



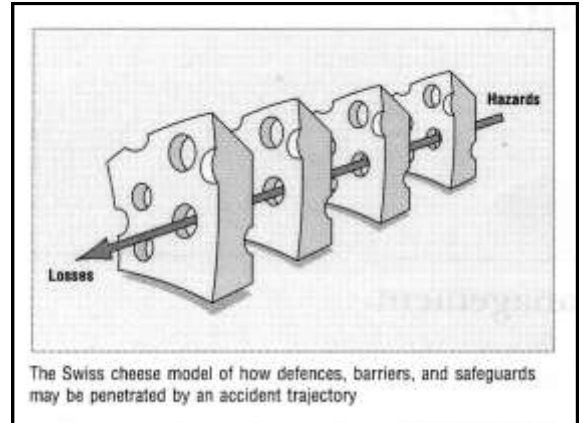
Getting it done

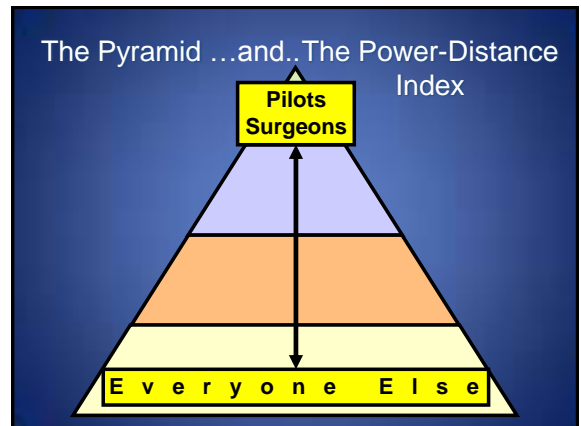
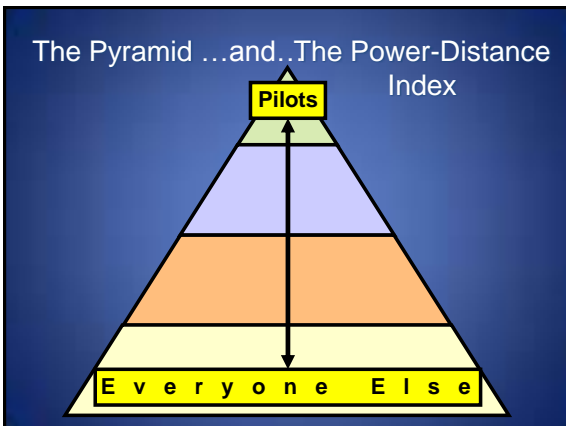
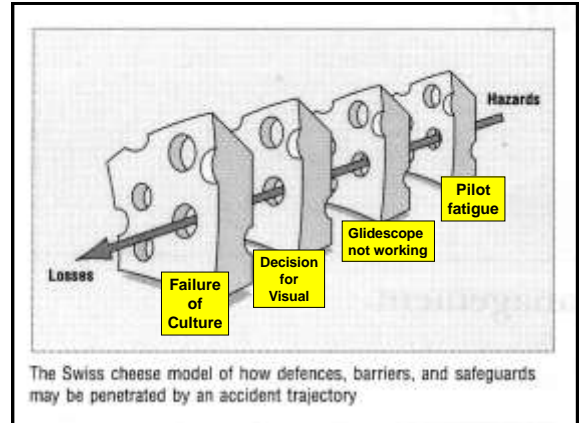
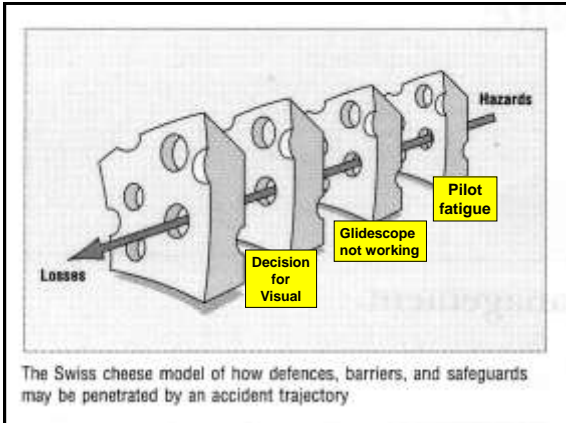
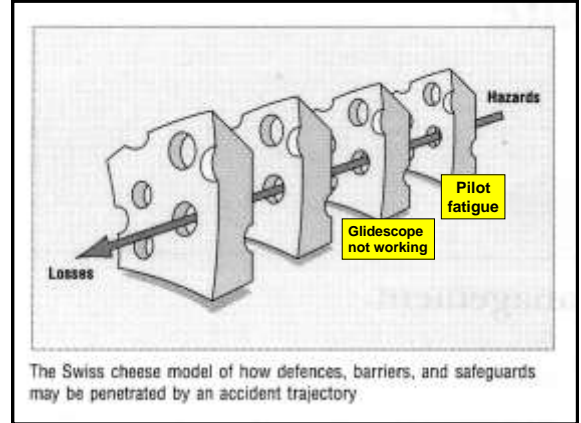
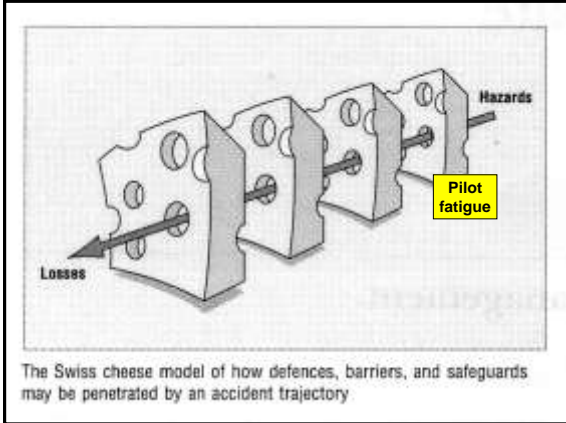
Implementing the Surgical Checklist

