



## THE IMPACT OF DRUG SHORTAGES ON PATIENT CARE ACROSS HEALTHCARE DISCIPLINES

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### ABSTRACT

**Background:** The use of multidisciplinary teams within hospital settings restricts the occurrence of adverse events (AE), improves results, and contributes to the happiness of both patients and employees. **Aim of Work:** This study aims to delineate the roles and responsibilities of pharmacists in ensuring optimal pharmaceutical outcomes during care transitions, addressing barriers to effective transitions and highlighting populations at risk for ADEs. **Methods:** Efficient and coordinated, multidisciplinary in-hospital teams consist of personnel from many levels of the treatment hierarchy, such as nurses' aides, surgical technicians, nurses, anesthesiologists, attending doctors, and others. Their improved collaboration mitigates the negative impact of isolated working environments by promoting effective communication among healthcare professionals at all levels. As a result, it decreases adverse events such as illness or death, while simultaneously raising patient and healthcare worker contentment. **Results:** Several publications from different fields include various notions of "teamwork" for personnel working in emergency rooms (ERs), hospital wards, intensive care units (ICUs), and most importantly, operating rooms (ORs). Enhanced collaboration among healthcare professionals at all levels resulted in enhanced communication, less negative incidents, better patient outcomes, shorter hospital stays, and increased satisfaction among both patients and staff. **Conclusion:** In hospitals, providing optimal medical and surgical treatment is a collaborative effort. The objectives include enhancing patient safety by minimizing adverse events, improving patient happiness, reducing the length of hospital stays, and enhancing the quality of results. Additional advantages include enhancing the efficiency of healthcare professionals, diminishing hospital expenses and problems, and augmenting job contentment. This review serves as a reminder to hospital administrators about the crucial importance of maintaining multidisciplinary teams. By doing so, hospitals can ensure the smooth functioning of their operations, leading to improved quality and safety of patient care. Additionally, this practice allows staff members to optimize their performance and enhance their job satisfaction.

**KEYWORDS:** *Enhanced results, Healthcare, Interdisciplinary methods, Patient well-being, Healthcare excellence, Spinal procedures, Surgical interventions, Collaboration.*

### INTRODUCTION

Hospital-based multidisciplinary teams often consist of several levels of staff members, such as aides, nurses, physician assistants, physical therapists, social workers, anesthesiologists, and attending doctors, who collaborate on patient care. These "teams" routinely outperform randomly allocating professionals to the emergency department (ER), the floors, the Intensive Care Unit (ICU), the operating room (OR), or other areas. These teams, functioning as efficient and coordinated entities, mitigate the negative effects of silo or halo mentality (e.g. the belief that one is too important due to a certain

attribute), dismantle communication obstacles among experts, and enhance collaboration among all professionals. By using cohesive teams, the occurrence of adverse events (AE) such as morbidity or mortality is minimized, leading to improved patient outcomes, reduced patient length of stay (LOS), and increased patient satisfaction. Additional advantages for the "staff" include enhanced work performance, less adverse events/complications, lowered expenses, and heightened job satisfaction. Simultaneously, both the "staff" and hospitals profit from the increased retention of experienced professionals. We must maintain

collaboration with our hospital administrators to guarantee the cohesion of these "multidisciplinary teams" for the overall benefit of the patient, staff, and institution.

### **The role of teamwork in respiratory care**

The respiratory team provided consistent treatment regardless of whether a junior or senior resident is assigned to the service. Tsai *et al.* investigated whether there was a difference in the quality of care provided by junior and senior medical residents in a respiratory care center (RCC). The RCC had a well-established team in place, which included attending physicians, a nurse practitioner, a case manager, a dietitian, a pharmacist, a social worker, registered respiratory therapists, and nursing staff. The team followed a standardized "weaning protocol". This 7-year retrospective research examined the performance of two medical residents, one at a junior level and the other at a senior level, who had received training in the intensive care unit (ICU). The study investigated several outcomes, including the monthly rate at which patients were successfully weaned off ventilators, the death rate, the average number of days patients spent on ventilators, the frequency of readmissions to the ICU, and the occurrence of hospital-acquired infections. Remarkably, there were no substantial disparities seen across any of these rates and the levels of training (e.g. junior vs. senior) of the residents in the ICU. Essentially, the presence of a well-established team and routine resulted in no rise in negative outcomes, regardless of the amount of training of the on-call residents.

