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Background

- The Surgical Safety Culture Survey highlights surgical team members' perspectives on factors affecting patient safety in the operating room
- This preliminary information is intended to be used to improve Checklist implementation and surgical outcomes
  - How fertile is the soil?
  - Where do we need to work most?

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Analysis

- Analyzed results for "percent problematic response (PPR)", i.e., neutral (4) or worse
  - Q1: Surgical team members are open to changes that improve patient safety, even if it means slowing down.
  - Problematic response: 1-4, strongly disagree to neutral
- A problematic response suggests a lack of safety climate
  - Low PPR is good; High PPR is bad
- Focus on PPR to highlight weaknesses in surgical safety climate in order to address them

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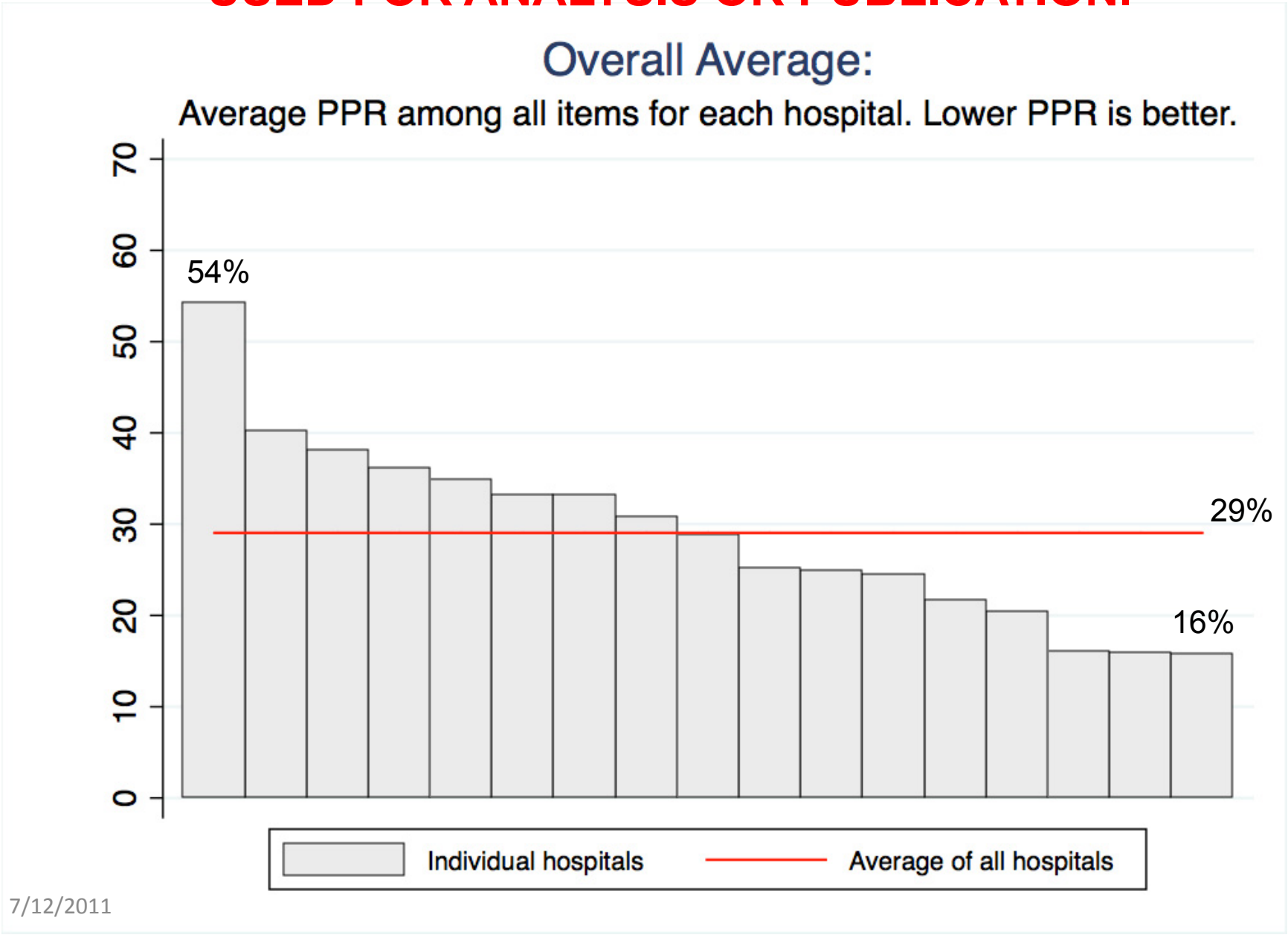

