A Guide to Leading Successful Perioperative Teams

AHRQ Safety Program for Improving Surgical Care and Recovery

**Purpose of the tool:** Assembling a multidisciplinary perioperative team is one of the first, and most critical, steps in your AHRQ Safety Program for Improving Surgical Care and Recovery (ISCR) journey. This document presents 24 critical behaviors for leading successful perioperative teams as well as practical tips on how to enact these behaviors in your organization. The behaviors are organized into six domains:

1. Assembling a team
2. Managing a team
3. Sustaining team collaboration
4. Providing training and feedback
5. Expanding team boundaries
6. Ensuring Access

The information in this document is based on results from a Delphi panel (i.e., a method for eliciting broad input from experts and generating consensus), conducted between October 2018 and March 2019 with 14 recognized experts (listed in Appendix) in researching, managing, or participating in project teams working to improve perioperative care.

**How to use the tool:** Hospital leadership (e.g., ISCR project leads, clinical champions) should review the recommended strategies and come to a consensus about which ones to prioritize. The following tables present the behaviors (column 1) that more than 50 percent of the Delphi experts rated as critical (i.e., “Must Do”) for supporting perioperative improvement teams. They also include examples of how to incorporate these behaviors into day-to-day practice (column 2).

Domain 1: Assembling a Team

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Develop and articulate a clear team mission | All need to know WHERE the desired destination is and to feel motivated to get there.  |
| Set explicit objectives | Set clear, specific goals around WHAT to do by WHEN.  |
| Clarify roles  | Ensure that team members know WHO is doing WHAT. |
| Involve key stakeholders and roles | Include as core team members those directly involved and those affected (e.g., patients) by the implementation. |
| Select complementary team members  | List desired roles, responsibilities, and skills (e.g., content experts, data experts), and recruit expertise that is missing. |
| Make room for flexibility  | Prepare team members to support each other. Roles should not be so rigid that they sacrifice wisdom for compliance. |

Domain 2: Managing a Team

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Collaborate using evidence | Encourage input from all team members to develop the best possible approach to the work. |
| Provide program leadership support  | Ensure that the team has the support of a program leader, or co-leaders, (other than busy clinicians) to enable success. |
| Set stretch goals | Set challenging but realistic SMART goals (Specific, Measurable, Attainable, Relevant, and Timely). |
| Defer to expertise | Seek opinions from those “in the trenches” who are doing the work. |

Domain 3: Sustaining Team Collaboration

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Give them a voice | Create a culture of empowerment. Stress that all opinions, positive and negative, will be heard without being judged. |
| Communicate the data | Begin team meetings by collectively reviewing the available performance data. Regularly report data to frontline staff via managers and department leads. |
| Lead by example | Do the work to show commitment and to motivate others. |
| Promote team learning | Create a nonjudgmental learning environment in which collaboration and continuous improvement are rewarded.  |
| Make decisions as a team | Invite ideas from a broad spectrum of stakeholders. Then work together to reach a consensus on the path forward. |

Domain 4: Providing Training and Feedback

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Respect and value each team member | Treating all team member opinions equally is essential and will build confidence and buy-in from the team. |
| Listen and ask good questions | Pause, listen, then offer thoughts. Ask open-ended questions, inviting input. Give everyone time to speak at meetings. |
| Create a space for ownership of the work | Have team members present their own work. Develop goals and timelines together as a team, not as a top-down approach. |
| Have a structured approach to learning | Plan forward, reflect back, and act on the learning. Periodically assess team strengths, weaknesses, opportunities, and threats. |
| Appreciate a good failure | Implementations often start and stall. When planning next steps, it is vital to learn from what did and did not work.  |
| Respond with encouragement  | Be aware of “initiative fatigue.” Make all team members feel that their contributions are important. |

Domain 5: Expanding Team Boundaries

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Publicize the value of the team’s work  | Describe program benefits to other groups in the institution and articulate how this program can benefit them. Report accomplishments at all department/quality meetings. |
| Obtain senior leadership buy-in | Meet with executives at least quarterly and during budget planning to maintain program support. Regularly email program updates to executives to keep them engaged and appraised of barriers, successes, and new opportunities.  |

Domain 6: Ensuring Access

| Behaviors | Examples of How To Incorporate Behaviors Into Practice |
| --- | --- |
| Facilitate access to data | Ask the team members what data they need to do their work and then ensure they have access to it. |

Domain Behaviors: Three Case Studies

Three case studies are provided to give you examples of how domain behaviors have been put into practice. Each case study highlights one behavior, but leading successful teams requires a combination of many behaviors to meet the needs of the team and the situation.

Domain 2 Example: Set Stretch Goals[[1]](#footnote-1)

 A critical behavior to manage high-performing teams is to set goals that are both challenging to reach but realistic to achieve. One approach is to set SMART goals that are Specific, Measurable, Attainable, Relevant, and Timebound.

