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TEAM COMMUNICATION



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MEDICAL ABBREVIATIONS & ACRONYMS

CMS – Centers for Medicare & Medicaid Services

HUDDLE – Healthcare Utilizing Deliberate Discussion Linking Events

I PASS the BATON – Introduction, Patient, Assessment, Situation, Safety Concerns, (the) Background, Actions, Timing, Ownership, Next

ICU – Intensive care unit

IHI – Institute for Healthcare Improvement

NOTSS – Nontechnical Skills for Surgeons

QI – Quality improvement

RN – Registered nurse

SBAR – Situation, Background, Assessment, Recommendation

SOP – Standard operating procedure

SURPASS – SURgical PATient Safety System

SWITCH – Surgical Procedure, Wet, Instruments, Tissue, Counts, Have You Any Questions

WHO – World Health Organization

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GUIDELINE FOR TEAM COMMUNICATION

The Guideline for Team Communication was approved by the AORN Guidelines Advisory Board and became effective January 15, 2018. It was presented as a proposed guideline for comments by members and others. The recommendations in the guideline are intended to be achievable and represent what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the guideline can be implemented. AORN recognizes the many diverse settings in which perioperative nurses practice; therefore, this guideline is adaptable to all areas where operative or other invasive procedures may be performed.

Purpose

This document provides guidance for improving perioperative team communication through a culture of safety that incorporates team training, simulation training, standardized transfer of patient information (commonly referred to as **hand overs** or hand offs), **briefings**, **time outs**, surgical safety checklists, and **debriefings**. In 1999, the Institute of Medicine report *To Err Is Human: Building a Safer Health System* stated that between 44,000 and 98,000 hospital patients die annually as a result of medical **errors** in the United States.¹ Subsequent studies have estimated the incidence to be as high as 180,000 to 400,000 deaths annually.² Since this landmark report, the health care industry has embraced the need for change. Numerous organizations have written position statements on the importance of team communication and the use of a safe surgery checklist to reduce the incidence of medical errors.³⁻⁹

The collective evidence¹⁰⁻¹³ demonstrates that communication breakdowns in the perioperative setting are a factor in events that adversely affect patients. Seventy percent of adverse events in the surgical environment are caused by breakdowns in communication among health care providers.^{14,15} The perioperative environment is stressful, and perioperative team members are under increasing pressure from numerous demands and complex functions that lend themselves to error. Despite these pressures, patient safety is a top priority for perioperative RNs and cannot be sacrificed for efficiency. Communication tools and team training programs provide a foundation to improve the chances that communication is conveyed effectively and received accurately. The surgical safety checklist is one tool that the literature supports as improving communication in the perioperative environment.¹⁶⁻⁶² The use of checklists in hand overs,

briefings, and debriefings provides a defense against adverse events.^{46,63,64}

Successful perioperative team communication requires a **high-reliability team** with a shared goal. According to Wahr et al,⁵⁰ high-reliability teams have six elements in common: communication, coordination, cooperation, cognition, conflict resolution, and coaching. An understanding by each team member of his or her role and responsibilities is necessary to achieve a successful surgical outcome for the patient. Beginning with the patient's decision to consent to the procedure, valuable information is collected and handed over to multiple personnel during the patient's surgical encounter. Effective communication among team members is important for understanding the surgical plan for each individual patient. A **shared mental model** increases the effectiveness of communication between team members because each team member is knowledgeable about his or her own role, other team members' roles, and how these roles interrelate. As the surgery progresses, a shared mental model facilitates timely communication and response by each team member to changes in the surgical plan.⁵⁰

Communication is a process that consists of sending and receiving messages; however, a variety of **distractions** can impede the ability to send or receive the message accurately. Distractions can be internal or external. Internal distractions are related to the individual's nontechnical skills and individual **resilience** to human factors (eg, hunger, thirst, anxiety, anger, fatigue) when communicating within the team.⁶⁵ External or environmental distractions can be divided into two types: essential and nonessential. Essential distractions come from components necessary for patient care, such as equipment alarms, telephones, pagers, and equipment **noise**. Nonessential distractions occur in the environment but are not necessary for patient care, such as irrelevant conversations, music, and **interruptions** from personnel not essential to the procedure. Hierarchical and personal relationships among the individuals on the team can be barriers to effective communication. Other individual barriers include educational background, language preference, culture, race, and gender.⁶³

Interprofessional team members send and receive multiple messages throughout a patient's surgical experience. Mohorek and Webb⁶⁶ described the Linear Model of Communication as a conceptual framework for hand overs between physicians and described different reasons for errors during the hand-over process. Viewing the flow of communication in a linear model may be beneficial for mapping out the critical messages that are covered in each team conversation and for preventing repetition of information that is not critical.