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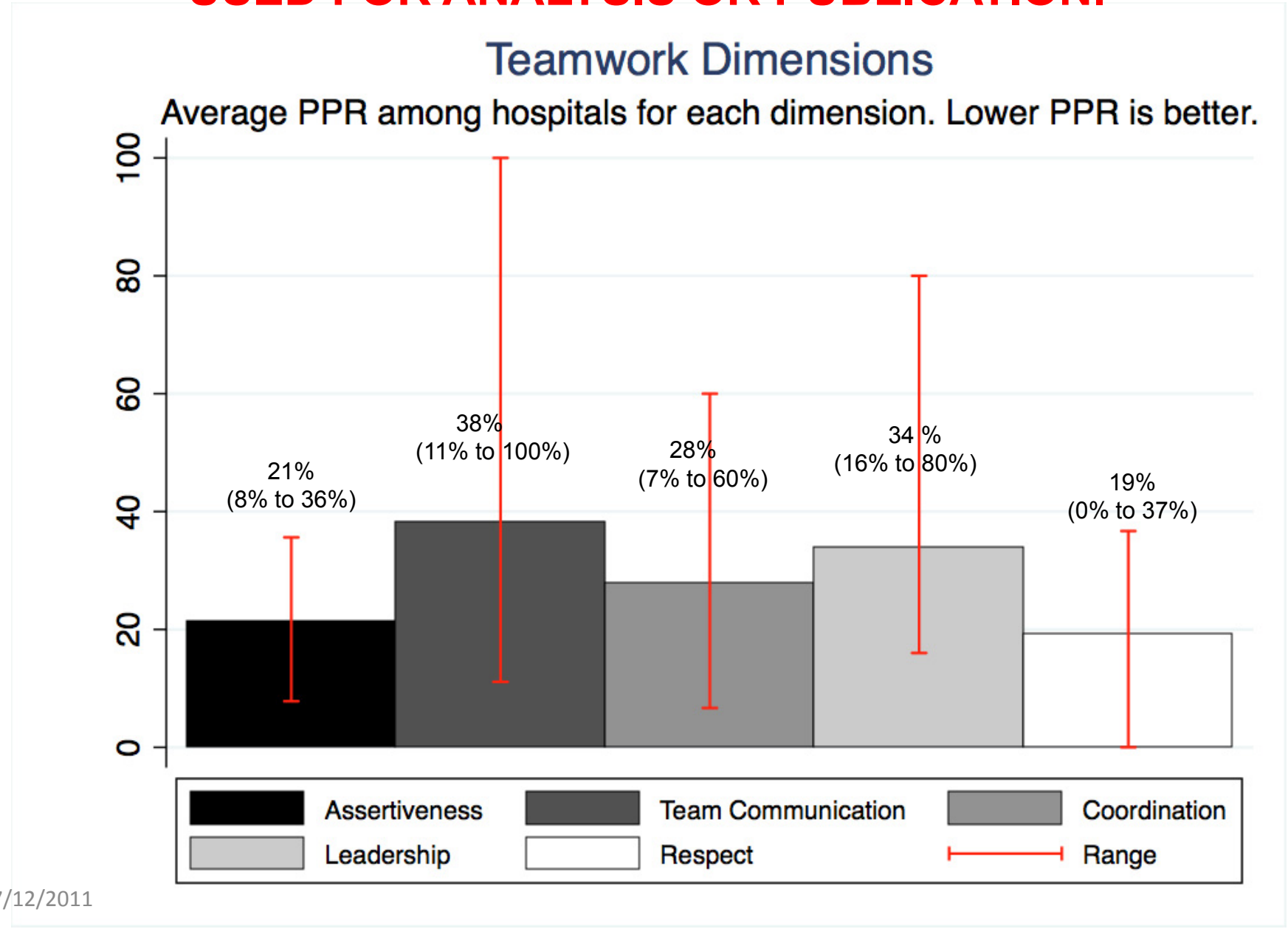

Opportunities for improvement

- Assertiveness Q9 (27% problematic)
  - … it is difficult to speak up when I perceive problems with patient care.(R)
- Team Communication Q11 (54% problematic)
  - … communication breakdowns frequently lead to delays in starting surgical procedures.(R)

(R) Indicates that item is reverse-scored.

