Time Out! It’s Game Time
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No Financial Relationships
Development and Pilot Evaluation of a Preoperative Briefing Protocol for Cardiovascular Surgery

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Table 3. Per Case Average of Total Surgical Disruptions, Procedural Knowledge Disruptions, and Miscommunication Events for Preimplementation and Postimplementation Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Preimplementation group, n</th>
<th>Postimplementation group, n</th>
<th>Decrease, %</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total surgical disruptions per case</td>
<td>9.5</td>
<td>5</td>
<td>47</td>
<td>0.0002</td>
</tr>
<tr>
<td>Procedural knowledge disruptions per case</td>
<td>4.1</td>
<td>2.17</td>
<td>46</td>
<td>0.007</td>
</tr>
<tr>
<td>Miscommunication events per case</td>
<td>2.5</td>
<td>1.2</td>
<td>55</td>
<td>0.03</td>
</tr>
</tbody>
</table>


Association Between Implementation of a Medical Team Training Program and Surgical Mortality

Julia Neily, RN, MS, MPH

Table 3. Improvements Reported by Medical Team Training Facilities From Structured Interviews

<table>
<thead>
<tr>
<th>Reported Improvements</th>
<th>No. (%) of Facilities (n = 74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication among operating room staff</td>
<td>35 (47.2)</td>
</tr>
<tr>
<td>Staff awareness</td>
<td>34 (46.0)</td>
</tr>
<tr>
<td>Overall efficiency</td>
<td>49 (66.2)</td>
</tr>
<tr>
<td>Equipment use during surgery</td>
<td>44 (59.9)</td>
</tr>
<tr>
<td>Reduced length of procedures</td>
<td>15 (20.3)</td>
</tr>
<tr>
<td>Improved first-case start times</td>
<td>30 (40.5)</td>
</tr>
<tr>
<td>Other types of efficiency improvements</td>
<td>6 (8.1)</td>
</tr>
</tbody>
</table>

JAMA. 2010;304(15):1693-1700
Teamwork, Communication, Formula-One Racing and the Outcomes of Cardiac Surgery

Alan F. Merry, FANZCA,* Jennifer Weller, FANZCA;† Simon J. Mitchell, FANZCA*  

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Presented at Winter Meeting Perfusion Downunder 2013, Hayman Island, Queensland, Australia, September 1-3, 2013.  

JECT. 2014;46:7–14

Six Approaches to Improving Teamwork  
- Subspecialize and replace tribes with teams  
- Sort out the leadership while flattening the gradients of authority  
- Introduce explicit training in effective communication  
- Use checklists, briefings, and debriefings and engage in the process  
- Promote a culture of respect alongside a commitment to excellence and a focus on patients  
- Focus on the performance of the team, not on individuals

Patient Safety in the Cardiac Operating Room: Human Factors and Teamwork  
A Scientific Statement From the American Heart Association

Joyce A. Wahr, MD, FAHA, Co-Chair; Richard L. Prager, MD, FAHA; J.H. Abernathy III, MD; Elizabeth A. Martinez, MD; Eduardo Salas, PhD; Patricia C. Seifert, MSN; Robert C. Groom, CCP; Bruce D. Spiess, MD, FAHA; Bruce E. Searles, MS, CCP; Thoralf M. Sundt III, MD; Juan A. Sanchez, MD; Scott A. Shappell, PhD; Michael H. Culig, MD; Elizabeth H. Lazzara, PhD; David C. Fitzgerald, CCP, FAHA; Vinod H. Thourani, MD; Pirooz Eghtesady, MD, PhD, FAHA; John S. Ikonomidis, MD, PhD, FAHA; Michael R. England, MD; Frank W. Sellke, MD, FAHA; Nancy A. Nussmeier, MD, FAHA, Co-Chair; on behalf of the American Heart Association Council on Cardiovascular Surgery and Anesthesia, Council on Cardiovascular and Stroke Nursing, and Council on Quality of Care and Outcomes Research

Circulation. 2013;128:1139-1169
1. Checklists and/or briefings should be implemented in every cardiac surgery case, and postoperative debriefings should be encouraged by leadership in cardiac ORs (Class I; Level of Evidence B).
Standard 3: Communication

Standard 3.1: A patient-specific management plan for the cardiopulmonary bypass (CPB) procedure shall be prepared and communicated to the surgical team either during the pre-operative briefing or prior to beginning the procedure.³


- Before patient goes to sleep
- All disciplines present
- Hangs on the wall in each OR
- Each discipline expected to communicate their care plan