### **Staff training effect on patients who are receiving mechanical ventilation**

Bloos *et al.* conducted a study to determine if training staff in pre-defined interventions, known as a "ventilator bundle," would enhance the quality of care for mechanically ventilated patients. The study took place in a 50-bed ICU and involved implementing a bundle that included specific interventions such as semi-recumbent positioning, lung protective ventilation for patients with acute lung injury (ALI), ulcer prophylaxis for hospital-acquired pressure ulcers (HAPUs), and deep vein thrombosis prophylaxis (DVTP). Prior to and during the training of the personnel, all aspects were assessed in order to provide care for postoperative patients who required mechanical breathing for at least 24 hours. Before staff training, there were 133 patients under their care, whereas after staff training, the number of patients being cared for increased to 141. During the trial, the overall "bundle adherence" or the extent to which participants followed the essential criteria for patient care, improved from 15% to 33.8% ( $P < 0.001$ ). This increase was seen in the following specific areas: semi-recumbent posture (from 24.9% before to 46.9% after), deep venous thrombosis prevention (from 89.5% to 91.5%), and ulcer prophylaxis (above 90% in both groups). Moreover, the duration of ventilator use decreased from 6 days to 4 days. While the mortality rate and incidence of ventilator-associated pneumonia (VAP)

in the ICU did not change, the median length of stay in the ICU was decreased by 9 days. The authors determined that staff training conducted by an ICU change team resulted in enhanced adherence to a pre-established ventilator bundle.

### **The role of nursing teamwork in the prevention of psychiatric disorders**

The role of nursing in the identification and prevention of ICU psychosis is crucial. ICU psychosis is not an illness, but rather a complication or failure in the nursing therapy. The author of the study questioned whether ICU psychosis should be considered a treatment failure rather than a disease. The focus was on how improved nursing care could prevent this complication in the future. The study highlighted that ICU psychosis does not affect all patients, but many are susceptible to hypoactive, hyperactive, or mixed delirium. The study emphasized prevention strategies such as reducing medications that contribute to psychosis, providing appropriate psychiatric treatment, and managing physiological conditions that can lead to psychosis. The author's main focus was on the various adverse events (AE) that occur after the onset of delirium. These include increased morbidity and mortality rates, longer length of stay (LOS) in hospitals, decreased level of functioning, higher rates of nursing home referrals, and a greater occurrence of post-discharge "stress response syndromes." The author emphasized the crucial role that effective nursing can play in preventing delirium by implementing specific protocols and methodologies. This includes carefully monitoring and selecting medications and dosages, as well as closely monitoring and identifying any potential side effects.

Undoubtedly, it is important for ICU medical professionals, including physicians, nurses, and other staff, to acknowledge and address the occurrence of "ICU psychosis" in elderly individuals. This condition arises due to factors such as the absence of medication, the unfamiliar ICU environment, the disruption of their daily lives by unfamiliar individuals, and the fear of the unknown. These factors can significantly contribute to a person's mental instability (personal communication, James I. Ausman, MD). To effectively address this kind of psychosis, it is necessary to provide guidance and understanding from staff members who are often burdened with excessive workloads and insufficient training. Additionally, support from family members and the presence of psychiatrists and social workers should be readily accessible. It is also important to encourage early mobilization and release to home.

