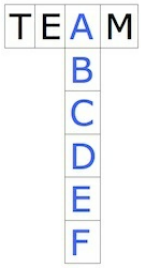
ICU
MANAGEMENT & PRACTICE

Teamwork Checklist As Simple as ABCs



Team confidence, cohesion, empathy and esprit de corps as well as patient safety may be improved by using a simple checklist, according to a letter published in the Journal of Critical Care. Lead author, Peter Brindley, from the University of Alberta Hospital, Edmonton, Canada, with colleagues from St. Michael's Hospital, Toronto, introduces an easy-to-remember checklist designed to provide structure during crisis scenarios. While the checklist is not yet supported by empiric data, it includes familiar elements and has been well received in their own institutions across different specialities, professions, seniority and crisis scenarios, they write.

The checklist has just 6 parts, half to strengthen the team from the inside, the other half to strengthen the team from the outside.

Strengthen the Clinical Team from the inside - the ABC

"A":

- **Assemble** the team
- **Assign** responsibilities
- **Assess** (personnel and equipment are present or easily accessible)

"B":

- **Brief**
- **Backups**
- **Be proactive**

"C":

- **Close the loop** (confirm that instructions are heard, understood, and done)
- **Call-outs** (alert the team to dangers and encourage collective vigilance)
- **Captain Co-lead** (both pre-emptively appointed in case mini-teams are assembled for complex cases, e.g. intubation team, central line team. Captains are usually a doctor, co-leaders are usually a nurse.

See Also: Study: Intensive Care Quick Reference Checklist Manual

Strengthen the Clinical Team from the Outside - the DEFs

The wider team enhances patient safety, according to the writers.

"D":

- **Debrief & Defuse** (Immediate debriefing can defuse team tension, and should include compliments for what went well as well as recommendations)

"E":

- **Education & Evaluation** (encourage perpetual improvement and evaluation, identify education gaps)

"F":

- **Follow up & Feedback**

Brindley et al. note: “Latent errors and systemic barriers may require change at a level not accessible to frontline clinicians.” Administrators have a follow-up role, they suggest and they remind physicians to engage administrators as partners. At the same time, administrators should seek clinician feedback.

They conclude: “We believe that ‘safety is no accident’: it requires deliberate preparation, familiar structure, open communication, and collective action. Every team member should benefit, especially the patient.“

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