Welcome

We will begin shortly at 4:00pm MT
KRISTYN SEEMAN, MLS BSN RN CNOR
Clinical Perioperative Nurse Research Librarian
Association of periOperative Registered Nurses (AORN)
Hot Topic Virtual Forum: Agenda

MT Time Zone

4:00pm – 4:10pm – Opening with Kristyn Seeman
4:10pm – 4:30pm - Lisa Spruce: Journey to Zero Harm
4:30pm – 4:33pm – Introduce Stryker Representatives
4:33pm – 4:53pm – Stryker Presentation
4:50pm - 5:30pm – Audience Q&A
Submit your Questions
Open the Chat box and ask our speakers your questions
We will have Q&A time at the end
Lisa Spruce, DNP RN ACNP CNOR CNS-CP ACNS FAAN

Director of Evidence-Based Perioperative Practice
Association of periOperative Registered Nurses (AORN)
Tools

• to improve teamwork and communication
Briefing

Process
Timing
A Briefing Is a Discussion That—

- Facilitates clear and effective communication
- Gets the team on the same page
- Creates a sense of teamwork and collaboration
- Fosters an environment where team members can openly address a perceived problem
- Every member of the team actively participates in
- Can set the tone for the day and/or procedure
Briefings Help Us To

- Better “know the game plan” and “be on the same page”
- Monitor a situation and raise red flags
- Ensure each other’s needs and expectations are met
- Avoid unwanted surprises
- Reduce surgical flow disruptions
- Improve patient safety

AORN | HOT TOPIC VIRTUAL FORUM
Safety in the OR: Journey to Zero Harm

Sponsored by Stryker
• Every Time Out must have one common thread—team engagement. If every member of the team isn’t part of the conversation, mistakes can still happen, and they do.
Conducting a time-out

- Site marking
- Standardization
- Regional anesthesia
- Second time out
- Safe surgical checklist

AORN HOT TOPIC VIRTUAL FORUM
Safety in the OR: Journey to Zero Harm

Sponsored by Stryker
# Surgical Safety Checklist

## Before induction of anaesthesia
(with at least nurse and anaesthetist)
- **Has the patient confirmed his/her identity, site, procedure, and consent?**
  - Yes
  - No
  - Not applicable

- **Is the site marked?**
  - Yes
  - No
  - Not applicable

- **Is the anaesthesia machine and medication check complete?**
  - Yes
  - No

- **Is the pulse oximeter on the patient and functioning?**
  - Yes
  - No

- **Does the patient have any:***
  - Known allergy?
    - Yes
    - No
  - Difficult airway or aspiration risk?
    - Yes
    - No
  - Risk of >500ml blood loss (7ml/kg in children)?
    - Yes
    - No

## Before skin incision
(with nurse, anaesthetist and surgeon)
- **Confirm all team members have introduced themselves by name and role.**
- **Confirm the patient’s name, procedure, and where the incision will be made.**

- **Has antibiotic prophylaxis been given within the last 60 minutes?**
  - Yes
  - No
  - Not applicable

## Anticipated Critical Events

### To Surgeon:
- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

### To Anaesthetist:
- Are there any patient-specific concerns?

### To Nursing Team:
- Has sterility (including indicator results) been confirmed?
- Are there equipment issues or any concerns?

## Before patient leaves operating room
(with nurse, anaesthetist and surgeon)
- **Nurse Verbally Confirms:**
  - The name of the procedure
  - Completion of instrument, sponge and needle counts
  - Specimen labelling (read specimen labels aloud, including patient name)
  - Whether there are any equipment problems to be addressed

- **To Surgeon, Anaesthetist and Nurse:**
  - What are the key concerns for recovery and management of this patient?

