HARVARD
School of Public Health

Tool 3: Surgical Teamwork Observation Instructions

This tool collects information regarding teamwork in order to improve surgical outcomes. Below are a few notes to help you use the tool.

Teamwork observer information:
This tool should be completed by a surgical nurse manager, quality improvement / patient safety personnel or other staff member with appropriate clinical experience. Before using the tool, observers should complete the web-based training at http://safesurgery.teamtraining.sgizmo.com/s3.

- This tool should be used in cases that last longer than one hour. It should be completed for the same cases as the Surgical Safety Checklist Observation Tool. Someone designated to coordinate this monitoring effort at your hospital should indicate which cases you should observe.
- The teamwork observer should be present for at least the first hour of the surgical case being observed and may complete the tool during or immediately after the observation.
- The teamwork observer should introduce him/herself to surgical team at the beginning of the case. S/he should explain that they (teamwork observer and circulating nurse) will be completing short tools during the surgical procedure assessing teamwork and checklist use. Emphasize that these tools are for quality improvement and are not for evaluation purposes. The teamwork observer should encourage surgical team members to ask questions about the project and the results of their observations.
- Following the case, please give the completed observation tool to the person coordinating the monitoring effort.

General instructions:
- Fill in the bubble (○) that corresponds to your choice.
- If you make a mistake, ~~strike through~~ your error and fill in the correct choice.
- Please include comments or additional information on the back of the tool, if desired.

In the upper right-hand corner:
- Write the date the observation was performed.
- Write the name of your hospital.

In the Procedure and Observer Information boxes:
- Record each item requested.
- "Significant nonclinical disruptions" include interruptions that are not directly related to the procedure that disturb or distract from the progress of the operation (e.g., urgent pages requiring the surgeon's attention, scheduling, or other external concerns that demand surgical team members' attention).
- Case delays greater than 30 minutes from the scheduled start time should also be recorded.

Teamwork statements:
- For Questions 1-18, rate each item on a scale of 1 to 5. One indicates that a behavior "NEVER" occurred during the observation. Two indicates that a behavior occurred about 25% of the time. Three indicates that a behavior occurred ABOUT HALF of the time. Four indicates that a behavior occurred about 75% of the time. Five indicates that a behavior "ALWAYS" occurred.
- For Questions 15-18, mark N/A if none of the referenced behaviors (e.g., potential errors or mistakes, concerns, or struggles) occurred.
- For Question 19, 1 indicates "POOR" surgical teamwork and 5 indicates "EXCELLENT" surgical teamwork.