### **The advantages of fostering a "Team" Mentality and Positive attitudes among nurses working in acute psychiatric units**

Koivunen *et al.* conducted a study to assess the influence of team climate and attitudes towards information and communication technology (ICT) on the working environment of nurses and staff in acute psychiatric

wards. They used a modified version of the Team Climate Inventory, specifically designed for Finnish participants, and administered it to nursing staff working on nine acute psychiatric wards. This survey consisted of 28 significant inquiries that spanned from question #1: The team's communication is normally transparent to question #28: Adequate acknowledgement is provided for a task executed excellently. Subsequently, it presents an intricate system for scrutinizing the outcomes of the questionnaire. The researchers discovered that nurses who preferred information and communication technology (ICT) were usually members of a more seasoned team. As a result, they recommended that more emphasis should be placed on psychosocial elements, such as group education and cooperation, in the workplace when using ICT applications in nursing.

### **The Skin and Wound evaluation team**

In 2008, McGuinness *et al.* conducted a study to determine if the occurrence of Hospital-Acquired Pressure Ulcers (HAPUs) in a neurosurgical/neurological in-patient Intensive Care Unit (ICU) could be decreased by implementing a Skin and Wound Assessment Team (SWAT). The strategies employed to reduce HAPUs included frequent patient repositioning every 1-2 hours, the use of specialized beds, and the presence of a dedicated SWAT. The team just comprised of the individuals already on duty, without any extra personnel, resulting in no additional expenses. In addition, one or two proficient nurses or nursing assistants, selected from the personnel already on duty, conducted regular rounds on all patients once a week. Comprehensive examinations were conducted to assess all pressure ulcers across the whole body. Additionally, primary nurses and nursing assistants were instructed on how to provide treatment for these patients. In 2010, the following additions were made: (1) eight Stryker beds, (2) pressure-relieving heel protection boots, and (3) new hospital orientees saw the SWAT team for a single shift lasting 7.5 hours. The SWAT team achieved a reduction of 48% in HAPUs in 2009, followed by a fall of 57% in 2010 and a further decline of 61% in 2011. The very successful SWAT program, first implemented in the neurology unit, has now been extended throughout the whole hospital.

An investigation of the satisfaction levels of family members of survivors in a neurological intensive care unit (ICU). Hwang *et al.* conducted a study to assess the satisfaction of families whose loved ones were cared for in a neuroscience ICU. They compared the level of satisfaction to that of families whose loved ones were in the medical ICU (MICU) of the same hospital. The study spanned 38 days and involved administering the Family Satisfaction-ICU questionnaire to families of neuro-ICU and MICU patients upon discharge. Families who experienced deaths were not included in the study. In 76.3% of instances, patients expressed total satisfaction with the level of respect and compassion they got from the personnel in the neurosurgery intensive care unit

(NICU), compared to 92.7% in the medical intensive care unit (MICU). Participants who reported not attending any formal family meetings were shown to have a lower likelihood of being entirely happy with the politeness of staff. Less than 60% of families in the neuro-ICU expressed total satisfaction with the frequency of contact from physicians, their involvement and support in decision making, and the level of control they had over the care of their loved ones. Parents of patients had a higher likelihood of experiencing a strong sense of inclusion and support in the decision-making process compared to other relatives. The authors recommended that future research prioritize the assessment of techniques aimed at enhancing decision-making support for neuro-ICU nurses and doctors, as well as implementing more regular family meetings. Exploring the happiness of families whose loved ones died during their neuro-ICU stay is a possible area for future research. However, it is important to approach these questionnaire answers with a reasonable amount of doubt, especially as patients and their families may worry that revealing any unfavorable experiences might have a detrimental impact on their future healthcare (personal communication, James I. Ausman, MD).

### **Collaboration and Training in the Intensive Care Unit (ICU) and Operating Rooms (ORs)**

Paige *et al.* conducted a study to assess the influence of effective teamwork in the operating room (OR) and how it is often hindered by the "silo mentality" among different specialists, such as not listening to colleagues and adhering to a hierarchy. To tackle the insufficient interprofessional (IP) education for undergraduate medical and nursing students, the authors implemented a program that involved training IP student OR teams using high-fidelity simulation (HFS) to modify the attitudes and behaviors of team members. There were a total of 10 training sessions for the IP student team, which included assessments conducted before and after each session. The participants consisted of 18 nursing students, 20 nurse anesthetist students, and 28 medical students. Statistically significant improvements were seen on 11 out of the 15 self-efficacy assessments during the HFS sessions. Consequently, the training provided to HFS or IP student teams enhances their attitudes and actions while working as a team. Interestingly, it was also shown that students had a tendency to exaggerate their team-based actions.