Dr. Elizabeth Wick, a colorectal surgeon, found that setting SMART goals could help hold the entire team accountable for working to improve process measure compliance. For example, her team decided to increase the percentage of patients prescribed multimodal analgesic agents that target multiple pain pathways to reduce the use of opioids for pain management after surgery. They created a SMART goal that was specific by explicitly encouraging the use of nonsteroidal anti-inflammatory drugs (NSAIDs) in colorectal surgery. The goal was measurable because the team agreed on a target of 80 percent, recognizing that some patients should not receive NSAIDS because of contraindications. Setting an 80 percent target rather than 100 percent also made the goal attainable as it was aspirational but practical. Importantly, the goal was relevant because the implementation team and the surgeons agreed via consensus that postsurgical multimodal analgesia was a priority. Lastly, the team gave itself several months to achieve the goal, making the goal timebound.

Dr. Wick’s team engaged all of the providers in achieving this goal and shared monthly reports on compliance. As the team worked toward the 80 percent goal, team members gained a better understanding of appropriate prescribing and realized their goal should be bumped up to 90 percent. The team consistently worked to keep everyone on the same page about what NSAID and dosage it wanted to use and which patients should not receive NSAIDs. The team also looked at the data periodically to keep accountable for reaching the 90 percent goal. Reflecting on this effort, Dr. Wick attributes the team’s success to its efforts to engage surgeons on reaching consensus on what was appropriate NSAID use and the appropriate target goal.

In summary, setting SMART goals will help your team focus its efforts, increasing your team’s chance of making progress and maintaining momentum in the face of competing demands.

Domain 3 Example: Give Them a Voice[[2]](#footnote-2)

A critical behavior to sustain high-performing teams is to give team members a voice. The goal here is to set the expectation that both positive and negative opinions are valued.



One way to invite the voices of team members is to broaden the discussion during a meeting by asking questions such as, “What do others think?”, “What are we missing?”, or “What other options could we consider?” For example, Deb Hobson, a safety and quality improvement nurse at The Johns Hopkins Hospital, found that asking these questions got more than a yes or no answer. Team members opened up and talked about their current workflow and what works best. They also identified potential and current barriers to using ISCR.

Another way to invite the voices of team members is to deepen the discussion by asking, “What leads you to think so?” or “Do you have any concerns about this?” For example, Deb Hobson identified a barrier in the workflow for post anesthesia care unit (PACU) nurses by asking about their concerns around decreasing patients’ narcotic use right after they left the operating room. She found that nurses were not starting patients on patient-controlled epidural analgesia (PCEA) pumps with narcotics because bupivacaine was not available without fentanyl in the automated medication-dispensing machine. Nurses had to order bupivacaine-only bags from the pharmacy, and this took several hours for delivery. After discovering this barrier, the ISCR team made sure that premixed bupivacaine bags were stocked in the PACU automated medication-dispensing machines so nurses could connect patients to PCEA pumps as soon as they came out of the operating room.

In summary, by asking questions that both broaden and deepen the discussion, you can help support a team culture that empowers members to speak up, and in turn, arrive at more informed team decisions.

Domain 4 Example: Have a Structured Approach to Learning[[3]](#footnote-3)

A critical behavior to facilitate training and feedback is to have a structured approach to learning. It is important for your team to hardwire time for reflection, and not save debriefings for a crisis or a rare moment of peace.



One way to hardwire reflection is by periodically reviewing the team’s strengths, weaknesses, opportunities, and threats (called a SWOT analysis). For example, the team could use a whiteboard displayed in a common space, and every member of the team could contribute their perceptions to the team’s SWOT.

As an example of an innovative way to support a structured approach to learning, Dr. Elizabeth Lancaster, a general surgery resident at the University of California, San Francisco, designed an interactive curriculum to help reduce opioid overprescribing after common general surgery operations. This curriculum has feedback reports for current prescribing patterns, highlighting strengths and areas for improvement. It also describes current best practices, summarizing the existing literature into clear and attainable goals. Finally, it has a forum to discuss concerns and anticipated challenges. Through this work, Dr. Lancaster found that a formal learning approach centered on evaluating current and best practices is a reliable way to achieve results.

In addition to reflection, it is imperative that your ISCR project team has commitment and resources from leaders who can act on what is learned. This approach will require an infrastructure to manage the work and give feedback to team members. If people feel things are not improving, they will become discouraged, and this can be worse than not debriefing at all.

In summary, through building a structured approach to learning, you will have a systematic way to reflect back and plan forward.