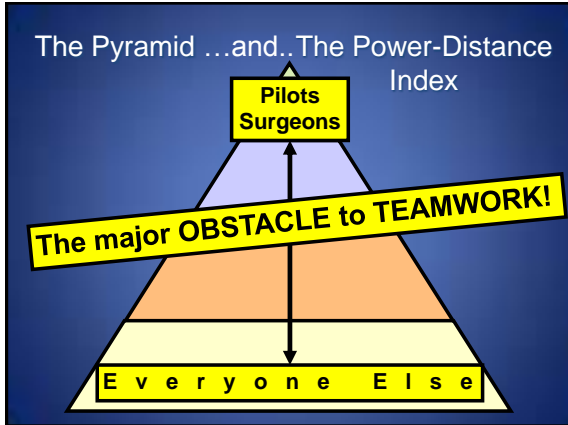
Bryce Taylor, Dublin, October 2009



August 5, 1997







- ### The Surgical patient ...2009 vs 1989
- Patient expectations ↑
 - Awareness of patient safety ... PROFILE
 - More complex patients every year
 - Medico-legal implications significant
 - Modelling of *patient care processes* after the auto industry, and modelling of *patient safety* after the airline industry
 - **SAME DAY ADMIT****
- Change is difficult!*



- ### The Surgical patient ...2009 vs 1989
- Patient expectations ↑ especially in Canada
 - Awareness of patient safety ... PROFILE
 - More complex patients every year
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 - **SAME DAY ADMIT****
- Change is difficult!*

It's about culture change and looking after the little things!

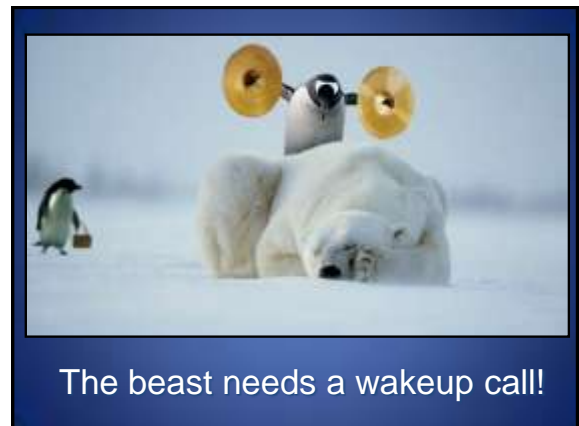
The NEW ENGLAND JOURNAL of MEDICINE

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, Dale Sevrin, Sean Rosenfeld, David Spector, et al. The New England Journal of Medicine. Boston Dec 29, 2006; Vol. 355, No. 26, pp. 2725-33

Abstract (Summary)

