Worcestershire Acute Hospitals NHS Trust

# Safety Standards for Team Briefing

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

## Introduction

- The Team Brief is a safety check which should be completed at the start of any elective or emergency procedural session.
- There is an established positive link between briefing practices and attitudes towards safety. Better communication reduces intra-operative disruption, minor complications and operation times.
- Briefing helps give team members a clear understanding of the session and what is expected of them.
- Team briefing is a therefore a key element in the delivery of safe patient care. Productivity is improved by predicting, discussing and solving issues early. The Team Brief is a simple, easy to use tool which allows sharing of vital patient information.
- The Team Brief helps foster a culture of safety and encourages all members of the team to contribute regardless of hierarchy.
- By meeting to identify safety concerns, equipment issues and staffing then safety incident reporting can be incorporated into everyday routines.

## This guideline is for use by the following staff groups :

All anaesthetists
All surgeons
Midwives
Theatre staff
Interventional Radiologists
Interventional Cardiologists
Endoscopists
All practitioners performing procedures outside of theatre environment

**Lead Clinician(s)**

James Hutchinson — Consultant Anaesthetist

Approved by *TACCSS* ……. on: — 17th January 2024

Review Date 17th January 2027

This is the most current document and should be used until a revised version is in place:

## Key amendments to this guideline

| Date | Amendment | Approved by: |
|---|---|---|
| 17th Jan 24 | Document approved | TACCSS |

Worcestershire Acute Hospitals NHS Trust

# Safety Standards for Team Briefing

## Summary of guideline

- **There is an established link between briefing practices and attitudes towards safety**
- **A successful team brief can improve productivity by predicting problems**
- **Team briefing should occur before the first patient arrives in the procedural area**
- **The team brief should be attended by as many members of the procedural team as possible. This includes the operator, anaesthetist, scrub practitioner, anaesthetic assistant, circulating practitioner and any other healthcare professionals.**
- **Team introductions familiarise a team and encourage all members to speak up**
- **Anticipated changes or uncertainties about the list are communicated**
- **Each patient is considered in turn from the perspective of the operator, anaesthetist and theatre practitioners**
- **Key items to discuss from each perspective include (further guidance within full policy):**
- **Operator/surgeon – confirms:**
    - **diagnosis and planned procedure, including site and side**
    - **approach and positioning requirements**
    - **equipment requirements**
    - **prosthesis requirements, when relevant**
    - **antibiotic prophylaxis requirements, when relevant**
- **Anaesthetist – confirms:**
    - **relevant co-morbidities and complications (including patient weight and bmi)**
    - **anaesthetic technique and any airway difficulties**
    - **specific monitoring requirements**
    - **specific post-operative analgesic requirements (i.e. epidural pump or pca)**
    - **allergies**
- **Lead theatre practitioner – confirms:**
    - **availability of any equipment**
    - **availability of any prosthesis requested (see prosthesis verification locssip)**
    - **availability of any specific equipment for patient positioning**
- **In the emergency situation team briefing may be modified. Further guidance is given within the full policy.**

## Introduction

- The Team Brief is a safety check which should be completed at the start of any elective or emergency procedural session.
- There is an established positive link between briefing practices and attitudes towards safety. Better communication reduces intra-operative disruption, minor complications and operation times.
- Briefing helps give team members a clear understanding of the session and what is expected of them.
- Team briefing is a therefore a key element in the delivery of safe patient care. Productivity is improved by predicting, discussing and solving issues early. The Team Brief is a simple, easy to use tool which allows sharing of vital patient information.
- The Team Brief helps foster a culture of safety and encourages all members of the team to contribute regardless of hierarchy.
- By meeting to identify safety concerns, equipment issues and staffing then safety incident reporting can be incorporated into everyday routines.

## Details of Guideline

### When a Team Brief is performed

- Prior to any procedural session involving invasive procedures governed by LocSSIPs. This includes elective, unscheduled and emergency procedure sessions.
- The Team Brief should be completed before the first patient arrives in the procedural area. On occasion the patient may have arrived in the procedural area. In this case the Team Brief should still be completed, although in a location which maintains patient confidentiality.
- For elective theatre sessions it is anticipated that the Team Brief for the AM list should take place at 08:30 and the Team Brief for the PM list should take place at 13:15.

