The "WHO Huddle" ; Introducing a Theatre Team Brief as part of the World Health Organisation Surgical Safety Checklist in a District General Hospital.

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Purpose

The WHO surgical safety checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform focused safety checks during vital phases of peri operative care [1]. The first of these five steps to safer surgery is the theatre team briefing. This project aimed to implement a multidisciplinary team briefing at the start of every theatre list.

Methods

The most important and challenging part was engaging staff from multiple specialties to participate in the briefing process. WHO champions were identified from each surgical specialty to help disseminate information to their teams and provide feedback to facilitate and streamline the implementation process. Further information was provided to clinical directors, consultants, surgical managers, matrons and clinical staff via email, displayed posters and departmental meetings.

Multidisciplinary team presence of a surgeon, anaesthetist, scrub nurse and operating department practitioner was expected prior to the start of each theatre's surgical list to discus its salient points including anaesthetic, surgical and equipment factors; logistical factors (such as list order) and concerns.

A form covering the main points discussed was completed during the briefing and this data was collected over a 3 month period

Results

484 forms were completed with over 95% of debriefs having a full team present.

Identified Issue	% Lists Affected	Examples
List changes	44%	Cancellations, list order, procedure, side/site
Surgically complex	22% (37% in DCU)	Major resections
High estimated blood loss	10% (10% in DCU)	>500ml
Specific surgical requirements	46%	Equipment, radiology, medications
High anaesthetic risk	40% (42% in DCU)	High BMI, comorbidities, anticipated difficult airway.
Concerns	10%	Beds, missing notes/equipment, infection risk

Conclusion

The implementation of the team brief creates an opportunity for the operating team to share information and discuss potential safety issues in advance, creating operating theatres run by teams that put safety first, communicate well, and are more efficient.

The project illustrated most lists, including those in day surgery theatres, are subject to complex issues with nearly half of lists subject to last minute changes. Clear communication from both surgical and anaesthetic teams regarding these issues, requirements and concerns may improve the smooth running of the list and reduce harm in the perioperative period [2].

References

1. The World Health Organization Second Global Challenge Safe Surgery Saves Lives www.who.int/patientsafety/safesurgery/en
2. Haynes A, et al. (2009) A surgical safety checklist to reduce morbidity and mortality in a global population. The New England Journal of Medicine; 360: 491–9.