Catheter-related bloodstream infections occurring in the intensive care unit (ICU) are common, costly, and potentially lethal. We conducted a collaborative cohort study predominantly in ICUs in Michigan. An evidence-based intervention was used to reduce the incidence of catheter-related bloodstream infections. Multilevel Poisson regression modeling was used to compare infection rates before, during, and up to 18 months after implementation of the study intervention. Rates of infection per 1000 catheter-days were measured at 3-month intervals, according to the guidelines of the National Nosocomial Infection Surveillance System. A total of 108 ICUs agreed to participate in the study, and 103 reported data. The analysis included 1041 ICU-months of data and 275,757 catheter-days. The median rate of catheter-related bloodstream infection per 1000 catheter-days decreased from 2.7 infections at baseline to 0 at 3 months after implementation of the study intervention ($P=0.002$), and the mean rate per 1000 catheter days decreased from 3.7 at baseline to 1.4 at 18 months of follow-up ($P<0.001$). The regression model showed a significant decrease in infection rates from baseline, with incidence-rate ratios continuously decreasing from 0.69 (95% confidence interval [CI], 0.47 to 0.91) at 0 to 3 months after implementation of the intervention to 0.34 (95% CI, 0.23 to 0.50) at 18 to 36 months. An evidence-based intervention resulted in a large and sustained reduction (up to 68%) in rates of catheter-related bloodstream infection that was maintained throughout the 18-month study period.



The surgical checklist

- How we implemented it at UHN
- How YOU can implement it in your hospital!

Bryce Taylor
Dublin
October, 2009

The ideal setting for change

- Clear recognition of a problem
- A desire to correct the problem
- Intervention to mitigate the problem
- Evidence that the intervention is effective
- Intervention is cheap, doable, not disruptive, and has additional unexpected benefits
- Passionate leadership and troops that buy in



What is this tool that addresses the 10 objectives?



TIME OUT

- COMPLETE ALL TEAM MEMBERS MUST INTRODUCED THEMSELVES BY NAME AND ROLE
- SURGICAL ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM:
 - PATIENT
 - SITE
 - PROCEDURE
- ANTICIPATE CRITICAL EVENTS
- SURGICAL REVIEW: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE EDUCATION, ANTICIPATED BLOOD LOSS?
- ANAESTHESIA TEAM REVIEW: ARE THERE ANY PATIENT/SPECIAL CONCERNS?
- NURSING TEAM REVIEW: HAS STABILITY INCLUDING MONITORING RESULTS BEEN CONFIRMED AND TONS EQUIPMENT, SOLES OR ANY CONCERNS?
- HAS ANTIBIOTIC PREVENTIVES BEEN GIVEN WITHIN THE LAST 60 MINUTES?
 - YES
 - NOT APPLICABLE
- IS ESSENTIAL IMAGING DEPENDENT?
 - YES
 - NOT APPLICABLE

Time Out

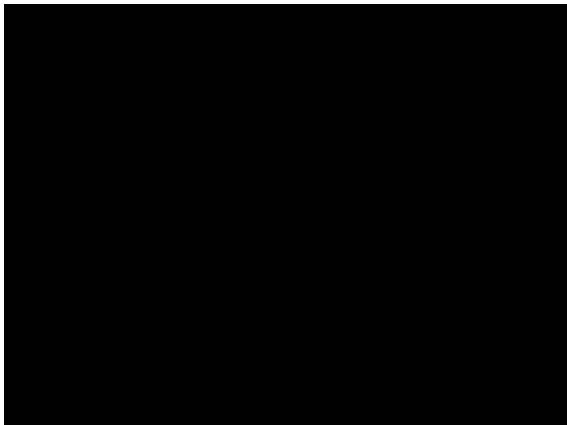
- IDENTIFICATIONS - NAME AND POSITION
- ANAESTHESIA OVER CONFIRM
- ESSENTIAL IMAGING DEPENDENT
- ANTICIPATE CRITICAL EVENTS
- SURGICAL REVIEW: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE EDUCATION, ANTICIPATED BLOOD LOSS?
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SIGN OUT

- NURSE VERBALLY CONFIRM WITH THE TEAM:
 - THE NAME OF THE PROCEDURE TO BE DONE
 - THAT INSTRUMENTS, WOUNDS AND NEEDLE COUNTS ARE CORRECT (YES/NO)
 - APPLICABLE
- HAVE THE INSTRUMENTS LABELED (INCLUDING PATIENT NAME) (YES/NO) (CORRECT/NOT)
- WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED?
- SURGICAL ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THE PATIENT