### Team Briefing in Emergency Scenarios

- For emergency life or limb saving procedures it is desirable to conduct a team brief, even if this is as the patient is brought to the procedural area or after the patient has arrived in the procedural area.
- If it is judged by the senior operator/anaesthetist present that there is insufficient time to conduct a full team brief then key issues can be discussed prior to commencing the procedure. These may include:
    - Planned Procedure including site and side, when relevant
    - Equipment requirements and prosthesis requirements, when relevant
    - Allergies
    - Relevant co-morbidities
    - Arrangements in case of significant blood loss
    - Anticipated post-operative destination
- If a full team brief cannot be conducted this should be recorded using the Datix system to enable learning from these events.

- Separate guidance on Obstetric Team Brief is provided at the end of this document.

**Staff Present at Team Brief**

- As many members of the team as possible should attend, including the operator and, when present, the anaesthetist who have seen and consented the patients. This should include, when relevant:
  - Senior operator and trainees
  - Senior anaesthetist and trainees
  - Anaesthetic assistant
  - Scrub and circulating practitioners
  - Any other healthcare professional e.g. radiographer

- Any team member may lead the Team Brief. The Anaesthetist, when relevant, is well positioned to lead a team brief as they may have insight into patient factors which could affect the list.

- Whoever leads should foster an open environment where each patient is considered from surgical, anaesthetic and practitioner perspectives.

- Every team member should be encouraged to voice concerns.

## Location of the Team Brief

- The Team Brief should be held in an area which respects patient confidentiality, while enabling contribution and inclusivity from all team members. In Theatres the anaesthetic room is frequently an appropriate location for the Team Brief.

## Structure of a Team Brief

- There should be silent focus during the Team Brief. There should be no noise, distractions or non-essential conversation.

- Each member of the procedural team is responsible for **introducing themselves** by name and role. This process is important for identifying roles and encouraging people to speak up. When possible the names of key personnel should be made easily visible throughout the session, for example on the theatre whiteboard.

- Each patient should be considered in list order from a surgical, anaesthetic and theatre practitioner perspective. As a guide the surgeon, anaesthetist and theatre staff should provide the following information about each patient (when relevant).

- The Operator should confirm:
  - Diagnosis and planned procedure, including site and side
  - Approach and positioning requirements
  - Equipment requirements
  - Prosthesis requirements (see Prosthesis Verification LocSSIP)

- Antibiotic prophylaxis requirements
- Any anticipated need for blood or blood products
- Requirement for frozen sections
- Any known infection risks, i.e. MRSA

- The Anaesthetist should confirm:
  - Relevant patient co-morbidities and complications (including patient weight and BMI)
  - Anaesthetic technique
  - Anticipated airway difficulties
  - Specific monitoring requirements
  - Specific post-operative analgesic requirements (i.e. epidural pump or PCA)
  - Allergies
  - Anticipated need for blood or blood products
  - Anticipated postoperative destination for the patient including need for HDU

- The lead theatre practitioner should confirm:
  - Availability of any equipment
  - Availability of any prosthesis requested (see Prosthesis Verification LocSSIP)
  - Availability of any specific equipment for patient positioning
  - Confirmation of staff members responsible for conducting intraoperative safety checks

- The team should be made aware of any proposed changes to list order. When a change to list order is agreed a corrected session list should be generated and old session lists should be destroyed.

- The team should be made aware of any uncertainties on the list and means for ensuring that updates are communicated and shared across the whole team.

- Requirements for X-ray in the list should be discussed and communicated to the X-ray department following the Team Brief.

- Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.

- Staff members responsible for completing WHO safety checks during the list should be designated. This clarifies staff roles and ensures responsibility for conducting the safety checks.

**Team Brief Record**

A record of the Team Brief occurring should be made on BlueSpier at the time of the Team Brief. This can be found in Appendix 1.

### Elective Obstetric Operating Lists

Additional information is required at the Team Brief for elective and emergency Obstetric procedures. This is due to the additional requirements of the foetus, increased risk of maternal complications and requirements for specific specialty input, i.e. paediatrics.

### Staff attending the Obstetric Team Brief

As many team members of the procedural team as possible should attend. This will include:

- Senior Obstetric surgeon and trainee
- Senior Anaesthetist and trainee
- Scrub practitioner
- Anaesthetic practitioner
- Circulating theatre team members
- Midwifery staff

The Team Brief should be led by a senior theatre team member.

