Spend five to save lives

A five-minute team briefing before starting the day's surgical list reduces patient harm.

It also:

- saves time
- improves team communication
- creates a culture of safety.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

A briefing is used at the start of the day's surgical list, with all surgical team members present. It creates greater understanding throughout the team about what needs to happen for each operation taking place that day.

By sharing information proactively at a start-of-list briefing, factors that might affect the smooth-running of the surgical list can be identified early, for example, patient, staffing or equipment matters.

Briefings also provide an opportunity to identify any human factors that can lead to error, including tiredness, nutritional or emotional state.[1]

How do we do a briefing?

A briefing typically opens with team introductions, which include the name and role of each team member. Staffing matters are raised; anaesthetic safety checks are talked about; changes to the list or clarification about the list are discussed; equipment and instrumentation issues are communicated; and the time for the list is confirmed.

But briefings take too long... don't they?

A briefing is a simple discussion that usually lasts less than five minutes.

There is growing evidence that the time taken to have a briefing is well spent, because it saves time later by reducing delays and creating better flow. In fact, a UK orthopaedic surgeon, who regularly holds briefings, reported he was able to expand his list by another hip arthroplasty.[2]

In an orthopaedic setting, briefings lasted on average less than a minute per case, and were deemed to be non-disruptive to work flow.[3] A study into the introduction of a 5–10-minute pre-operative surgical briefing found there was no significant difference in operation start times after the introduction of the briefing.[4]

My team knows what I want, so I don't need to hold a briefing, do I?

This is an assumption and won't always be true. Where patient safety is concerned, it's better to be sure than to assume.

We know, from international and local research, and adverse event reporting, that when things don't go well, it often turns out that someone on the team had information that may have helped prevent harm but they didn't have an opportunity to share the information with others.

Briefings give everyone the chance to share information with the whole team.

Can't we just troubleshoot as we go?

Briefings help create a broader knowledge base for the planned surgical list. This means each team member has a better understanding of the tasks at hand and can anticipate potential events and plan accordingly.

It also means everyone is at the same starting point, surprises are avoided and there is a positive impact on how the team works together.

Briefings don't really make any difference, do they?

A 2015 study in an orthopaedic setting reported a 72 percent reduction in the rate of unexpected delays per case (from 23.1 percent to 6.5 percent).[5]

A US study reported an improvement in the median surgeon-rated flow (from 5/10 to 9/10), and a reduction in questions asked outside of the briefing.[6]

Briefings also help to increase the safety culture of surgical teams.[7]

We already use a checklist – do we really need to do a briefing?

Briefings involve a simple discussion. They are not intended to replace or duplicate the surgical safety checklist.

Briefing and checklist techniques complement each other, build teamwork, improve communication and reduce errors. These are important because patient safety improves when teams communicate well and work well together.

What if some staff are too shy to speak up?

Briefings improve communication and teamwork. An observational study found information was five times more likely to be communicated effectively if it was mentioned in a formal communication setting, such as a briefing.[8]

More information

For more information and resources to help you hold regular briefings, please go to:

www.hqsc.govt.nz/ssnz

[1] Brennan PA, et al. 2016. Good people who try their best can have problems: recognition of human factors and how to minimise error. *British Journal of Oral & Maxillofacial Surgery* 54(1): 3–7.

[2] Civil I, Shuker C. 2015. Briefings and debriefings in one surgeon's practice. *ANZ J Surg* 85: 321–3.

[3] Jain AL, Jones KC, Simon J, et al. 2015. The impact of a daily pre-operative surgical huddle on interruptions, delays, and surgeon satisfaction in an orthopedic operating room: A prospective study. *Patient Safety in Surgery* 9: 8.

[4] Ali M, Osborne A, Bethune R, et al. 2011. Preoperative surgical briefings do not delay operating theatre start time and are popular with surgical team members. *J Patient Safety* 7(3): 139–43.

[5] Jain AL, Jones KC, Simon J, et al. 2015. The impact of a daily pre-operative surgical huddle on interruptions, delays, and surgeon satisfaction in an orthopedic operating room: A prospective study. *Patient Safety in Surgery* 9: 8.

[6] Allard J, Bleakley A, Hobbs A, et al. 2011. Pre-surgery briefings and safety climate in the operating theatre. *BMJ Qual Saf* 20(8): 711–7.

[7] Leong KBMSL, Hanskamp-Sebregts M, van der Wal RA, et al. 2017. Effects of perioperative briefing and debriefing on patient safety: a prospective intervention study. *BMJ Open* 7:e018367. DOI: 10.1136/bmjopen-2017-018367.

[8] Cumin D, Skilton C, Weller J. 2016. Information transfer in multidisciplinary operating room teams: a simulation-based observational study. *BMJ Quality & Safety* 16: 16.

With thanks to Capital & Coast DHB for allowing us to photograph a start-of-list briefing.

New Zealand Government