Top Ten Things To Know
Patient Safety in the Cardiac OR: Human Factors and Teamwork

1. Of the roughly 350,000 to 500,000 patients who undergo cardiac surgery each year, about 8% will have an adverse event.

2. Preventable errors are most often due to mistakes in nontechnical skills such as communication, cooperation, coordination, teamwork and leadership.

3. Communication skills are a key aspect in successful teamwork in the OR.

4. Elements of successful teamwork are described by the 6 “C’s”: communication, cooperation, coordination, cognition, conflict resolution, and coaching.

5. Teamwork-training efforts, requiring repetition and ongoing coaching, can aid in reducing errors in the OR.

6. Check-lists, preoperative briefings and postoperative debriefings can also aid in reducing errors and improving outcomes.

7. Standard briefings can help minimize distractions and flow disruptions, optimize team performance, and may reduce patient complications.

8. Scenario training can successfully assess and train surgical staff in nontechnical skills and integration of those skills with already known technical skills.

9. Interventions designed to improve quality of care when cardiac patients transfer between surgical teams can improve information being omitted or misinterpreted.

10. Creating a culture and physical environment of safety will ultimately lead to greater patient satisfaction and clinical outcomes.


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