*Do you feel as though the facility you work at utilizes interdisciplinary teamwork? If so, does it help provide better patient-centered care?*

In my current practice setting at Providence Alaska Medical Center surgery department we have several common procedures which are examples of interdisciplinary care. One example of interdisciplinary care is the Transaortic Valve Replacement (TAVR) procedure in which the interventional cardiologist cardiac surgeon and anesthesia work together to provide patient care during the procedure. They are unable to provide care for the patient without collaboration with radiology, nursing, and supply vendor representation. The entire team meets the morning of the procedure in TAVR conference to coordinate the cases for the day. They review the diagnostic tests and discuss the needs of each particular patient related to each speciality. The interventional cardiologist and the cardiac surgeon discuss the approach and concerns with access. They discuss the implant need and sizing with the product representatives to ensure the correct product is available. Anesthesiologists discuss the best anesthesia approach with the interventional cardiologist and cardiac surgeon. Nursing is present to discuss the positioning and skin prep concerns. Radiology is present to determine if there are concerns related to visualization on c-arm such as body weight. The collaborative approach to care coordination is where each person works in conjunction with the other professionals and not just working independently with communication of care provided. All of these professionals working together in such an interdisciplinary manner provide better patient-centered care.

Finkelman, A. W., & Kenner, C. (2016). Provide patient-centered care. In A. Martin, R. Myrick, & S. Bayle (Eds.), *Professional nursing concepts: Competencies for quality leadership* (3rd ed., p. 310-311). Burlington, MA: Jones and Bartlett.

*Have you, as a nurse or patient, ever experienced an error due to miscommunication in team members and how do you think it could have been prevented?*

Sadly as a manager I have experienced a break down in the communication process related to timeout and patient consent. The surgeon had consented the patient for a cubital tunnel release with ulnar nerve transposition. The procedure performed was a carpal tunnel release with ulnar nerve transposition. The patient phoned several days later when the bandage was removed to question the incision at the wrist. During the Root Cause Analysis it was determined that though the timeout was performed it was not done according to Universal Protocol (Watson, 2009) recommendations or policy. The consent was not read from nor was the activity stopped. The scrub tech did question the carpal tunnel procedure that was not on the schedule. The response from the surgeon was “It’s on my consent.” so the scrub tech did not question it further. The wrong site surgery could have been prevented if the time process was followed correctly. It also would have been prevented if the scrub tech would have used their Caring Reliably tools of CUS (I have a concern, I am uncomfortable with, and stop the line), and verify/validate. They are empowered to drive safety by utilizing the tools and escalating the situation up the chain of command.

Watson, D. S. (2009, August 1). Implementing the Universal Protocol. *AORN Journal*, 90 (2), 283. DOI: http://701-ezproxy2.bismarck.lib.nd.us:2114/10.1016/j.aorn.2009.07.019

*What sort of communication techniques do you use or see being used in practice to hand-off patient care?*

Providence Alaska Medical Center has officially adopted the SBAR (situation, background, assessment and recommendation) format of communication. It is a clear, concise and easily used method of communication. It is such a versatile method of communication that SBAR is to be used for all communication even if not related to patient care. SBAR is designed to get an action that is required or desired related to the situation. If I am to justify the purchase of capital equipment, I am to write an SBAR communication related to the equipment need. The need is clearly defined and justified by the background and assessment portion of the method. Even though PAMC has adopted the SBAR for communication, the operating room continues to be unique. The operating room has used checklists for safety for the entire 30 years I have been practicing OR nursing. We have numerous checklists such as preoperative, timeout, count, intraoperative, and post-operative. The checklist style of communication has been a standard in task-oriented high risk care settings. The airline industry had proven the checklist to be an effective way to communicate all safety tasks have been completed. In the operating room we have numerous safety requirements which must be completed in order to prevent patient harm. Utilizing a form of communication found to effective by an industry that also prevents harm to people was a natural progression.

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