### Timing of the Team Brief

- There should be a Team Brief prior to elective obstetric operating sessions.
- The Team Brief will need to be repeated if there is a change in key team members during a procedure session.
- It is anticipated that the Team Brief commences at 08:30 for the AM session and 13:30 for the PM session. These timings are flexible and the PM timing may be earlier or later depending on when changes of key personnel occur.
- If no change of key personnel is anticipated then the team could be briefed on all patients on the list.

### Location of the Team Brief

The Obstetric Team Brief should be held in an area which respects patient confidentiality, while enabling contribution and inclusivity from all team members. Theatre 1 anaesthetic room is frequently used.

### Recording the Obstetric Team Brief

- The Team Brief is recorded on the Obstetric Timeline document for each patient. This should be kept available for reference by the team.
- When the timeline document has been produced and tested for EZ notes it should be kept with the patient notes and scanned into the patients electronic record.

### Structure of an Obstetric Team Brief

- The generic principles of Team Brief as detailed above apply.

- Each member of the maternity team is responsible for introducing themselves by name and role.
- The team should be made aware of any proposed changes to list order. When a change to list order is agreed a corrected list should be generated. Old lists should be destroyed.
- Equipment checks should be confirmed. The exact equipment will vary, but will usually include anaesthetic equipment and machines, resuscitation equipment (i.e. defibrillators) and surgical equipment.
- Staff members responsible for completing safety checks during the obstetric list should be designated. Under usual circumstances this would be:

    - Sign In – Anaesthetic Practitioner and Anaesthetist
    - Time Out –Anaesthetist
    - Sign Out – Scrub Practitioner and Circulating Staff
    - Debrief – Scrub Practitioner

- The Team Brief should consider each patient, in list order, from an operator, anaesthetic, practitioner and midwifery perspective.
- For each patient:
  The Obstetric Surgeon should be asked to confirm:

    - Procedure and indication
    - Recent US for breech presentations
    - LSCS Category
    - Additional procedures planned
    - Previous LSCS
    - Placental site
    - Risk for major blood loss and arrangements in case of haemorrhage (i.e. cell saver)
    - Risk for foetal compromise
    - Requirement for paediatric support at delivery
    - Anticipated time for procedure

  The Anaesthetist should be asked to confirm:

    - Presence of co-morbidities including ASA status
    - Anaesthetic technique
    - Allergies
    - Any anticipated airway difficulties
    - Suitability for NSAID
    - Consent for PR medication
    - Risk for major blood loss and arrangements in case of haemorrhage (i.e. cell saver)
    - Anticipated postoperative destination if there are special circumstances

  The Midwife should be asked to confirm:

    - Staring haemoglobin and platelet levels

- Validity of Group and Save or Cross-match
- Venous Thromboembolic risk (High, Medium or Low)
- For breech babies, confirm recent USS (i.e. within 6 hours)
- Requirement for paediatric support at delivery
- Whether cord blood samples are required

**Emergency Obstetric Cases**

Caesarean Section (LSCS) urgency is categorised as 1-4 to help delivery in a timely manner with urgency appropriate to the risk to the baby and the safety of the mother.

Current classification is described as:

| **Category** | **Clinical condition** | **Recommended decision to delivery interval** |
|---|---|---|
| **Category 1** | Immediate threat to life of woman or foetus | 30 minutes |
| **Category 2** | Maternal or foetal compromise which is not immediately life threatening | 75 minutes |
| **Category 3** | No maternal or foetal compromise but needs early delivery | |
| **Category 4** | Delivery timed to suit woman or staff | |

- For Category 1 LSCS it is desirable to conduct a formal Team Brief. However it is recognised that there is a time urgency which means a formal Team Brief similar to that described above may not be feasible and the patient will need to attend theatre prior to the Team brief.

- For Category 1 C/S the obstetrician must accompany the patient to Obstetric theatre and provide a team briefing with the theatre team in theatre. There is a modified checklist for this process which is found in Appendix 2.

- The principle of as many team members as possible attending a Category 1 CS briefing applies. All team members should be encouraged to seek clarification during the brief when required.

- The **obstetrician** present is **responsible** for conducting the Category 1 Surgical Checklist. This may be performed as the anaesthetist prepares for anaesthesia and theatre team members prepare equipment. For example spinal anaesthetic drugs may be being prepared by the anaesthetist. If a General Anaesthetic is being given it is often preferable to catheterise, prep and drape the woman prior to induction of GA, this reduces the risk of foetal drug exposure and hypotension. In these cases the obstetrician could run the checklist as the woman is being catheterised or, if already catheterised, while she is being pre-oxygenated and GA drugs prepared and checked.

