Background
- As part of our organization’s journey to become a High Reliability Organization we have embraced the need to be a learning organization
- The WHO surgical safety checklist includes a element of postoperative debriefing, however this process is the most neglected
- Often issues arise during a surgical case, some repeatedly, but are not communicated back to administration for improvement
- The AJH Perioperative Quality and Safety Council is a multidisciplinary group meeting every other week and charged with overseeing all QI/PI issues for the perioperative services

Aim
To improve care quality and patient safety by developing a closed-loop process for identifying and reporting, in real-time, any problems, issues, or delays in the operating room furthering the organizational journey to becoming a high-reliability organization.

First Pilot
- Paper Debriefing form designed
- Piloted on three small service lines
- 6 Month Trial

Limitations/Barriers Identified
- Participation/Compliance with form completion
- Buy in by providers/professionalism with responses
- Risk Management/Legal – opening for liability?
- Needs to be separate from EMR
- Management of collected data
- Paper forms
- Manual abstraction
- Who best to respond to issues?

Second Pilot
- An online form was developed in Qualtrics
- Yes answers for issues and delays prompted the user for more information
- Asks for something that went well/complement an individual
- Completed forms entered into database
- If yes selected for issue form automatically emailed to appropriate administrative team for action
- Compliance/completion rates monitored by department administrative staff
- Tested on three small service lines
- Colorectal, Bariatrics, Ortho-Spine Surgery
- Form completed by circulating prior to surgeon leaving OR
- Added to existing “sign-out” process
- Lead by attending surgeon
- Must have Anesthesia, Circulator, Scrub, Attending Surgeon involved
- BUT ALL personnel in room should participate

Results
- In 3 months:
  - 330 cases (75% compliance)
  - 95 issues reported (28% of cases)
  - 4 Urgent issues
  - 5 Incident Reports

Leadership Review
- Urgent issues dealt with immediately i.e. unsafe equipment
- Remainder forwarded to physician-nurse leadership dyads for remedy i.e. broken non-essential equipment
- Feedback form developed for posting on unit “learning boards” for staff to see actions being taken

Next Steps
- Plan to roll out to entire operating room
- Easy access to debriefing form
- Reminders in EMR to complete debriefing
- Evolve plan for issue escalation and report back
- Quarterly reports from Preadmission testing, Intra-op and PACU Dyad leadership forwarded to The Perioperative Quality and Safety Council for executive level review for trends over time
- Urgent issues forwarded to Center for Safety and Quality
- Develop process for debriefing in case where patients are awake