---

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

---

**AORN HOT TOPIC VIRTUAL FORUM**

**Safety in the OR: Journey to Zero Harm**

Sponsored by **stryker**

---

*Revised 1/2019 © WHO 2009*
### Safety Pause: Checklist

**Anesthesia Machine Installed:**
- Make sure...
- Anesthesia machine staff
- Oxygen and air supply
- Ventilator
- Anesthesia machine in working order

**Conscious Patient:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Preoperative Medications:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Surgical Team:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Intubation:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Surgical Team:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Crossing:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

**Debriefing:**
- Anesthesia machine staff
- Ventilator
- Oxygen and air supply
- Anesthesia machine in working order

---

**Create your own checklist**

**Plan for admission postop (ICU)**

**Reperfusion solution**

---

**AORN HOT TOPIC VIRTUAL FORUM**

Safety in the OR: Journey to Zero Harm

Sponsored by **stryker**
Form an Interprofessional Team

• Create a team that will help lead this work in your facility
• At a minimum, the team should include at least one

  • Administrator
  • Surgeon/physician
  • Anesthesia professional
  • Nurse
  • Scrub technician
Things To Consider When Customizing Your Checklist

It should be customized to fit the needs of your facility

Think about—

- Cases
- Patient population
- Special needs

Do not make your checklist too long
When Considering Items for the Checklist, Ask

<table>
<thead>
<tr>
<th>Question</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it a critical safety step at risk of being missed?</td>
<td>Known allergies, Essential imaging, Antibiotic prophylaxis</td>
</tr>
<tr>
<td>Is it a safety step you might not have noticed if it wasn’t executed?</td>
<td>Iodine/tinted prep – Doesn’t belong on a checklist, Antibiotic prophylaxis – Does belong on a checklist</td>
</tr>
<tr>
<td>Is it an item discussed at a time when all relevant team members are present?</td>
<td>Changes to the operative/procedure plan</td>
</tr>
<tr>
<td>Is the checklist the best way to take care of it?</td>
<td>Fire risk assessment, Hair removal, Checking pressure points</td>
</tr>
<tr>
<td>Can something be done about it?</td>
<td>Hair removal</td>
</tr>
<tr>
<td>Does it improve communication among team members and set a positive tone?</td>
<td>Team introductions, Surgeon/physician asks team members to voice concerns during the case</td>
</tr>
</tbody>
</table>
Testing Your Checklist Outside of the Patient Environment Using Tabletop Simulation

AORN HOT TOPIC VIRTUAL FORUM

Safety in the OR: Journey to Zero Harm

Sponsored by Stryker
Testing Your Checklist Outside of the Patient Environment Using Tabletop Simulation

• After reviewing the checklist, discuss the changes needed before using it on a patient.

• Assign team members tasks and make changes based on feedback if necessary.
Use your new checklist on a real patient
Debriefing

• Process
• Discussion
Benefits of Debriefing

• Ensures all team members are on the same page
• Confirms critical information
• Provides a place to discuss adverse or potentially adverse events that occurred
• Facilitates discussion of how to stop problems from reoccurring
• Promotes patient safety
Timing the Debriefing Discussion
Problems Identified by Debriefings

- Near misses
- Incorrect sponge and needle counts
- Equipment issues
- Mislabeling of specimens
Using Debriefings for Continuous Quality Improvement

• Create a way to collect identified problems or other important information
• Designate someone in the facility to monitor and fix problems identified
• Update those who reported problems about steps taken to fix them
Hand-overs
• Interdisciplinary team
• Process
• Roles and responsibilities
• Read back method
Hand-overs

- SBAR
- I PASS the BATON
- SWITCH
- SURPASS
Hand-overs

Locations of care
Scheduling
Preop
Intraop
Postop
Resources

• AORNs guideline for Team Communication
• AHRQ Teamwork and Communication tools
  • https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/implementation/training-tools.html
• Ariadne Labs, Surgical Checklist Implementation Guide
  • https://www.ariadnelabs.org/areas-of-work/safe-surgery-checklist/resources/#Downloads&%20Tools
"To do what nobody else will do, a way that nobody else can do, in spite of all we go through; that is to be a nurse."

— Rawsi Williams, RN, attorney
KRISTYN SEEMAN, MLS BSN RN CNOR
Clinical Perioperative Nurse Research Librarian Association of periOperative Registered Nurses (AORN)
Welcome to Stryker

Erin VanBogelen, Stryker Brand Manager, Invuity
erin.vanbogelen@stryker.com

Andrea Zornman, Stryker Brand Manager, SurgiCount
andrea.zornman@stryker.com
Mission

Together with our customers, we are driven to make healthcare better.