**Three** important factors are initially checked once the woman enters theatre:

1. The woman's identity is confirmed by asking her to state her name and DOB and checking against the ID band and consent form. The Hospital ID or NHS number should also be checked on ID band and consent form.
2. The consent form is checked to ensure it is for the appropriate procedure and that any additional procedures are mentioned.
3. The indication for emergency delivery is communicated to the rest of the theatre team. Any specific concerns the Obstetric surgeon has should also be communicated. Placenta site must be confirmed and its position checked to ensure it is not low lying.

A. Following these checks, the **A** checks are made:

- **A**llergies must be asked about and communicated to the team
- **A**naesthetic concerns – the anaesthetist is asked if they have specific concerns or requirements
- **A**irway plan – in cases where GA is anticipated the anaesthetist is asked about the airway plan and the rescue plan if the patient cannot be intubated. This will be in line with the DAS/OAA guidance on failed intubation.
- **A**ntacid given – if an antacid has not been given it will be appropriate to give it now, i.e.Sodium Citrate 30 ml 0.3 molar.
- Anticoagulant status must be checked to ensure that recent clexane has not been given/or that if it has contingency plans can be made.

B. Then the B checks are made:

- **B**lood – have blood results been checked? Is a valid Group and Save/X-match available and is cell saver warranted?
- **B**aby – is foetal monitoring applied? Has the neonatal team been called? Is the resuscitaire check complete?

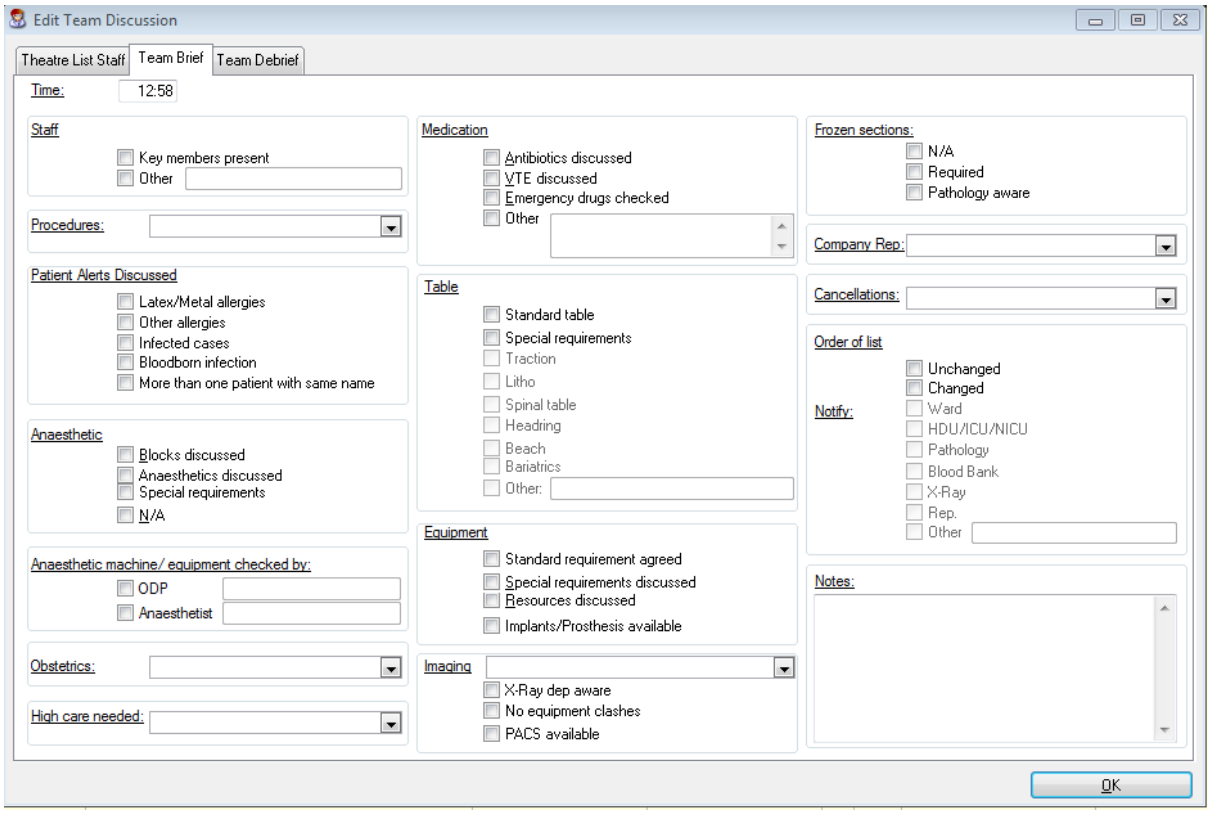
C. Then the C checks are made:

