Title: Understanding of Interprofessional Communication to Impact Patient Safety in the Operating Room

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Dates of Support: Total Award Amount: $1,729

Funding Agency: IN Nurses Foundation, End Date: May, 2018

Abstract:

Intraoperative adverse events (IAEs) occur approximately every 79 minutes during surgical procedures in the United States, resulting in paid malpractice claims at an estimated cost of $65,000,000 annually. Examples of IAEs include incidents such as procedural delays, episodes of decreased patient safety, unintended bleeding, anaphylactic reaction, unintentional dissection/resection, electrocautery injury, laparoscopic conversion to open procedure, cardiac arrhythmia, and occurrences classified as surgical 'never' events. Root-cause analyses indicate over half of these adverse events were directly preventable through effective interprofessional communication. While the implementation of surgical safety checklists has significantly reduced patient mortality and surgical complications, these checklists only provide for the minimum amount of communication necessary to protect patient safety during surgical procedures. Effective interprofessional communication in the operating room facilitates situational awareness, teamwork, decision-making, leadership, and stress management, but this process is often hindered by professional barriers and cultural constraints inherent to healthcare delivery. And although intraoperative communicative events have been determined to influence patient outcomes, studying them has proven to be methodologically difficult. The primary goal of this pilot study is to use a grounded theory approach to explore the psychosocial processes involved during the establishment and maintenance of interprofessional communication surrounding IAEs or potential IAEs in the operating room. In-depth interviews with members of surgical teams will be audio-recorded, de-identified, transcribed, and coded to better understand the psychosocial processes involved. Understanding the psychosocial processes involved in interprofessional communication in the operating room is the crucial first step toward establishing a safety culture to directly impact patient outcomes.