Has your checklist effort stalled? Some advice on how to restart it

Fifth in a series on ten elements of safer surgery.

This marks the fifth year since the worldwide roll-out of the World Health Organization (WHO) Surgical Safety Checklist. In some hospitals, the checklist has taken root and become a way of life. In others, acceptance is slower. For others, after an initial burst of enthusiasm, the checklist has become just a series of tick boxes.

What’s the difference between a checklist effort that is alive and one that lags?

For this article, experts, including the Safe Surgery 2015 team led by surgical checklist pioneer Atul Gawande, MD, offer 12 key factors for ensuring that the checklist fulfills its true purpose—serving as a tool to aid team communication and minimize risks to patients.

The first question: Was the checklist implemented effectively to begin with?

A study of 5 hospitals in Washington State indicates the effort can falter without strong leadership by senior clinicians and extensive education. Conley et al found effective implementation depended on leaders explaining the rationale for the checklist persuasively and showing how to use it, along with extensive education, including demonstrating best practices; pilot testing; providing coaching and feedback; and anticipating the need for long-term training, observation, encouragement, and quality control. When leaders didn’t provide this groundwork, and clinicians didn’t understand the checklist’s rationale or weren’t adequately prepared to use it, they became frustrated and disinterested, and use of the checklist fell off, even though the hospital mandated its use.

Safe Surgery 2015

To foster checklist adoption, the Harvard School of Public Health in Boston, home of Dr Gawande’s initiative Safe Surgery 2015, has partnered with the South Carolina Hospital Association (SCHA) to have all hospitals in the state adopt the checklist for routine use in their ORs by the end of 2013. The effort recently expanded to North Carolina and Virginia.

Based on the evidence, Safe Surgery 2015 estimates successful implementation and proper use of the checklist could save more than 500 lives per year in South Carolina.

The Harvard team offers webinars, conference calls, and other resources to help ORs introduce the checklist meaningfully and monitor its impact. Free resources are at www.safesurgery2015.org.

Here’s advice to help ensure the checklist continues to be a living document in your ORs.

A process, not a checklist

Keep in mind that safe surgery is a process, not just a checklist, advises Kathleen Harder, PhD, a cognitive psychologist and human factors expert at the University of Minnesota.

“The focus is on the process—a checklist alone will not prevent an error if the process is not done well.”
Harder assisted the Minnesota Hospital Association and the Minnesota Department of Health in developing the state’s Safe Surgery Process and has conducted workshops throughout the state. The process includes a 5-step time-out based on human factors research and observations in hospital ORs (sidebar).

**Identify the critical elements**
Modify the checklist to meet the needs of your organization and individual specialties, and involve the teams that will use the checklist. Teams will be more likely to use the checklist if it’s relevant to their needs.

“Ask what your critical issues are, and make sure those are on your checklist,” advises David Young, MD, director of presurgical testing at Advocate Lutheran General (ALG) Hospital in Park Ridge, Illinois, where the checklist is part of the Safer Surgery process.

**Approach physicians one-on-one**
Approaching physicians individually, though time-consuming, is an effective way to get buy-in, Bill Berry, MD, MPH, MPA, program director for Safe Surgery 2015, noted in a recent webinar.

In working with hospitals, he has found that 10% to 20% of physicians immediately see the checklist as helpful and will actively participate.

“This is generally where you find your champions,” he said.

Of the remaining physicians, about half are passively compliant and won’t fight the checklist. “This is the group I think you can influence with a one-on-one conversation.” And those who are resistant or even hostile might also be persuaded not to actively oppose the checklist if a champion explains it to them.

Safe Surgery 2015 offers these tips for one-on-one conversations:
- Don’t try to “fix” a physician with the checklist. The goal is to open their minds, engage them, and get them to try the checklist.
- Have a respected peer talk with them one-on-one.
- If you believe a physician isn’t going to use the checklist, don’t try to force it.
- Ask the physician not to obstruct others in using the checklist.

(Resources for how to conduct a one-on-one conversation are at www.safesurgery2015.org.)

Peer pressure can make a difference.

One ambulatory surgery center posted a photo of each physician who agreed to try the checklist, notes Lizzie Edmondson, senior project manager for Safe Surgery 2015.

When one hold-out asked why his photo wasn’t posted, he was told, “Those are the people who are checklist champions.” He agreed to try the checklist so his photo could be displayed.

**Give each team member a role**
“We have speaking parts for the surgeon, anesthesiologist, and nurse,” says Jennifer Misajet, MHA, RN, CNOR, regional director of perioperative services for Kaiser Permanente’s Northern California region based in Oakland.

“If you have a speaking part, you are more engaged because you have something to contribute to the activity.”

The Kaiser region has embedded the checklist as part of its Highly Reliable Surgical Teams (HRST) initiative, which involves all of the region’s medical centers.

Advocate Lutheran General uses a challenge-and-response approach for the OR portion of the checklist.
"You want to require an answer to each part," explains Cindy Mahal-van Brenk, MS, RN, CNOR, executive service line director for surgery.

