

Reinforces sharedmental models

#### **Time-out Audits**



IMPROVES EFFECTIVENESS



REVIEW AUDIT RESULTS WITH TEAM MEMBERS



PROVIDE STRATEGIES TO IMPROVE



ASSIGN A
CHAMPION TO
INITIATE AUDITS

#### Polling Questions

- 1. Who is the designated champion at your facility to initiate the timeout?
- 2. Do you perform Time-Out audits at your facility?

#### **Shared-Mental Model**

- Team commitment to following protocols and guidelines
- Delivering the same message
- Sets behavior standards (unspoken code of conduct)
- Essential for team cohesiveness
- Improves effective and timely communication of team members
- Improves situational awareness
- Surgical conscious

Teams are more effective and efficient when a shared mental model is established.





#### **Huddle**

- Increased satisfaction & engagement
- Increased patient safety
- Increased collaboration
- Increased job satisfaction
- Increased work environment

Thomas, T., Hampton, D., Butler, K., & Hudson, J. L. (2023). Assessing the Value of Huddle Implementation in the Perioperative Setting. AORN Journal, 118(1), 14-23. https://doi.org/10.1002/aorn.13949

# Polling Question

Do you utilize huddles at your facility?

#### **Huddles**

#### **Benefits**

- Timely and consistent messaging
- Effective in disseminating essential information
- Increased feelings of enhanced connection

#### **Consider using**

- Visual huddle boards
- Video recordings

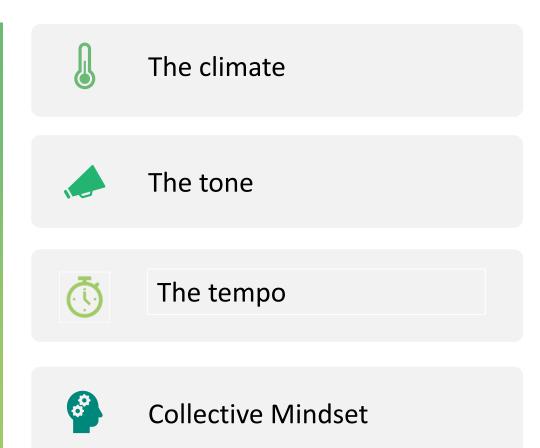


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## Culture

Culture plays a significant role in creating a positive environment for success.

### Culture



# Leaders create culture. Culture drives behavior. Behavior produces results.

Urban Meyer



Perioperative
Steering
Committee
Sample
Roster

Position	Representing				
Co-Chair	Chair of Surgery				
Co-Chair	Perioperative Services Director / VP				
Co-Chair	Medical Director of Anesthesiology				
Executive Lead	Administration/COO				
Executive Lead	Nursing Leadership/CNO				
Member	Medical Staff Leadership/CMO				
Member	General Surgery				
Member	Neurosurgery				
Member	OB/GYN				
Member	Orthopedics				
Member	ENT				
Member	Interventional Radiology				
Member	Cardiac Surgery				
Member	OR Business Manager				
Member	OR Nurse Manager				
Member	Urology				
Member	Plastic Surgery				

#### **Culture of Safety**

Transparency

Accountability

Safety is everyone's priority

Mutual respect

Event reporting—
near misses, unsafe
conditions, &
adverse events

Multidisciplinary collaboration

Assessment of culture

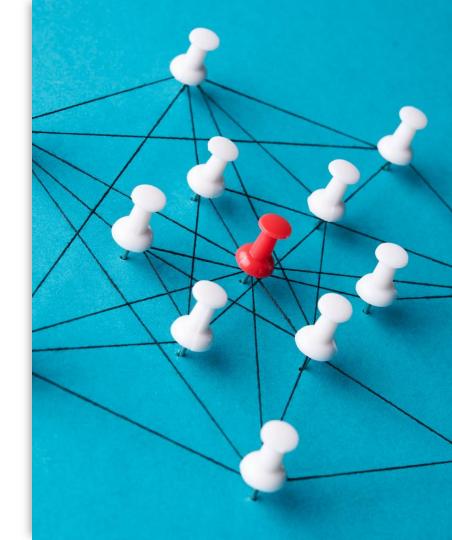


## Teamwork and Communication Training

#### **Communication techniques**

- Closed-loop communication
- Assertive communication
- Standardized communication tools

#### **Simulation training**



### Communication Tools for Handoffs

**SBAR-**-Situation, Background, Assessment, Recommendation

I PASS the Baton—Introduction, Patient, Assessment, Situation, Safety Concerns, (the) Background, Actions, Timing, Ownership, Next

**SURPASS**—SURgical Patient Safety System

**SHARED**—Situation, History, Assessment, Request, Evaluation, Document

#### SBAR Communication Handoff

**Situation:** Mechanism, mode of arrival, and known injuries. Patient Identification.

Background: Pre-hospital critical events, interventions, difficulties.