Ausman asserts that the effectiveness and attitudes of surgical teams rely on the leadership of physicians, as he explains: "It originates from the highest level of authority." Surgeons not only have the responsibility of planning the surgery beforehand, but they must also provide the necessary information and education to the operating room staff regarding the specific requirements of the procedure (such as positioning, techniques, and equipment) in advance. Ausman perceptively highlights the need of surgeons possessing both technical proficiency and strong interpersonal skills to effectively

manage and engage with their colleagues in a respectful manner.<sup>[5]</sup>

Ausman further highlights additional significant issues in the operating room (OR), such as the presence of music and talking, which can serve as distractions and potentially raise the risks associated with the surgery. Additionally, residents who are assisting in the OR may have limited knowledge about the patient's condition and the reasons for the surgery, as they were not present during the initial patient work-up. Furthermore, due to a decrease in the number of required surgical hours, these residents have fewer opportunities to develop their technical surgical skills and their ability to interact effectively in the OR. Ausman's conclusion is that it is important to standardize as many aspects as possible, such as the operational crew, equipment, and procedural phases.

#### **The collaboration of IP (Intellectual property) teams enhances the performance of students in simulated coding scenarios**

Garbee et al. conducted a study to assess the effectiveness of using crisis resource management (CRM) principles and high-fidelity human patient simulation (HFHPS) for interprofessional (IP) team training in educating undergraduate nurses, nurse anesthetists, medical and respiratory therapists in the management of codes. The objective of the study was to enhance teamwork and communication by addressing hierarchical barriers in education. Their one-year research evaluated the acquisition and retention of cooperation and communication abilities. The study included 52 students during the autumn semester, and 40 of them continued in the spring. It was shown that average scores climbed and remained higher after training. In cases where there was a reduction, this was counteracted or enhanced by more training in the spring.

There are fewer instances of communication failures when ICU fellows/residents are on call at the hospital compared to when they are at home. Williams et al. conducted a study to determine if having fellows present in the hospital (in-hospital fellow coverage or IHFC) instead of being at home (HC) in ICUs had an impact on clinical outcomes related to cardiorespiratory events. They found that high-intensity staff coverage strategies were associated with reduced morbidity and mortality. The researchers hypothesized that having fellows easily accessible in the hospital would lead to better teamwork and communication in developing patient care strategies. To investigate this matter, they collected sufficient data from 306 out of 312 cardiorespiratory incidents that took place in 114 patients in the surgical ICU during a span of 134 days. Out of a total of 103 instances involving communication problems, a smaller number of errors were seen among those who were on in-house call. Specifically, residents communicated successfully in 89% of cases during in-house call, compared to just 51% of cases during regular call. Interestingly, the occurrence

of communication errors was similar for both junior and senior residents. The researchers determined that the occurrence of communication mistakes decreased among residents who were on in-house call duty.

The performance and quality of patient care are influenced by the proficiency of individuals with non-technical skills in handling acute trauma patients. Pucher et al. recognized that effectively managing the acute trauma patient requires the essential and prompt collaboration of a "team" consisting of various specialists.<sup>[21]</sup> Nevertheless, previous studies have conducted limited assessments of the proficiency of individuals with nontechnical skills (T-NOTECHS) who are also part of the trauma team. The researchers evaluated the duration of care evaluation and treatment, the occurrence of delays or mistakes, the influence on Injury Severity Scores (ISS), and if any of these parameters were affected by the time of day. The researchers assessed 50 trauma calls and found that improved collaboration and nontechnical performance led to a considerable reduction in disposition times.