- The **C**atheter is checked, if a catheter has not been inserted yet a person is designated to insert a catheter prior to surgery.
- **C**lip – any FSE clip is removed if not already removed.
- **K**it – the scrub nurse is asked to confirm they have the appropriate kit and that it is sterile.
- **C**ord – the midwife confirms the cord samples required – in most cases cord gases will be required and depending on mothers blood group cord blood will be required for Rhesus testing.

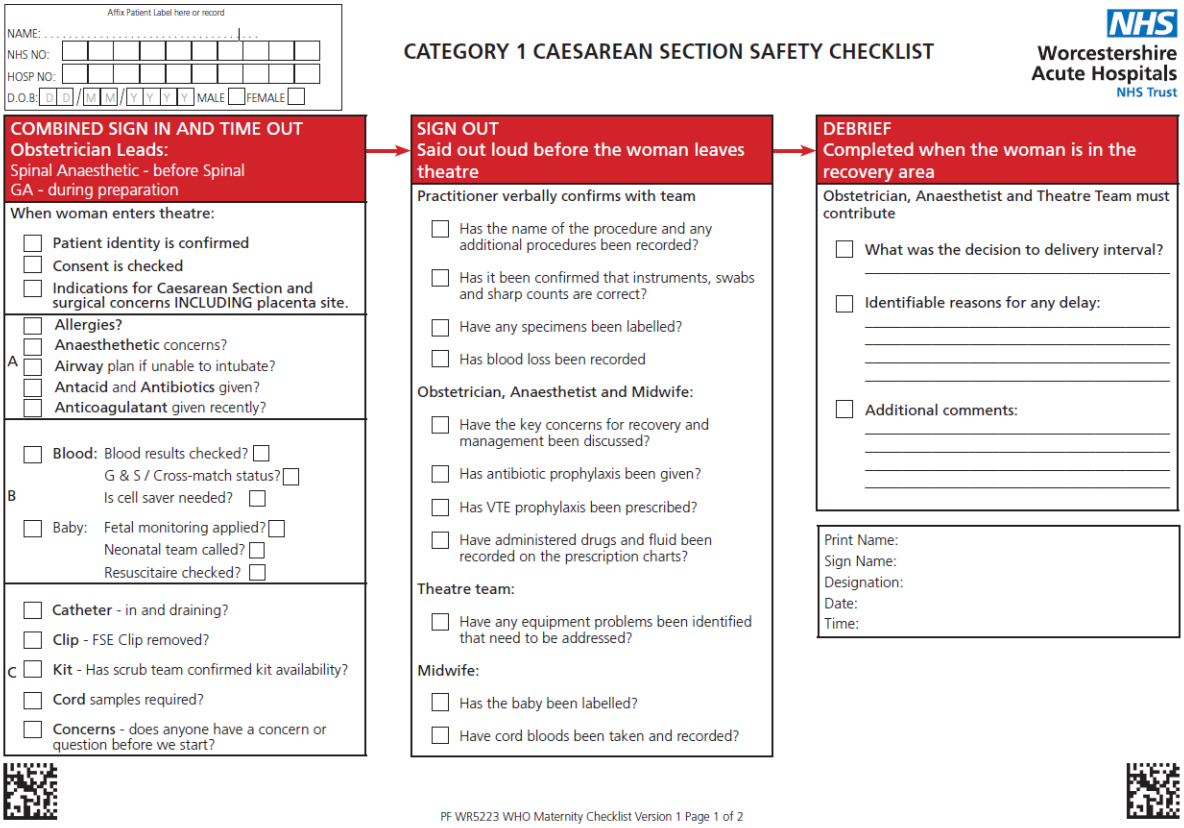
- **C**oncerns – an open question to the team inviting anyone to speak up if they have any concerns about the procedure or patient.