Values

- **Integrity**
  We do what’s right

- **Accountability**
  We do what we say

- **People**
  We grow talent

- **Performance**
  We deliver
Our goal is Zero splash and spills
Zero smoke
Zero retained sponges
Zero blind spots
Zero trips and falls
Zero drug diversion

Zero doubt your operating room is doing everything for everyone who steps inside it – patients, surgeons, nurses and perioperative team members included

*Zero splash and spills, zero airborne contaminants, zero smoke, zero retained surgical sponges, zero blind spots, zero trips & falls, zero drug diversion, and zero doubt messages are not guarantees and are aspirational in nature.
Together, your OR processes and our integrative technologies create **systematic solutions** that support your journey to **zero harm**.
We are on the journey to zero together.
The basic premise in the system approach of high-reliability organizations is that humans are fallible and errors are to be expected, even in the best organizations.


Human error: models and management. Volume 172 June 2000 wjm 393
**Human error** ['hjuːmən ˈɛrə] noun – deviation from intention, expectation or desirability.

**Byproduct** [ˈbɑːhɪ-prod-uh kt] noun – a secondary or incidental product; the result of another action, often unforeseen or unintended.


Human error: models and management. Volume 172 June 2000 wjm 393
Our mutual goal is zero

Stryker has been investing in caregiver safety for two decades. We are evolving to meet the demands of your journey to Zero harm with simple solutions, education and implementation resources.
Standardization opportunity

Neptune

Smoke solutions

SurgiCount
Our Goal is Zero retained sponges

Industry wide problem
Retained surgical items are the #1 sentinel event.†

Industry standard
Not a process problem
Joint Commission launched Sentinel Event reporting in 1996 and RSI’s have been on the list every year. Process improvement cannot solve for the root cause of RSI: false correct counts.

Stryker solution
SurgiCount
With over 210 million sponges counted, SurgiCount is the only adjunct technology with a track-record of zero retained surgical sponges.* SurgiCount provides full EMR connectivity and back-end compliance.


*when SurgiCount is implemented and used correctly
**Our Goal is Zero blind spots**

**Industry wide problem**

- Challenges of **access and visualization** in open surgery

**Industry standard**

- **Minimize clinical risk**
  - Solve challenges of access and visualization in open surgery
  - Reduce risk of patient burns from surgical instruments
  - Lower incidence of lead damage in EP
  - Reduce flap infection rates of breast surgery

**Stryker solution**

- **Intelligent photonics**
  - With thermally-cool illumination, our tools provide enhanced visualization so you have confidence in your minimally invasive techniques.
  - From enabling oncoplastic techniques and precise joint placement to spotting bleeders and preventing tissue damage, illuminated instruments gives you control over patient outcomes, your way.

---

- Dupree, B. (2015). Retrospective Chart Review of Nipple Sparing Mastectomies with and without an enabling intracavity illumination and visualization system. [PDF]
- Thermal and Insulation Characteristics related to Safety Issues Involving Illumination and Retraction Devices Utilized in Breast Surgery; A Comparison of Fiberoptics to the Solid Core Illumination Technology
Our goal is **Zero**

- **Zero splash and spills**
- **Zero airborne contaminates**
- **Zero smoke**
- **Zero retained sponges**
- **Zero blind spots**
- **Zero trips and falls**
- **Zero drug diversion**
Our goal is zero

Standardized solutions to reduce risks & hazards in every OR
Thank you to Erin VanBogelen, Stryker Brand Manager, Invuity 
erin.vanbogelen@stryker.com

Andrea Zornman, Stryker Brand Manager, SurgiCount 
andrea.zornman@stryker.com
KRISTYN SEEMAN, MLS BSN RN CNOR
Clinical Perioperative Nurse Research Librarian
Association of periOperative Registered Nurses (AORN)
Submit your Questions

Open the Chat box and ask our speakers your questions

CHAT NOW

AORN HOT TOPIC VIRTUAL FORUM
Safety in the OR: Journey to Zero Harm

Sponsored by Stryker
This webinar will be available in a recording early next week here to share with colleagues:
https://www.aorn.org/events/hot-topics

Contact our Hot Topic Presenters:
- Lisa Spruce, DNP, CNOR, CNS-CP, FAAN, AORN Director of Evidence-Based Perioperative Practice
  LSpruce@aorn.org
- Erin VanBogelen, Stryker Brand Manager, Invuity
  erin.vanbogelen@stryker.com
- Andrea Zornman, Stryker Brand Manager, SurgiCount
  andrea.zornman@stryker.com

Scheduled Hot Topic Webinars here: https://www.aorn.org/events/hot-topics