#### **Shift change handovers**

In France, Estryn-Behar et al. conducted two surveys to evaluate the effectiveness of shift changes/handovers (SCH) between shifts. This involved analyzing questionnaires from 29 registered nurses (RNs), 18 nursing aides (NAs), and 14 full-time physicians [Table 1] to assess the frequency of interruptions and the quality of care provided to patients. The authors concluded that SCHs are being minimized or eliminated in France as a means to cut down on staffing expenses. The authors aimed to document the impact of shortening SCH on the efficiency, teamwork, and quality of care delivered by these teams of medical professionals. Initially, it was noted that Registered Nurses (RNs) dedicated an average of 15 minutes to Shift Change Handoff (SCH) at the beginning of their shifts, however this time decreased to 13 minutes at the conclusion of the shift. This entailed an average of 50 disruptions, which accounted for around 16% of the total working time. In the case of NAs, SCHs were comparable, as interruptions resulted in a reduction of 10.3% of the working time. However, for doctors, SCHs were either shorter or non-existent. The authors suggested that enhancing and extending the exchange of information during shift changes, while minimizing disruptions, would enhance and uphold patient safety and the quality of care provided.

#### **The Advantages of Collaboration in the Operating Room: The Importance of "Time Outs" and Minimizing Distractions**

D'Amours et al. conducted a study to evaluate the benefits of integrating interventional radiology and operative suites in the treatment of severely injured patients with trauma to the chest, abdomen, pelvis, and extremities in specific trauma centers. The hybrid suite model, which involved a skilled team from various disciplines, allowed for faster control of bleeding by

combining surgical, interventional radiology, and resuscitative techniques. Implementing this model required collaboration between different teams, consideration of ergonomic and workplace factors, and a fundamental change in the approach to trauma care.

Porter et al. conducted a study to assess the effectiveness of "Time Out" protocols in evaluating the readiness of the operating room (OR) team. The study used a checklist and "preprocedural pauses" (PPP) to improve teamwork, outcomes, and ensure the correct patient and operative site. These practices align with the Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. This research assessed the impact of feedback from several team members on the effectiveness of the Time Out. After the implementation of this technique, there was a significant improvement in compliance with surgeon-led pauses, rising from 54% to 97%. Prior to the change, members introduced themselves only 44% of the time, but this increased to 94% after the change. The authors reached the conclusion that the PPP, which included all members of the OR team, facilitated improvement in overall collaboration. This incurred no additional expenses and needed very minor administrative assistance beyond the first deployment of the PPP.

Antoniadis et al. conducted a study to examine the occurrence and intensity of distractions and interruptions during surgery. They also assessed the impact of these distractions on the surgical procedure, patient health, and the stress levels of the surgical team. The study included 65 surgical cases, primarily involving abdominal and orthopedic procedures, conducted at two locations in Germany. The findings are presented in Table 1.<sup>[3]</sup> The instances had an average duration of 1 hour and 23 minutes, and had a total of 803 interruptions/disruptions, with an average frequency of 9.82 occurrences per hour. The predominant disruptions were of individuals entering or leaving the operating room, followed by incoming phone calls or pager notifications. Equipment failures and interruptions linked to the operating room environment were identified as the most significant obstacles to the operation of the operating room team. These issues often occurred at the start of the surgical procedure. The researchers determined that disruptions and distractions are common occurrences in the operating room and have a negative impact on the functioning of the surgical team. Ideally, it is advisable to restrict these factors in order to maximize efficiency and improve the safety of the surgical procedure.

The study conducted by Haugen et al. examined the factors that contribute to surgical errors, such as the possibility of performing the incorrect surgery on the wrong patient at the wrong site. The researchers administered a questionnaire to surgeons, anesthesiologists, nurse anesthetists, and OR nurses, consisting of 14 items. The questionnaire aimed to gather information about their experiences with "near misses or mistakes" in the

operating room and how these incidents could be prevented in the future, for example, by implementing the Time Out protocol. Despite the fact that 91% of team members expressed a preference for the Time Out protocol, the team itself had uncertainties regarding the patient's identity (38%), the surgical site/side (81%), being prepared for the wrong procedure (60%), and assuming responsibility for performing the correct procedures (63%). Additionally, it was observed that only nurse anesthetists consistently conducted identity checks before surgery ( $P \leq 0.001$ ). The authors' conclusion is that a significant majority of surgical professionals in the operating room have had near misses in the past, and that the implementation of the Time Outs model has effectively prevented these errors.