Here’s an excerpt:

Circulator to anesthesia provider: “Would you please state the patient’s name?”
Anesthesia provider: “David Smith.”
Circulator: “Please tell me which antibiotic you gave.”
Anesthesia provider: “I gave 1 g Ancef at 15:30.”
Circulator: “Is the patient on a beta-blocker?”
Anesthesia provider: “No beta-blocker is indicated.”
Circulator to the surgeon: “Dr Jones, please state the procedure you will be performing.”
Surgeon: “I am performing a left hemi-arthroplasty.”
Circulator: “Is the site marked?”
Surgeon: “The site is marked.”

Add teamwork training

Team training provides a foundation for communication, the checklist’s fundamental purpose. Studies show combining team training with the checklist improves outcomes.

In a pilot study led by Bliss et al, use of a checklist plus structured team training produced a statistically significant difference in 30-day morbidity. The report is in the December 2012 Journal of the American College of Surgeons.

In a study of 74 facilities in the Veterans Health Administration published in 2010, Neily and colleagues found an 18% reduction in mortality when team training and the checklist were combined.

Stay vigilant

Never stop observing how teams use the checklist, the Harvard team advises.

“You can never turn your attention away. You have to continue to talk about it
and continue to keep people excited about doing it,” Edmondson suggests. Regularly observe teams using the checklist and offer coaching as needed, she advises. During the observations, ask surgical teams for feedback about the checklist effort and what could be improved. (Safe Surgery 2015 offers an observation tool on its website.)

In Kaiser Northern California, perioperative nurse managers audit regularly. “If you don’t do audits and see teams using the checklist, you will get drift,” Misa-jet says.

Managers use a rounding tool to guide audits and offer coaching on the spot if needed. If they see themes that need to be addressed, they bring the issue to the facility’s HRST group for discussion.

Harness the debriefing

Hospitals that are able to sustain the checklist do the sign-out (debriefing) phase of the checklist really well, Edmondson says.

During the debriefing, in addition to confirming counts and specimens, the team reviews any concerns about the patient as well as what could have gone better.

These hospitals have a process for tracking the concerns, fixing them, and giving feedback to the clinicians who raised the concerns.

Fixing problems gives OR teams an incentive to continue with the checklist and debriefings because their lives get easier as a result.

During one debriefing, Misajet notes, a surgeon raised concern about the state of the laparoscopic surgery light cords.

The manager enlisted the sterile processing department, which checked the cords in all of the sets and repaired and replaced cords as needed.

The surgeon, skeptical that the problem had been fixed, was invited to view and test cords from about a half-dozen sets and saw they all worked.

“He realized the value of the debriefing,” Misajet notes.

Nurse managers are piloting new software from Bowwave (Great Falls, Virginia) that is installed on their iPads and customized for tracking debriefing issues (sidebar).

Take your safety pulse

A safety culture survey provides a way to measure nurses’ and physicians’ responses to patient safety initiatives like the checklist over time, according to Safe Surgery 2015. It’s a way of taking the safety culture’s pulse.

The Joint Commission requires hospitals to use valid and reliable tools for measuring the culture of safety (LD.03.02.01, EP 1). One example is the AHRQ Hospital Survey on Patient Safety Culture from the Agency for Healthcare Research and Quality (www.ahrq.gov/legacy/qual/patientsafetyculture/hospsurvindex.htm).

Make it safe to speak up

The checklist won’t be effective in protecting patients if nursing staff are reluctant to speak up when something seems amiss. ALG weaves these skills into its team training, in which 91% of perioperative nurses and physicians have participated.

To learn whether nurses feel safe about speaking up, Mahal-van Brenk plans to survey the staff, asking them to rate on a scale of 1 to 5 how comfortable they feel bringing concerns to the attention of individual physicians. She plans to share the results privately with individual physicians.

It’s critical for nurses to be comfortable, she says, because “the last thing [physicians] want is not to get information about a concern.”
Keep senior leaders involved
Senior leaders not only must lend initial support for the checklist but also must stay in touch with the OR on how the effort is progressing.

“We encourage implementation teams to give higher-level leadership updates on their progress,” Edmondson says. “We also encourage senior leaders to go to the OR suite and talk to people who are using the checklist.”

Safe Surgery 2015 offers an observation tool senior leaders can use.

Share stories
Capturing stories about “good catches” by the checklist that prevented harm to patients is an effective way to gain support. Record some of these stories and post them where staff and physicians can see them, the Harvard team suggests.

“Keeping track of these stories is one of the best ways to measure the impact of the care you give in your hospital every day,” says Dr. Berry.

He estimates from reviewing the literature that using the checklist makes a difference for about 1 patient in 1,000.

“That is not a large number, but it is a life,” he says. That means that for 1 in every 1,000 patients who come through your doors, the checklist would make a difference between them going home unharmed or not leaving the hospital at all.

Always seek to do better
What key feature distinguishes hospitals that have embraced the checklist from those that have not? When the checklist is embedded, “the first thing they tell us is, ‘We could do better,’” says Edmondson. “They never feel they have completed the project.”

For them, the desire to improve is a continuing quest.

—Pat Patterson

References