Appendix: ISCR Delphi Panel Members

| Name | Institution/Location | Role | Experience |
| --- | --- | --- | --- |
| Samantha R. Silverstein, M.S.N., B.S.N., R.N., CNOR, CPHQ | White Plains HospitalWhite Plains, NY | Assistant Director of Surgical Quality | ISCR project leadIdentifies opportunities for improvement and works closely with teams to develop programs to improve surgical outcomesLeads ERAS implementation and expansion teamExperienced with Lean Six Sigma & Performance Improvement  |
| Donna Frazier, R.N., M.P.H., CIC | Saint Francis Health SystemTulsa, OK | System Manager for Infection Control and Prevention | ISCR Project Lead for two service lines32 years of experience in infection control and prevention |
| Donna Swartz, M.A.S., R.N., CPHQ, CPPS | Hackensack Meridian Health Hackensack, NJ | Improvement Advisor, Department of Patient Safety and Quality | ISCR Project Lead |
| Amy Matthis, B.S., M.S.H.A./M.B.A., FACHE, CPHQ | West Tennessee HealthcareJackson, TN | Quality Outcomes Director | ISCR Project Lead for two service lines |
| Martin G. Paul, M.D., FACS | Sibley Memorial HospitalJohns Hopkins MedicineWashington, DC | Regional Director of Minimally Invasive SurgeryAssistant Professor of Surgery, Division of Surgical Oncology | NSQIP Surgeon Champion at Sibley Memorial HospitalChairman, Department of Surgery, Sibley Memorial Hospital 2008–2016 Surgical Quality Forum, Johns Hopkins MedicineCo-Lead, Surgical Clinical Community, Johns Hopkins Health System – focusing on systemwide initiatives to improve patient safety and outcomes |
| Marilyn Kole, M.D., M.B.A. | Lee HealthFort Myers, FL | Vice President, Clinical Transformation and Infection Control Part-time Critical Care Physician | Current work involves continuous clinical QI, hospital-acquired conditions, and physician engagement, and leads physician-led, evidence-based practice council and workgroups for the system  |
| Toni Beninato, M.D., M.S.  | New York-Presbyterian Brooklyn Methodist HospitalBrooklyn, NY | Practicing Endocrine SurgeonAssistant Attending Surgeon, New York Presbyterian HospitalAssistant Professor of Surgery, Weill Cornell Medical College | Director of Surgical Quality and OutcomesNSQIP Surgeon Champion |
| Alex B. Haynes, M.D., M.P.H., FACS | University of Texas at Austin Dell Medical School Austin, TX | Associate Chair for Investigation and DiscoveryAssociate Professor of Surgery and Perioperative Care | Research experience focusing on development and implementation of tools to improve patient safety and outcomes at scale |
| Della Lin, M.D., M.S., FASA | Anesthesia Patient Safety FoundationHonolulu, HI | Board of Directors, APSFPracticing AnesthesiologistVisiting Faculty, JHU Armstrong InstituteHawaii State Lead and Improvement Coach for Safety Collaboratives | AHA-NPSF Patient Safety Leadership Fellow 2002Physician Leadership, Surgical Team High Reliability coach, Hawaii Safer Care convener and improvement coach since 2009 |
| Michael Englesbe, M.D., FACS | University of Michigan HealthAnn Arbor, MI | Professor of Surgery, Section of Transplantation | Director, Michigan Surgical Quality CollaborativeDirector, Michigan Opioid Prescribing and Engagement NetworkDirector, Michigan Surgical Home and Optimization Program |
| Derrick Lee, M.D. | Kaiser Permanente – Northern CaliforniaSan Leandro, CA | Enhanced Recovery Clinical LeadPracticing Anesthesiologist | Clinical Lead, Enhanced Recovery Program, Kaiser Permanente – Northern CaliforniaPhysician ERAS Lead, Kaiser Permanente – San Leandro and Fremont Medical CentersAssociate Chief of Quality, Kaiser Permanente – San Leandro and Fremont Medical CentersAnesthesiologist, The Permanente Medical Group |
| J. Michael Henderson, M.B., Ch.B., FRCSEd, FACS  | University of Mississippi Medical Center Jackson, MS | Chief Medical Officer, Professor of Surgery | Founding Member of the Global Patient Safety ForumChaired the NSQIP Advisory Committee Served on WHO Leaders Guide on Patient Safety and Quality of Care in Service Delivery |
| Sara Naomi Goldhaber-Fiebert, M.D. | Stanford University School of MedicineStanford, CA | Clinical Professor of Anesthesiology | Clinically active anesthesiologistSimulation teaching including multidisciplinary teams and train the trainerQuality improvement leadershipImplementation science research |
| Michael Leonard, M.D. | Safe and Reliable HealthcareEvergreen, CO | Co-founder and Managing Partner Practicing Cardiac Anesthesiologist | Experienced with providing frameworks and tools to enhance the delivery of safe and reliable healthcare  |

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1. Behavior linked to Domain 2 [↑](#footnote-ref-1)
2. Behavior linked to Domain 3 [↑](#footnote-ref-2)
3. Behavior linked to Domain 4 [↑](#footnote-ref-3)