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 (O) 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.

Tool 3: Surgical Teamwork Observation Tool

Date of procedure:______/_______/______
Hospital name:______________________________________

Procedure Information

Patient age: ________
Patient gender: ○ M ○ F
Surgeon's specialty: _____________________________________
Procedure performed: _____________________________________
Time of incision: ___:___ AM / PM
Surgical end time: ___:___ AM / PM
Urgent/emergent case (requiring same-day completion): ○ Yes ○ No
Significant nonclinical disruptions: ○ Yes ○ No
Case delayed >30min: ○ Yes ○ No
Patient disposition: ○ Inpatient ○ Outpatient

Observer Information

Observer age: ______
Observer gender: ○ M ○ F
Years in current role at this hospital: _____
Observer role: ○ Nurse Manager ○ QI / Patient Safety personnel ○ Other: ____________________

The statements in the table below relate to surgical team members' interactions during this procedure. Please consider the following definitions as you read them:

Clinical leadership: Exerting control or playing a decision-making role in the patient's clinical care. Any member of the team may demonstrate clinical leadership in the course of a surgical procedure.

Team members: Any individual present and participating in a surgical procedure (e.g., physicians, nurses, surgical techs).

Clinical tasks: The specific activities performed by team members in the course of a surgical procedure.

On a scale of 1 – 5, with 1 being "NEVER", 2 being about 25% of the time, 3 being about half the time, 4 being about 75% of the time, and 5 being "ALWAYS", please indicate how often the following behaviors occurred **during this procedure**:

Statement		Never				Always
1. Clinical leadership was shared among disciplines in response to changes in the patient's condition or issues that arose during the operation.		①	②	③	④	⑤
2. Physicians were open to suggestions from nurses.		①	②	③	④	⑤
3. Physicians were present and actively participating in patient care prior to skin incision.		①	②	③	④	⑤
4. Physicians maintained a positive tone throughout the operation.		①	②	③	④	⑤
5. Verbal communication among team members was easy to understand (e.g., clearly articulated and spoken at an adequate volume).		①	②	③	④	⑤
6. Team members shared key information as it became available.		①	②	③	④	⑤
7. Speakers made a visual or spoken effort to confirm that important information was received.		①	②	③	④	⑤
8. Recipients made a visual or spoken effort to confirm that they understood the information communicated.		①	②	③	④	⑤
9. Team members appeared eager to help one another.		①	②	③	④	⑤
10. Team members from different disciplines discussed the patient's condition and the progress of the operation.		①	②	③	④	⑤
11. Plans for patient care were adapted as needed.		①	②	③	④	⑤
12. Clinical tasks were well coordinated among team members.		①	②	③	④	⑤
13. Team members referred to each other by role instead of name (e.g., "Nurse" instead of "Dana").		①	②	③	④	⑤
14. Discussions took place in a calm, learning-oriented fashion.		①	②	③	④	⑤
15. Team members reacted appropriately when their potential errors or mistakes were pointed out.	○ N/A	①	②	③	④	⑤
16. Potential errors or mistakes were pointed out **without** raised voices or condescending remarks.	○ N/A	①	②	③	④	⑤
17. Team members made certain that their concerns were understood by other team members.	○ N/A	①	②	③	④	⑤
18. Team members appeared to struggle **and did not** ask one another for help.	○ N/A	①	②	③	④	⑤

On a scale of 1 – 5, with 1 being "POOR" and 5 being "EXCELLENT", please rate your overall impression of how well team members worked together **during this procedure**:

Statement	Poor				Excellent
19. Please rate surgical teamwork during this procedure.	①	②	③	④	⑤

■ Please use the back of this form to provide further comments.■