Papaconstantinou et al. assessed the perspectives of the surgical team on the effectiveness of the World Health Organization's (WHO) Surgical Safety Checklist or Time Out in reducing global morbidity, mortality, and complications [Table 1].<sup>[19]</sup> The surgical team completed questionnaires one month prior to (45%) and one year after (64%) the implementation of the Time Out protocol. The respondents to the questionnaire consisted of 153 (35%) nurses, 104 (24%) anesthesia providers, and 180 (41%) surgeons. In general, 65% of the respondents believed that the Time Out technique improved patient safety. However, they also saw "some disagreement... between surgeons and other members of the surgical team, suggesting that communication barriers are still present."

Jacobs and Wille examined the repercussions of surgeons' outbursts or temper tantrums in the operating room (OR). It is worth noting that there is less information in the medical literature on surgeons mistreating OR staff. Nevertheless, the inappropriate conduct of surgeons is no longer tolerable and must be restrained to prevent any compromise to patient safety or the initiation of disciplinary measures. The authors concluded that surgeons who mistreat other healthcare workers are in breach of institutional bylaws and compliance regulations. This behavior creates a hostile work environment that negatively impacts productivity and violates State and Federal laws that prohibit discrimination based on race, color, sex, religion, or national origin. Ausman recently observed that he has never witnessed an operating team improve as a result of the surgeon's outbursts. The patient experiences a decline in involvement, leading to increased deterioration. "This behavior is not acceptable," said James I. Ausman, MD in a personal correspondence.

Anderson and Talsma conducted an assessment of the positive effects of operating room (OR) teams on the safety and efficiency of general and neurosurgical operations. They examined the factors of centrality, team coreness, and the core/periphery network structure. The level of team cohesion, which indicates the frequency of the team's collaboration, was shown to be associated

with the length of the surgical process. In the beginning of the day, there was a higher likelihood of maintaining a consistent core team, however as the day progressed, less team members were engaged. Registered Nurses (RNs) constituted the majority of the "core" multidisciplinary team members in both operating groups. The authors' conclusion is that several processes may include personnel who lack specialized training, and subsequent instances are more adversely affected compared to earlier ones.

Mangum and Cutler observed that the presence of more efficient subspecialty teams in the operating room leads to shorter turnover times and improved safety and effectiveness in a neurosurgical service. By redesigning the neurosurgical suite and streamlining processes, turnover times were reduced by 33-55% and team efficiency was increased. This improvement can largely be attributed to the enhanced capabilities of the specialized nursing team.

#### Strategies to enhance operational efficiency

Overdyk *et al.* conducted a study in an academic context to investigate the causes of delays in operating rooms (OR) and emphasized the use of multidisciplinary approaches to enhance efficiency. The study examined 94 cases both before and after a two-week educational program aimed at raising awareness of OR efficiency among nurses, surgeons, and anesthesiologists. After completing their education, data were collected from a total of 1787 participants. It was shown that after education, the start times for several stages of the surgical process, such as the first case of the day, patient entry into the room, anesthetic readiness, surgical preparation/start time, and operation start times, were considerably sooner ( $P < 0.01$ ). More precisely, the beginning time was shifted 22 minutes earlier, the time taken for turnover was reduced by an average of 16 minutes, and there was a decrease in delays caused by unavailability of surgeons, anesthesiologists, and residents. The authors' conclusion is that doing such studies may enhance the operational efficiency of the operating room (OR). Furthermore, they propose that adopting a multidisciplinary team approach can enhance effectiveness, leading to savings in both time and costs. Essentially, personal responsibility, simplification of processes, collaboration among different teams, and precise data gathering all played crucial roles in enhancing efficiency.

