Speak Up for Safety: Escalating Safety Concerns in the OR Setting

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Introduction

Safety in the Operating Room setting can be challenging due to production pressures, case intensity and power gradients. The Operating Room Leadership team at Sentara Martha Jefferson Hospital faced the challenge of having team members who were uncomfortable speaking up for safety, as well as providers who felt that their concerns were not being heard. Leadership, taking these risks and concerns seriously, developed an action plan to transform the OR culture into one of high reliability. As part of the safety program, a "Safety Concern" button was installed on the communication console in each OR suite. This button, when activated, prompted immediate notification of the OR Manager, Director or Medical Director (algorithm identified depending on who was present and accessible). When activated, the main OR desk staff paged the appropriate leadership personnel and that person reported to the room with the concern. The button was deliberately designed to be canceled only from within the room. (In the future, activation of the safety button will page leadership to the room).

Problem

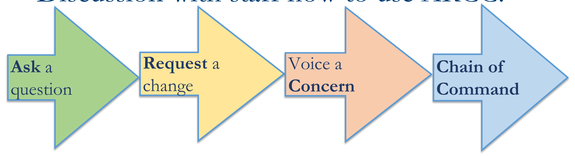
- Safety is an important component in healthcare
- The highly specialized OR setting presents unique situations that challenge safety measures
- Staff often feel unsupported and unable to accurately verbalize concerns
- Providers feel that safety concerns are not heard/listened to
- High staff turnover rate has led to decreased knowledge base of team members
- High call burden and an increase in patient acuity and case load leads to tired staff and burn-out
- Staff are commonly the last layer of defense in error prevention
- Errors in the OR can have significant impact on patients, families, staff, providers and the organization itself

Purpose

- To improve the culture of safety in the Operating Room
- Establishing a culture of safety is being recognized by healthcare organizations as a strategy to reduce errors and improve safety
- To be a highly reliable OR
- To develop an escalation pattern, allowing all team members to escalate concerns directly to leadership
- To develop predictive behaviors, focusing on risk prevention or early identification

Methodology

- Creation of an education plan:
  - Presentation on high reliability organizations to all staff members
  - Staff meeting that focuses on empowerment and supporting safe behaviors (proactive risk management)
  - Delivery of escalation training, focused specifically on OR scenarios
  - Discussion with staff how to use ARCC:



- Revision of daily OR huddle:
  - Safety issues and Great Catches/Near Misses are addressed first
  - Emphasis on commending staff who make a great catch or who speak up for safety
  - Communicate staffing concerns

- Installation of a Safety Button
  - Stops work in a room when a safety concern is present and immediate intervention is needed
  - When activated, an alert is generated at the central console at the OR front desk and also sends an alert to charge nurse phone
  - Light flashes on indicator outside the OR room door
  - Charge nurse or other front desk personnel will initiate a page to OR leaders
  - Leadership will report to that room in an effort to resolve the concern
  - Can be used by both staff and providers

References

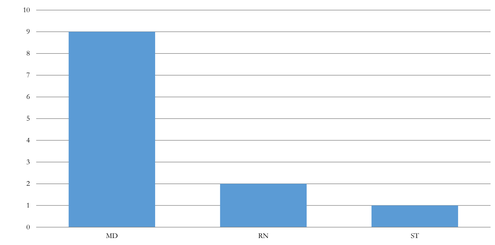
Roberts, K. H., & Bea, R. (2001). Must accidents happen? Lessons from high-reliability organizations. *Academy of Management Executive*, *15*(3), 70-79.
Van Beuzekom, M., Boer, F., Akerboom, S., & Hudson, P. (2012). Patient safety in the operating room: an intervention study on latent risk factors [Entire issue]. *BMC Surgery*.

Results

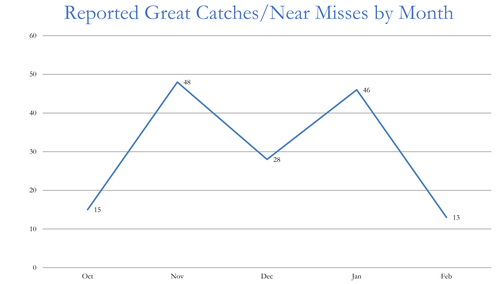
To date:

- The OR team has activated the Safety Button **12** times
- The OR team has identified **150** Great Catches/Near Misses

Activation of the Safety Button



Reported Great Catches/Near Misses by Month



Conclusions

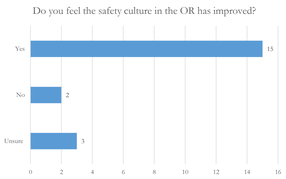
Increased safety due to:

- Staff feel there is a reliable avenue to escalate concerns
- Concerns are heard immediately and changes can be made in real time
- Empowerment of team to stop work when a safety concern is present

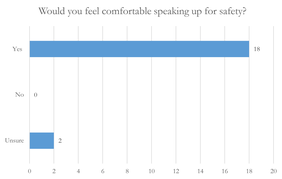
Barriers to improved safety identified by staff:

- Rushed by providers to get cases done and improve turnover time
- Staff and providers are not open to new ideas or processes

Do you feel the safety culture in the OR has improved?



Would you feel comfortable speaking up for safety?



Have recent efforts to improve safety and transparency helped you in your day-to-day work?