Appendix C: Surgical Specialty Case Analysis Tool

WERE THERE ISSUES RELATED TO:

Pre-OP → **Intra-OP** → **Post-OP**

1. Communication/care prior to surgical consult
2. Diagnosis
3. Staging investigations
4. Evaluation of fitness for surgery
5. Consultation
6. Other patient factors
7. Timing/prioritizing surgery
8. Other

1. Protocols/Checklists
2. Choice of surgical approach
3. OR leadership
4. Teamwork
5. Work environment (assistants/timing)
6. Equipment
7. Other

1. Post-op orders/pathways
2. Communication with ICU/PACU
3. Communication within surgical team
4. Communication with consultants
5. Identification/diagnosis:
    a. Recognition of adverse event
    b. Treatment of adverse event
6. Discharge instructions
7. Appropriateness of follow-up care
8. Other

For each area selected above, were there COGNITIVE and/or SYSTEM issues?

Pre-op	Definitions
1. Communication/care prior to surgical consult	- Includes referral from primary care physician and any specialist care prior to receiving consult
2. Diagnosis	- Includes cognitive issues such as anchoring on a simpler rather than a complex diagnosis (**Anchoring**: the tendency to perceptually lock on to salient features in the patient's initial presentation too early in the diagnostic process and failing to adjust this initial impression in the light of later information) - Includes a system issue such as delay in diagnostic imaging
3. Staging investigations	- Includes both cognitive and system issues where appropriate investigations may have been omitted
4. Evaluation of fitness for surgery	- Includes omission bias which may have led to incomplete information - Includes clarity of written communication
5. Consultation	- e.g. anesthesiology, cardiology etc. - Includes lack of appropriate consultation (system or cognitive issues) - Includes conflicting opinions potentially due to system related communication issues or teamwork failure - e.g of a cognitive issue: **Bandwagon** effect: the tendency for people to believe and do certain things because many others are doing so.
6. Other patient factors	- Includes patient's personality or potentially psychiatric diagnoses which may lead to affective bias (counter-transference) among health care provider/team.
7. Timing/prioritizing surgery	- Includes system issues which may have led to delays
8. Other	

Intra-Op	Definitions
1. Protocols/Checklists	- E.g. surgical checklists, sponge counts, antibiotic administration, etc. - Includes failure of an existing protocol to achieve objectives in a given case - Includes the identification of an opportunity to standardize care
2. Choice of surgical approach	- Includes cognitive biases which may have led to a given decision as well as other factors such as fatigue, personal impairment - Includes system issues if there was a lack of availability of equipment to perform a given preferred approach
3. OR leadership	- Was situational awareness maintained (did the leader know what was going on around them at all critical points or were they fixated on a task)? - Was decision making clear to all team members? - Was communication effective with team members?
4. Teamwork	- Consider all members of the team – was situational awareness maintained? (i.e. did all team members know what was going on around them at various critical points) - Were there any communication barriers within the team – could be related to personality conflicts or fatigue or team dynamics or response to stress
5. Work environment (assistants/timing)	- e.g. late night, post-call residents etc. - Includes fatigue of providers - Includes availability of personnel - Includes heating/cooling issues of room
6. Equipment	- Includes access/functioning/trouble-shooting of equipment
7. Other	

Post-Op	Definitions
1. Post-op orders/pathways	- Includes clarity of orders, errors of omission - Includes opportunities identified for standardization of care - Includes failure of existing protocols/pathways to achieve objectives
2. Communication with ICU/PACU	- Includes cognitive issues related to teamwork communication - Includes oral and written communication
3. Communication within surgical team	- Includes availability and responsiveness of team - Includes oral and written communication - Includes teamwork failure in communication
4. Communication with consultants	- Includes oral and written communication - Includes conflict management - Includes teamwork failure in communication
8. Identification/diagnosis: a. Recognition of adverse event 5. Treatment of adverse event	- a. Recognition of Adverse Events: o Includes appropriate identification of adverse outcome related to healthcare provided rather than progression of disease o Includes disclosure of adverse event to patient and/or family - b. Treatment of Adverse Events o Includes appropriate mitigation of harm once adverse event identified o Includes appropriate communication with team members involved and discussion of methods to prevent recurrence
6. Discharge instructions	- Includes errors of omission - Includes affective bias if patient factors influence communication - Includes written and oral communication
7. Appropriateness of follow-up care	- e.g. physio, social work etc. - Includes system issues such as access to primary care and specialist care - Includes system issues such as efficiency of booking - Includes communication issues with patients and/or family
8. Other	