Arriaga *et al.* conducted a study to assess the feasibility of implementing a "standardized teamwork training program" for entire surgical teams across multiple centers. Their hypothesis was that intraoperative teamwork failures were the main cause of operative complications, including patient injury or death. Hence, using operational simulation for these "teams" would effectively mitigate undesirable occurrences. The researchers examined four simulation programs associated with Harvard that focused on creating a

uniform training curriculum for operating room cooperation. This curriculum adhered to the safety checklist provided by the World Health Organization (WHO). Each team consisted of an average of seven individuals, including at least one attending surgeon, one attending anesthesiologist, and one operating room nurse. Out of the 221 total participants, 99% completed the questionnaires (218 out of 221). The teams concluded that the situations were realistic (94%), suitably demanding (95.4%), pertinent (96.3%), and would enhance patient safety (92.6%). Surgeons identified communication skills as their main area for improvement, while OR nurses and anesthesiologists believed that surgeons needed to work on being more assertive. The authors concluded that introducing a standardized team-training program for complete operative teams in the operating room had a positive impact on the team's performance.

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تأثير نقص الأدوية على رعاية المرضى في مختلف التخصصات الصحية الملخص الخلفية - يحد استخدام الفرق متعددة التخصصات داخل المستشفيات من حدوث الأحداث السلبية (AE) ، ويحسن النتائج، ويساهم في سعادة كل من المرضى والموظفين.

هدف العمل - تهدف هذه الدراسة إلى توضيح الأدوار والمسؤوليات التي يتحملها الصيادلة في ضمان النتائج الصيدلانية المثلى خلال انتقالات الرعاية، ومعالجة الحواجز التي تعيق الانتقالات الفعالة، وتبسيط الضوء على الفئات المعرضة لخطر الأحداث الضارة الناتجة عن الأدوية (ADEs).

الطرق - تتكون الفرق متعددة التخصصات داخل المستشفيات من موظفين من مستويات مختلفة من تسلسل العلاج، مثل مساعدي الممرضين، وفنيي الجراحة، والممرضين، وأطباء التخدير، والأطباء المعالجين، وغيرهم. إن تعاونهم المحسن يخفف من التأثير السلبي للبيئات المعزولة من خلال تعزيز التواصل الفعال بين المهنيين الصحيين على جميع المستويات. ونتيجة لذلك، يقلل من الأحداث السلبية مثل المرض أو الوفاة، بينما يزيد في الوقت نفسه من رضا المرضى والعاملين في مجال الرعاية الصحية.

النتائج - تتضمن العديد من المنشورات من مجالات مختلفة مفاهيم متنوعة عن "العمل الجماعي" للموظفين العاملين في غرف الطوارئ (ERs)، وأقسام المستشفيات، ووحدات العناية المركزة (ICUs)، والأهم من ذلك، غرف العمليات (ORs) أدى التعاون المحسن بين المهنيين الصحيين على جميع المستويات إلى تحسين التواصل، وتقليل الحوادث السلبية، وتحسين نتائج المرضى، وتقليل مدة الإقامة في المستشفى، وزيادة رضا كل من المرضى والموظفين.

الخاتمة - في المستشفيات، يعد تقديم العلاج الطبي والجراحي الأمثل جهدًا تعاونيًا. تشمل الأهداف تعزيز سلامة المرضى من خلال تقليل الأحداث السلبية، وتحسين سعادة المرضى، وتقليل مدة الإقامة في المستشفى، وتعزيز جودة النتائج. تشمل الفوائد الإضافية تحسين كفاءة المهنيين الصحيين، وتقليل نفقات المستشفى والمشاكل، وزيادة رضا العمل. تعتبر هذه المراجعة تذكيرًا لمديري المستشفيات بأهمية الحفاظ على الفرق متعددة التخصصات. من خلال القيام بذلك، يمكن للمستشفيات ضمان سير عملياتها بسلاسة، مما يؤدي إلى تحسين جودة وسلامة رعاية المرضى. بالإضافة إلى ذلك، يسمح هذا الممارسة لأعضاء الطاقم بتحسين أدائهم وزيادة رضاهم عن العمل.