- On completion of these checks anaesthesia can commence and the procedure can be performed without the need for an additional Time Out.
- After the procedure the Sign Out is conducted in the usual way.
- Following the procedure the Obstetrician, Anaesthetist and Theatre Team should debrief. The decision to delivery interval time should be recorded. Any identifiable reasons for delay should be recorded and actioned when appropriate. This will serve as a useful audit tool and enable reflection and action to improve the service.

## Appendix 1. Blue Spier Team Brief Sheet



## Appendix 2. Category 1 Caesarean Section Safety Checklist



Affix Patient Label here or record

NAME: . . . . . |. . .
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

**CATEGORY 1 CAESAREAN SECTION SAFETY CHECKLIST**

NHS Worcestershire Acute Hospitals NHS Trust

**COMBINED SIGN IN AND TIME OUT**
**Obstetrician Leads:**
Spinal Anaesthetic - before Spinal
GA - during preparation

When woman enters theatre:

- ☐ Patient identity is confirmed
- ☐ Consent is checked
- ☐ Indications for Caesarean Section and surgical concerns INCLUDING placenta site.

A
- ☐ Allergies?
- ☐ Anaesthethetic concerns?
- ☐ Airway plan if unable to intubate?
- ☐ Antacid and Antibiotics given?
- ☐ Anticoagulatant given recently?

B
- ☐ Blood: Blood results checked? ☐ G & S / Cross-match status? ☐ Is cell saver needed? ☐
- ☐ Baby: Fetal monitoring applied? ☐ Neonatal team called? ☐ Resuscitaire checked? ☐

C
- ☐ Catheter - in and draining?
- ☐ Clip - FSE Clip removed?
- ☐ Kit - Has scrub team confirmed kit availability?
- ☐ Cord samples required?
- ☐ Concerns - does anyone have a concern or question before we start?

**SIGN OUT**
**Said out loud before the woman leaves theatre**

Practitioner verbally confirms with team

- ☐ Has the name of the procedure and any additional procedures been recorded?
- ☐ Has it been confirmed that instruments, swabs and sharp counts are correct?
- ☐ Have any specimens been labelled?
- ☐ Has blood loss been recorded

Obstetrician, Anaesthetist and Midwife:

- ☐ Have the key concerns for recovery and management been discussed?
- ☐ Has antibiotic prophylaxis been given?
- ☐ Has VTE prophylaxis been prescribed?
- ☐ Have administered drugs and fluid been recorded on the prescription charts?

Theatre team:

- ☐ Have any equipment problems been identified that need to be addressed?

Midwife:

- ☐ Has the baby been labelled?
- ☐ Have cord bloods been taken and recorded?

**DEBRIEF**
**Completed when the woman is in the recovery area**

Obstetrician, Anaesthetist and Theatre Team must contribute

- ☐ What was the decision to delivery interval? _____
- ☐ Identifiable reasons for any delay: _____ _____ _____ _____
- ☐ Additional comments: _____ _____ _____ _____

Print Name:
Sign Name:
Designation:
Date:
Time:

PF WR5223 WHO Maternity Checklist Version 1 Page 1 of 2

## Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

| Page/ Section of Key Document | Key control: | Checks to be carried out to confirm compliance with the policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe. | What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.) | Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'. | Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description? | Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference. | Use terms such as '10 times a year' instead of 'monthly'. |
| | Compliance with key consent and site marking standards | Regular reporting via Theatre dashboard | At TACCSS governance meetings | Theatre staff | Governance lead<br>Band 7 and Band 8 Theatre staff | 6 times per year |

## References

NatSSIPS 2. Team Brief. Published by Centre for Perioperative Care 2023. https://cpoc.org.uk/sites/cpoc/files/documents/2022-12/CPOC_NatSSIPs2_TeamBrief_2023.pdf

**Contribution List**

This key document has been circulated to the following individuals for consultation;

| Designation |
|---|
| Matthew Trotman Theatre Manager |
| Miss Lakshmi Thirumalaikumar Obstetric Consultant |
| Miss Hillman Cooper Obstetric Consultant |
| Jenny Martin Lead Midwife for Obstetric Theatre |

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

| Committee |
|---|
| TACCSS |

## Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | NA | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | NA | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | NA | |
| **7.** | **Can we reduce the impact by taking different action?** | NA | |

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval