**Bonnie**

**OR scenario**

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In this scenario, the first error identified is when the OR staff starts to tend to their normal duties during the end of the case. When the surgeon called out for an instrument to be used, none of the OR staff were available to hand it to him because the staff members were busy tending to other jobs. As this is a very complex case, staff members should have been more aware and alert of errors that could occur and develop safety preventions, since this is an open procedure that is prone to infections. Possibilities that could explain the lack of awareness and attentiveness could be due to a poor management system that allowed the surgical team to relax towards the end of the procedure.

The universal skill bundles would be most effective in this case as it includes practices of communication, attention, critical thinking skills, checklist and protocol use, and speaking up for safety. The attention portion of the bundle includes self-checking and bringing their focus and attention on performing the tasks at hand. Instead of thinking about other tasks and duties, it is important that the surgical staff members stay focused on their case in order to promote high quality and safety. Secondly, with the universal skill bundles, a checklist and protocol use would be most appropriate in this case because this allows for continuous guidance that are beneficial for complex cases. If a protocol was used and a checklist was followed throughout the entire procedure, it is possible that the malleable would not have been left in the patient and a more standardized process would have been followed. There was also a lack of communication between the surgical team assisting the case, as there was a miscommunication regarding the count of the instrument tools they used. The universal skill bundle can be most appropriately applied to this scenario.

The second error identified in this scenario is during the most critical portion of the case, during which multiple staff members were not involved in the procedure, walked into the OR to converse with the surgeon performing the closure, and distracting the surgeon with irrelevant messages and conversations. Unfortunately, with multiple irrelevant distractions going on, a malleable slipped into the abdominal cavity, which truly compromised patient safety! This procedure that started off on a good note, ultimately failed because of human errors and provided more harm than benefit to the patient. This surgical team failed to adhere to evidence-based approaches to safely operate on the patient without putting the patient at more risks. Developing a safety culture within the organization could prevent this event from occurring as this encourages everyone to speak up and follow the universal skills of cross-checking. The establishment of protocols consistent with leading practices, can prevent safety harms to the patient.

Both errors can be improved and prevented by utilizing high reliability bundles, which opens up a discussion that shapes the culture of safety and high reliability. Discussing how to decrease patient harm and restating the purpose, can promote a culture that revolves around patient safety.

**References:**

(4th ed.). Chicago, IL: Health Administration Press.*The healthcare quality book: vision, strategy, and tools*Nash, D. B., Joshi, M., Ransom, E. R., & Ransom, S. B. (2019).

**Response:**

The case scenario of OR is laden with the instances of mismanagement and nonchalant attitude of staff, which is perilous to the patient and totally against the perceived standards of healthcare. According to all research studies and theoretical frameworks of healthcare métier, it is evident that surgical care is an integral part of healthcare professionals, especially in operation room premises. Therefore, careful planning, periodic checks, managerial efficacy, and communicational standards are imperative. As a matter of fact, the operation room is an intricate setting and entices a myriad of risk factors, and in this context, only the fixtures are not essential, but also the demeanor of the staff and surgical personnel is critical. Slipshod behaviors of surgeons, anthologists, and other assisting staff are lethal because any erroneous information or gap in relevant instructions can create regretful complications and even can rob the patient’s chance to live. Safe surgeries standards should be implied to ensure the quality of work, augmented efficiency, and less accountability and mortality.

**Reference:**

Chowbey, P. (2019). Surgical Safety in Operation Theatres | *Facilities & Operations.*   
 https://www.asianhhm.com/facilities-operations/surgical-safety-operation-theatres

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**Kenzi**

**OR assignment**

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This week we spent a lot of time learning about the safety and HROs. I am a pharmacist, as some of you know, and a lot of errors in healthcare begin with improper orders entered by a physician or nurse for a physician. My job is to identify those errors and to ensure the safety of my patients. Communication is key when ensuring safety for patients. Healthy, non-confrontational communication has led me to be successful when questioning orders or making suggestions to providers. My organization has numerous policies in place to promote safety. It begins with the changing of culture in a facility and quite honestly, it is really important for someone to say something if they see something that may impede patient safety.

In this case, I was able to identify numerous errors. The two that stuck out the most to me were the surgeon taking the malleable without notifying other staff and the fact that the surgeon called out for the instrument and none of the support staff responded. I also thought it was interesting to use two teams to perform a surgery. Whether this was necessary or not, it causes chaos in an environment where chaos can cause massive problems for patient safety. In my opinion, you may need other experts involved but why not just perform the surgery together to reduce confusion? Additionally, the OR student thought he recalled the surgeon requesting a malleable but assumed that it wasn’t used. This is a perfect example of when someone who is concerned for patient safety should speak up. The idea is not to get anyone in trouble but to really ensure that we are providing the best care and safety to the patient. Ultimately, we are all here working toward a common goal.

**Response:**

It is an agreeable proposition that healthcare is more prone to erroneous practices, and such flaws are more fragile because of the nature of services healthcare provides. In this regard, people have to comprehend the contemporary archetype in dealing with medical organizations and have to implement organizational and managerial theories and standards on a competitive and updated level. The recent era of extensive research has equipped all spheres of life with numerous tools and models to elevate the operational and functional efficiency of allocated tasks. Healthcare management requires devising strict standards and communicational sessions to mitigate probable misunderstanding or communicational gaps during surgeries. In many cases, the subordinates hesitate in delivering their ideas or suggestions, which can pose severe consequences, and therefore all the staff on all the levels should be festooned with rigorous training to deal with such circumstances smartly. All the surgical staff should be mutually agreed on a similar objective that they have to save the life of the patient, and in due course, they will be allowed to take the most pragmatic and cautious initiatives without hesitation. General patient’s safety guidelines are necessary to be adapted and religiously followed by all surgical staff to avoid the situations as the OR case scenario. Bottom of Form

**References**

Kim, F., da Silva, R., & Nogueira, L. (2015). Current issues in patient safety in surgery: a   
 review. *Patient Safety In Surgery*, *9*(1). doi: 10.1186/s13037-015-0067-4