DEBRIEFING

- CHANGED TO POST-OPERATIVE PATIENTS?
 - SURGICAL REVIEW WITH ENTIRE TEAM
 - WOUND PROCEDURE AND LOGS
 - SIGNOUT WITH OPERATIVE COUNTS
 - MANAGEMENT PLAN
- ANAESTHESIA PROFESSIONAL REVIEW WITH ENTIRE TEAM
 - IMPORTANT ANAESTHESIA EVENTS
 - RECOVERY PLAN
- NURSING REVIEW WITH ENTIRE TEAM
 - ANAESTHESIA OPERATIVE COUNTS
 - STERILE LANGUAGE
 - IMPORTANT PATIENT-SPECIFIC EVENTS
 - ESSENTIAL EQUIPMENT AND FUNCTION
- COULD ANYTHING HAVE BEEN DONE TO MAKE THE CASE SAFER OR MORE EFFICIENT?



The Challenge

Name	Position	Role

The Challenge

Name	Position	Role

Perioperative staff

- Nurses
- Anesthesiologists
- Surgeons
- Others

The Challenge

Name	Position	Role

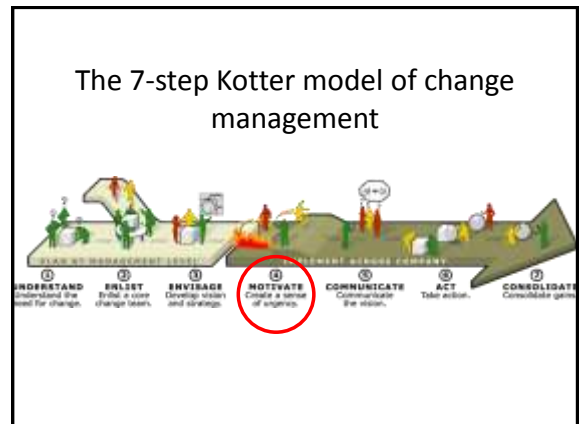
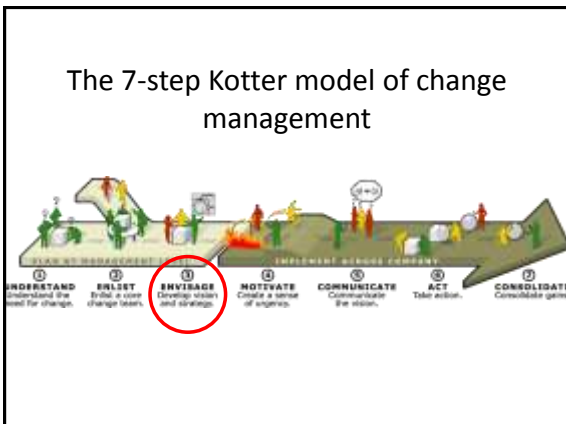
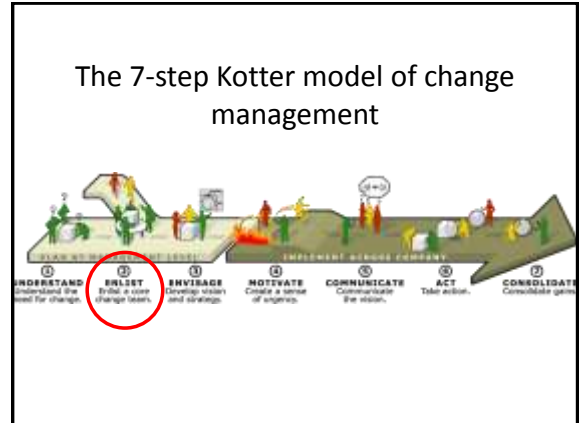
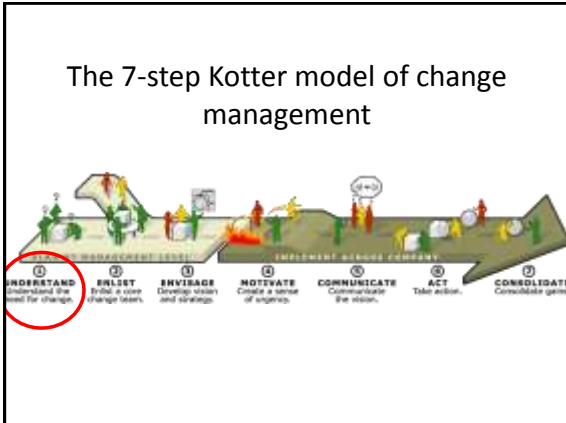
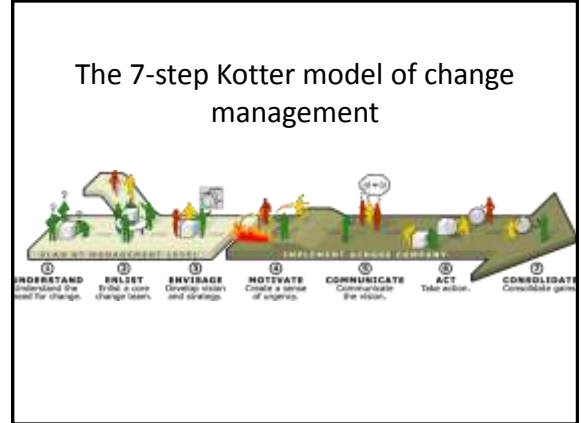
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Standard Operating Procedure