ED critical events, interventions, medications administered

**Assessment:** Airway and IV Access/functionality Blood administration/Belmont functionality. Additional critical information

**Recommendation:** MTP Order status
Blood/runner cooler status
Family

## SBAR Communication Handoff

SITUATION: GSW to abdomen
arrived via ambulance
No other injuries noted
Patient identified with two patient identifiers

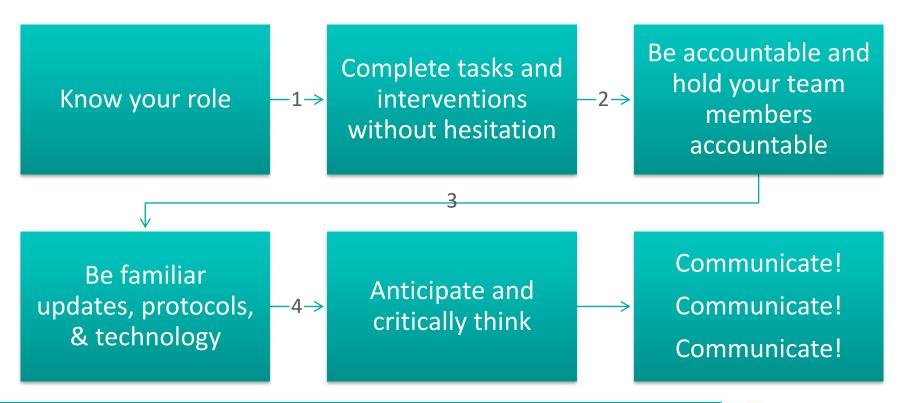
**BACKGROUND**: Patient shot at home by perpetrator.
Patient awake, alert, answering
questions following commands in field.
MTP initiated.

ASSESSMENT: Patient awake, responds to some commands, does not respond verbally. Blood cooler is here but not all blood products have been checked. One RBC given and one hanging. Family is here in hospital.

**RECOMMENDATION:** Check all blood products, send for more blood.

Provide family with updates

#### **OR Team Members**





#### Assess Your Team Environment

https://www.aacn.org/nursing-excellence/healthy-work-environments/aacn-healthy-work-environment-assessment-tool

#### HWEAT 2.0 Healthy Work Environment Assessment Tool



In my organization, the recognition taking place between RNs and top-level leadership (e.g., CNO, CEO, executives, directors) is	ō	Ö	O	Very Good	0	Outpanding
In my organization, the communication taking place between RNs and top-level leadership (e.g., CNO, CEO, executives, directors) is	0	Ö	O.	O	0	O
In my organization, the collaboration taking place between RNs and top-level leadership (e.g., CNO, CEO, executives, directors) is	0	O	Coort	Very Cook	Executives O	Outstanding
In my organization, the promotion of a professiona practice environment by top-level leadership (e.g., CNO, CEO, executives, directors) is	l ~	O	O	Stery Good	Consistent	0
In my work unit, the communication taking place between RNs and nurse managers is	Õ	Ö	O	Nery Good	Control	O
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In my organization, RNs influence organization-level decisions that affect the quality of patient care.	Strongly Disagree	Deagree	Stigning Disagrase	Signify Agries O	0	Secretary Agrees O
In my organization, there are staffing policies in place that help support RNs in providing high-quality care.	Strongly Oxogree	Ologne	Stahnly Disagree	Striphily Agree	0	O

#### **Healthy Work Environment**

### Data shows that a healthy work environment may lead to:

- More staff engagement
- less burnout
- Less turnover
- Quality of care

#### **Strategies For Success**

Reflect on the dynamics

Pod System

Time-out Audits

Check-off Sheets

Safety Briefings

Assertive communication

Standardized communication tools

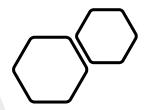
Cultivate a culture of safety



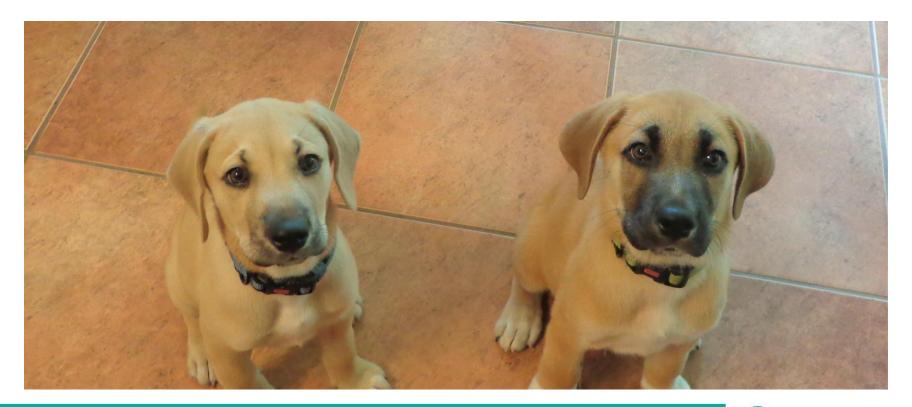


Collaboration is a key part of the success of any organization, executed through a clearly defined vision and mission and based on transparency and constant communication.

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#### **Thank You!**





#### **Questions?**

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