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More opportunities

- Coordination/Cooperation Q17 (41% problematic)
  - … surgical team members from different disciplines always discuss patients' conditions and the progress of operations.
- Clinical Leadership Q23 (42% problematic)
  - … physicians maintain a positive tone throughout operations.
- Respect Q27 (30% problematic)
  - … potential errors or mistakes are pointed out without raised voices or condescending remarks.

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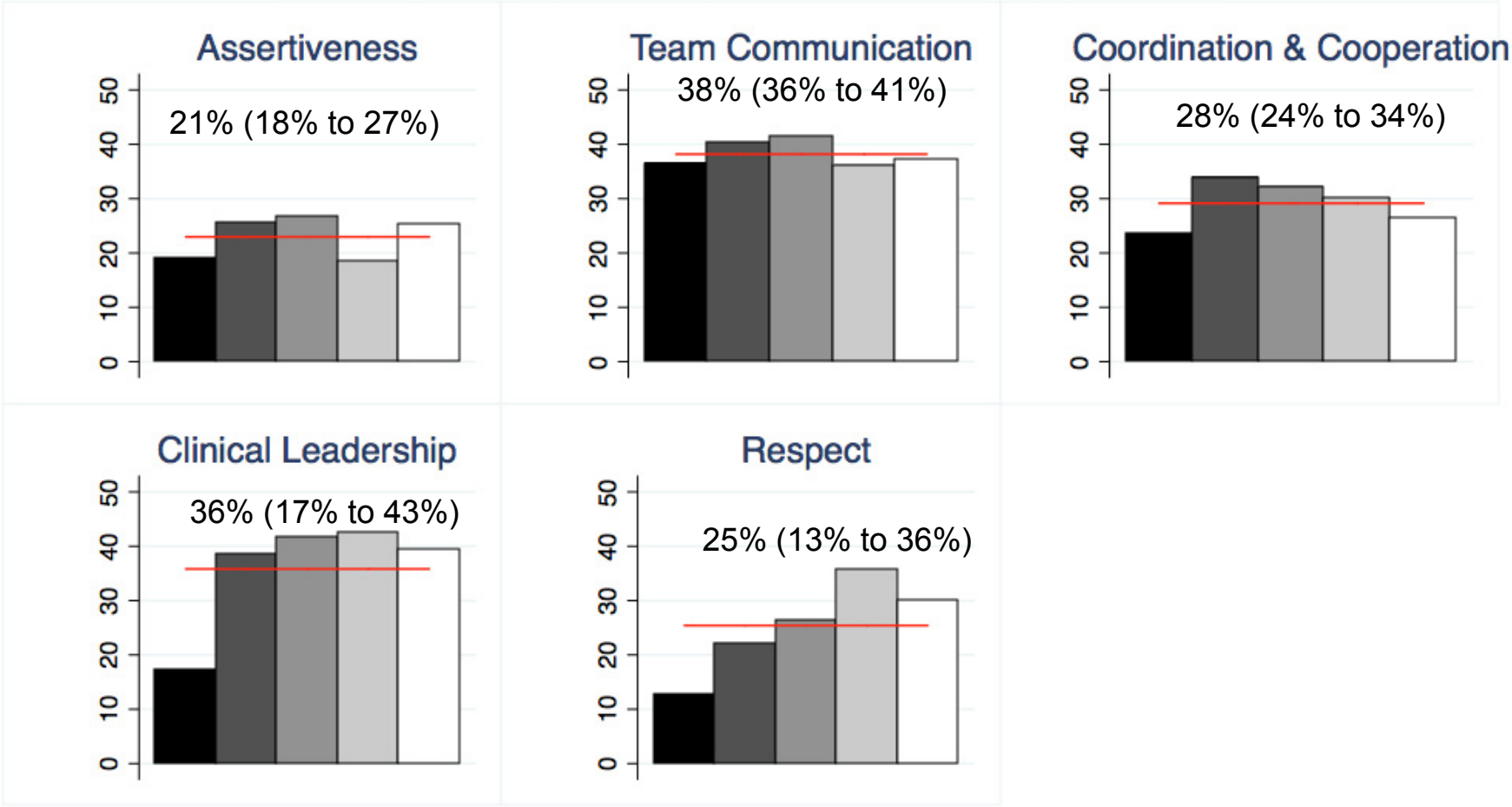
Summary of Dimensions by Role:

Average PPR of each dimension by clinical role. Lower PPR is better.



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Respondent Comments

- *[T]hey [anesthesia providers] will ask that we move rapidly or skip the team and role introductions. Thus, I really feel that it is just going through the motions rather than improving outcomes.*
  – Surgeon
- *Surgeons are flippant about the surgical checklist, and administration is more interested in case turnover and start times than patient safety.*
  – Unknown
- *[M]ost of the current generation surgeons still have the air of invincibility that allows them to believe that only the other, less qualified, docs need actually do this safe surgery checklist "I don't need it".*
  – Anesthesia Provider

- *The brief - debrief process has been a dream come true for me!*
  – OR Nurse

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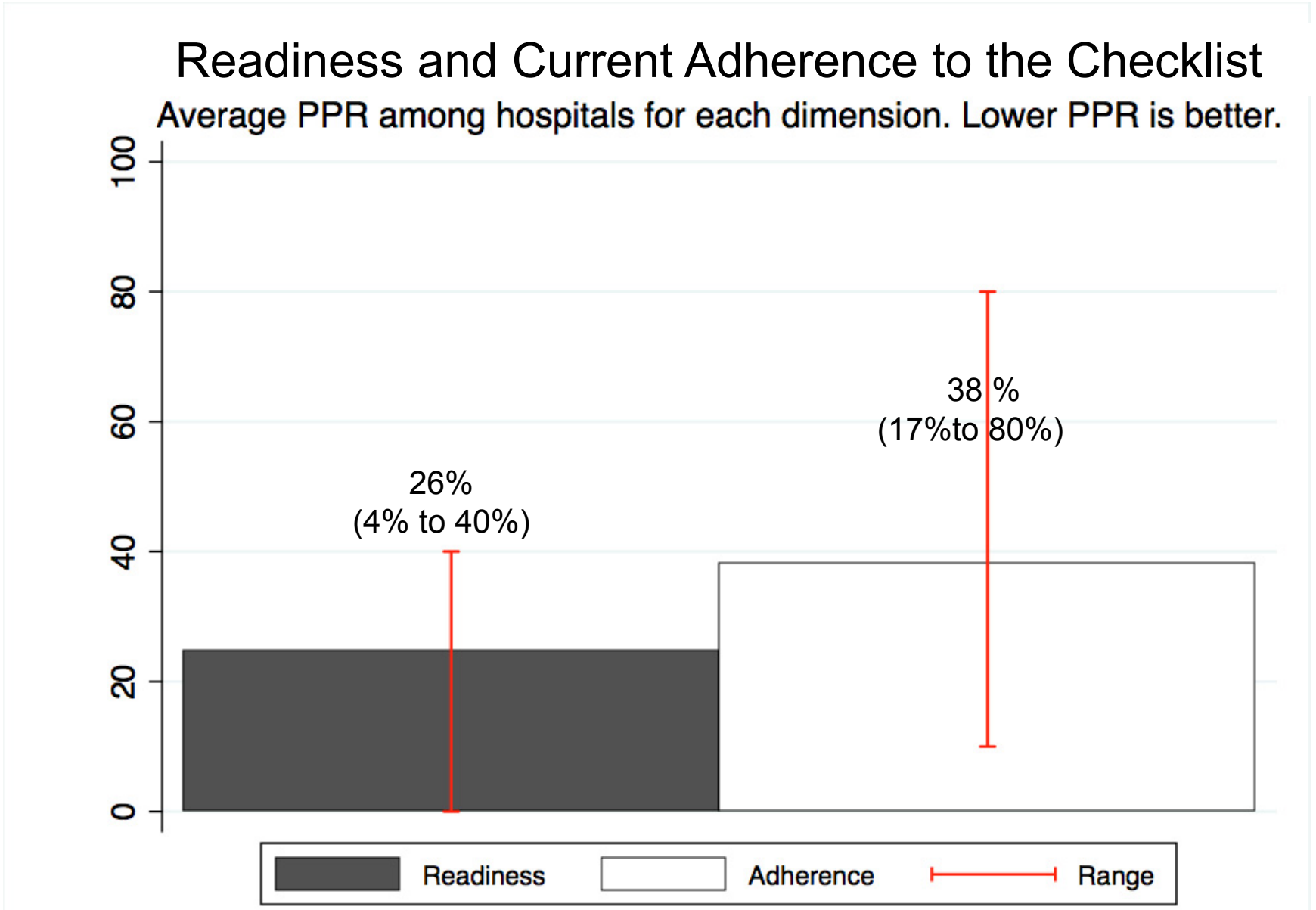

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Additional Items

Average of hospital means on a scale of 1-7. Higher is better.

