

## **Summary of Workgroup Recommendations National Surgical Patient Safety Summit August 4 and 5, 2016**

### **Workgroup 1**

- Operating Room Safety Checklist (OR-SC)
  - Consistent effective use of all communication tools contained in the Operating Room Surgery Checklist (OR-SC)
  - All surgical facilities must provide regular OR-SC training and education programs with compliance monitoring to assess proper use by all surgical team members.
  - Surgeon leadership supported by administrative facility safety commitment is key to development, implementation and maintenance of effective OR-SC use.
  - Surgical facilities should develop and implement Operating Room Safety Checklists (OR-SC) based upon the WHO model with local modification as appropriate
- Surgical Site Marking
  - For all 'suitable' surgical procedures, every surgical facility must implement and maintain a surgical site marking policies and program
  - For marking 'unsuitable' surgical procedures, NSPSS recommends use of standardized site marking guides such as the Minnesota Patient Safety Site Marking Recommendations and Guidance, July, 2010
- Shared-Decision Making
  - Consistent use by the surgeon (and appropriate surgical team members) of standardized 'Shared-Decision Making'
  - Use by the Surgeon, Surgical Team Members and Surgical Facility of AHRQ "Universal Precautions" for Limited Health Literacy
  - ACGME should include Shared-Decision Making science knowledge as a requirement for surgical residency programs
  - ABMS and member surgical Boards should include Shared-Decision Making science knowledge as a requirement for surgeon credentialing
- Surgical Consent
  - The surgeon as the primary patient advocate supported by the surgical team and surgical facility share accountability for an informed, timely and accurate surgical consent document and process
  - All errors or ambiguity in a surgical consent must be resolved and corrected prior to the patient entering the operating room
  - All surgical facilities should define and consistently use a standardized safe surgical consent process and document
  - ACGME should include knowledge and training of the surgical consent process as a requirement for surgical residency programs
  - TJC and similar surgical facility credentialing organizations should include assessment of the surgical consent process as a component of surgical safety programs
  - ABMS and member surgical Boards should include knowledge of the surgical consent process as a requirement for surgeon credentialing
- Surgical Information Transfer (Hand-Offs)

- All surgical team members should be educated and trained to use standardized communication tools to support accurate and efficient information transfer for all transitions of surgical patient care
- All surgical facilities should adopt, support and monitor use of validated standardized communication tools to improve accuracy and efficiency of surgical information transfer ('hand-offs') during the entire episode of surgical care.
- All surgical facilities adopt, support and monitor use of EMR supported information transfer tools for unit transfer, facility transfer or home discharge

## **Workgroup 2 – Human Factors**

- Individual
  - Education in personal resilience (including, but not limited to EI) begin in medical school, and continue throughout post-graduate training.
  - Research specifically devoted to fatigue management be immediately supported at the federal level. Such research, to be effective, must include assessment of at least the following: performance variability secondary to fatigue; stress recognition among providers; effect of any newly introduced care transitions to patient outcomes/care; effect of any introduced changes on provider well-being.
  - A component of MOC may be allocated (but not mandated) for work on personal resilience.
  - Research support be offered for clinicians and others interested in pursuing methods of improving provider resilience.
- Team
  - Basic teamwork skills applicable to patient care begin during undergraduate medical education.
  - Further developmental work in teamwork skills continues throughout postgraduate training.
  - MOC include a mandatory component dedicated to advanced teamwork training (e.g. enhancing debrief, huddle, assertiveness skills), which is instituted for professional development.
  - Surgical teams and team members should undergo multidisciplinary team training (TeamSTEPPS®, CRM or some other formal training).
- Clinician-Patient Communication
  - Basic communication skills applicable to clinician-patient encounters as well as clinician-provider encounters are taught in undergraduate medical education.
  - During graduate medical education, communication skills be reinforced with simulation training and appropriate feedback.
  - MOC include components to ensure that communication skills learned at the beginning of their medical education continue to be reinforced.
- Situation/System
  - All institutions embrace a restorative Just Culture model.
  - All institutions create Second Victim support equally available to all levels of providers.
  - Each health care institution recognize that all behavior is contextually bound, and therefore measurement techniques that assess Work As Done (as opposed to Work As

Imagined) (Woods et al, 1994) must be developed and applied to optimize both provider performance and well-being.

- Each health care institution adopt &/or derive evidence-based processes designed to create the foundation for safety emergence.

### **Workgroup 3- Data and Technology**

PROPOSAL FOR COLLABORATIVE EFFORT TO CREATE A COMMON DATA INFRASTRUCTURE TO MEASURE AND IMPROVE PATIENT SAFETY & OUTCOMES

- **Consistency** in reporting is essential to analysis – cannot be selective in what’s reported.
- **Uniform Definitions** – this provides a common, standardized method for health care providers to submit, collect and exchange information regarding patient safety events.
- **Usability** – data needs to be accessible. Some safety events occur so infrequently that it is nearly impossible to learn how to prevent an incident using only one institution’s data.
- **Collaboration** – hospitals, care providers, etc., need work together in a non-punitive way and have access to valuable information in order to learn from their peers.
- **Team-based** shared accountability measures.
- **Unique Patient Identifier** – collaborative work between the medical society databases.

### **Workgroup 4 – Education**

- Educational programs should target: Surgeon, perioperative team, institutions and systems, residents, and medical students
- Educational content focus will be on non-technical skills related to safety, i.e., communications, human factors, hand offs, teamwork; not on technical surgical skill
- Educational formats – didactic, simulation-based –
  - Should be inclusive of the whole team – train with surgeons, nurses, anesthesiologist, surgical tech, PAs, etc.
- Collaborative with other groups – professional societies, ABMS, ACGME and RRCs, other stakeholders
- Accreditation/certification programs – both for the individual and institutions
- Need an assessment of competence