Increasing Adherence to Debriefing of the Surgical Safety Checklist

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Toronto Academic Health Sciences Network program (TAHSNp)
Collaborative Academic Practice Innovation Fellowship

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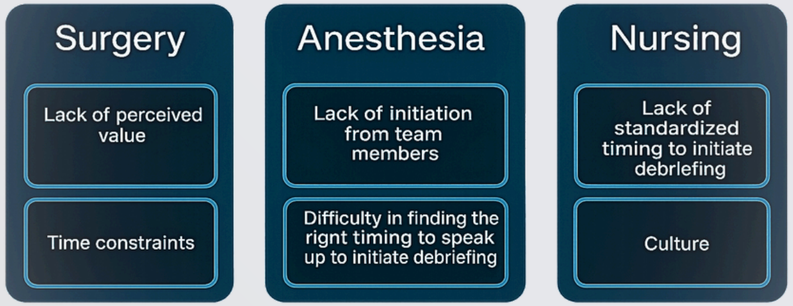
BACKGROUND

- Surgical Safety Checklist is a communication tool promoted by the World Health Organization that reduces morbidity and mortality in operating rooms worldwide.
- Only **38%** of all cardiac surgeries at Toronto General Hospital's operating room had "*initiated*" debriefings - where debriefing was done with lack of participation from all three teams - surgery, anesthesia, and nursing.
- Baseline data collection showed **0%** adherence to *complete* debriefings with participation from all three teams.

AIM

- Increase the rate of complete debriefings of the Surgical Safety Checklist by 15% in elective aorto coronary bypass surgeries (ACBs) via sternotomy at Toronto General Hospital's Cardiac Operating Rooms by March 2026.

ROOT CAUSE ANALYSIS



- Anesthesia and nursing team showed a common theme - ***timing***.
- Lack of perceived value in debriefing was an underlying theme in all three interprofessional teams, with most promincence amongst the surgery team.

CHANGE IDEAS

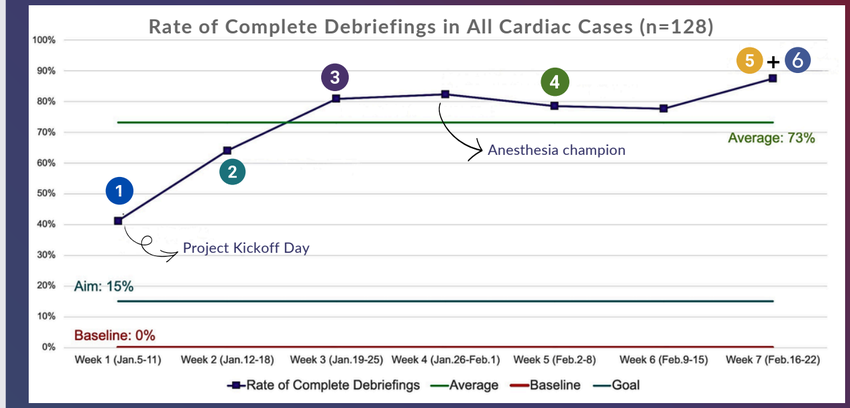
- 🎓 Interprofessional Team Eduction
- 🕛 Standardized timing
- 🔄 Surgery to prompt anesthesia

EDUCATION PRESENTATION

- Impact of debriefing to patient safety
- Contents of debriefing and responsibilities of each team members
- Benefits of debriefing that impacts team communication and cost
- Recommended standardized timing of debriefing - dressing placement

IMPLEMENTATION & TIMELINE

Six Plan Do Study Act (PDSA) cycles were implemented:



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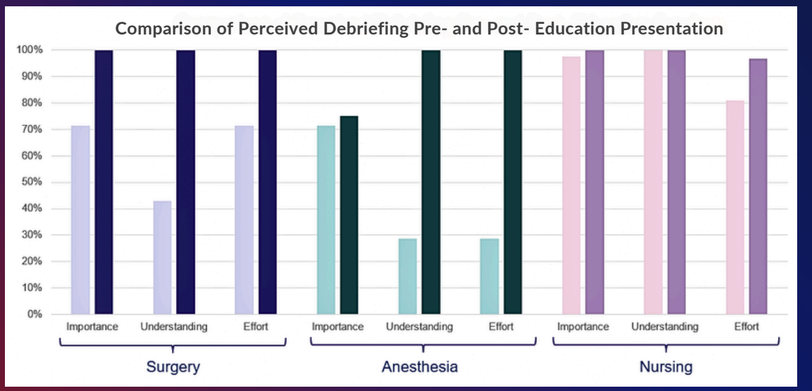
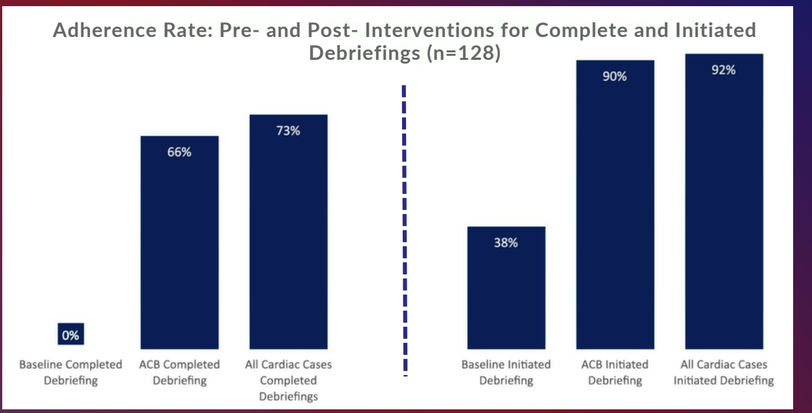


PROCESS MEASURES

- Comparison between the perception of debriefing before and after the educational presentation shows dramatic difference, especially in the surgery and anesthesia team

OUTCOME MEASURES & IMPACT



★ With increased rate of *complete* debriefing from **0%** → **73%** in all types of cardiac surgeries, notable cultural shift occurred where initiating debriefing slowly became a part of daily practice in cardiac surgery department