Item	Mean	Low	High
33. I would feel safe being treated here as a patient.	6.0	4.8	7.0
34. If I were having an operation, I would want a surgical safety checklist to be used.	6.5	6.0	7.0
35. Pressure to move quickly from case to case gets in the way of patient safety. (R)	4.0	3.0	5.1

(R) Indicates that item is reverse-scored.

Appendix A

Item
Readiness[a]
1. In the ORs where I work, surgical team members are open to changes that improve patient safety, even if it means slowing down.
2. In the ORs where I work, the Joint Commission "Time Out" is used in every case by every surgical team.
3. In the ORs where I work, the Joint Commission "Time Out" was difficult to implement.*
4. In the ORs where I work, surgical team members all agree on the importance of using checklists in surgery.
5. In the ORs where I work, interest in checklist implementation is limited to one profession (e.g., surgery, anesthesia, or nursing).*
Assertiveness[a]
6. In the ORs where I work, I am encouraged to report any patient safety concerns I may have.
7. In the ORs where I work, it is difficult to discuss medical mistakes.*
8. In the ORs where I work, surgical team members appear to struggle **and do not** ask one another for help.*
9. In the ORs where I work, it is difficult to speak up when I perceive problems with patient care.*
Team Communication[a]
10. In the ORs where I work, team discussions (e.g., briefings or debriefings) are common.
11. In the ORs where I work, communication breakdowns frequently lead to delays in starting surgical procedures.*
12. In the ORs where I work, surgical team members make sure their comments or instructions are heard.
13. In the ORs where I work, surgical team members share key information as it becomes available.

Notes: [a]Construct scores are an average of the items that follow. *Reverse-scored item.

Appendix A

Item
Coordination and Cooperation[a]
14. In the ORs where I work, surgical team members appear eager to help one another.
15. In the ORs where I work, physicians and nurses work together as a well-coordinated team.
16. In the ORs where I work, surgeons and anesthesia providers work together as a well-coordinated team.
17. In the ORs where I work, surgical team members from different disciplines **always** discuss patients' conditions and the progress of operations.
18. In the ORs where I work, plans for patient care are adapted as needed.
Clinical Leadership[a]
19. In the ORs where I work, physicians are **only** open to suggestions from other physicians.*
20. In the ORs where I work, disagreements are resolved with an emphasis not on **who** is right but **what** is right for the patient.
21. In the ORs where I work, decision-making is shared among disciplines in response to changes in patients' conditions or issues that arise during operations.
22. In the ORs where I work, physicians are present and actively participating in patient care prior to skin incision.
23. In the ORs where I work, physicians maintain a positive tone throughout operations.

Notes: [a]Construct scores are an average of the items that follow. *Reverse-scored item.

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Appendix A

Item
Respect[a]
24. In the ORs where I work, surgical team members communicate with me in a respectful manner.
25. In the ORs where I work, my input about patient care is well received by other surgical team members.
26. In the ORs where I work, I am always treated as a valuable member of the surgical team.
27. In the ORs where I work, potential errors or mistakes are pointed out **without** raised voices or condescending remarks.
28. In the ORs where I work, surgical team members refer to each other by role instead of name (e.g., "Nurse" instead of "Dana").*
Adherence[a]
29. In the ORs where I work, surgical teams **always** discuss the operative plan (i.e., more than the location of the incision and name of the procedure) before incision.
30. In the ORs where I work, for complex patients or cases, preoperative briefings **always** include planning for potential problems.
31. In the ORs where I work, postoperative debriefings **always** include a discussion of key concerns for patient recovery and post-op management.
32. In the ORs where I work, equipment issues or other problems discussed in postoperative debriefings are addressed in a timely manner.
Other Items
33. I would feel safe being treated here as a patient.
34. If I were having an operation, I would want a surgical safety checklist to be used.
35. Pressure to move quickly from case to case gets in the way of patient safety.*

Notes: [a]Construct scores are an average of the items that follow. *Reverse-scored item.