Perioperative staff

- Nurses
- Anesthesiologists
- Surgeons
- Others



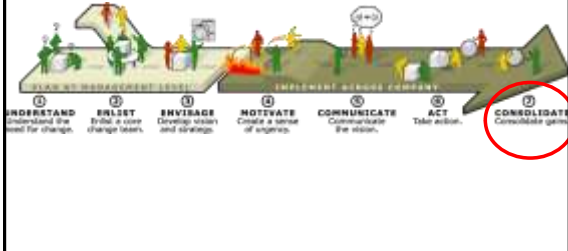
The 7-step Kotter model of change management



The 7-step Kotter model of change management



The 7-step Kotter model of change management



Implementation of the surgical checklist

1. UNDERSTAND

M&M rounds
Complications
Sepsis
Delays
3-15% comp'n rate
Avoidable deaths

Implementation of the surgical checklist

2. ENLIST

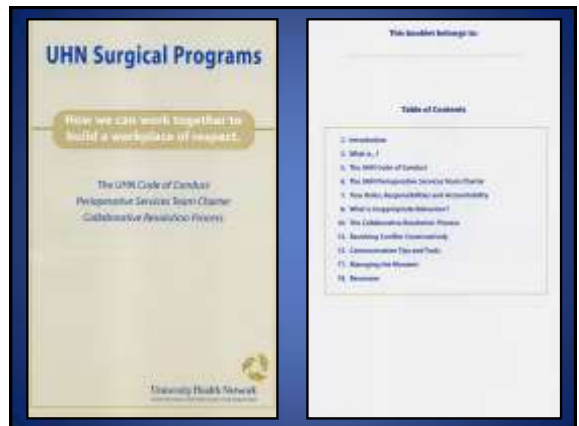
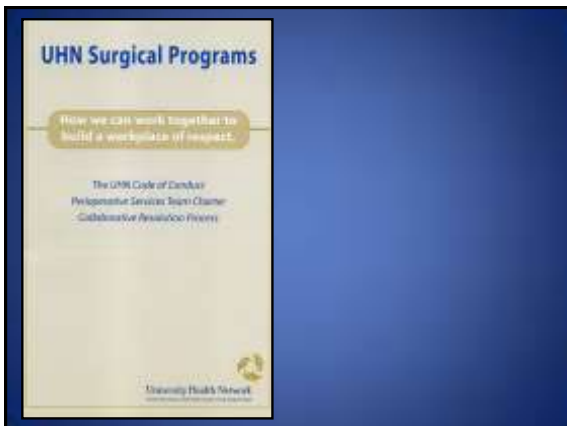
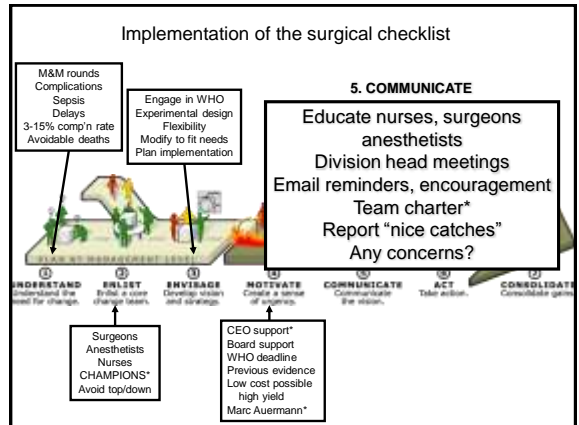
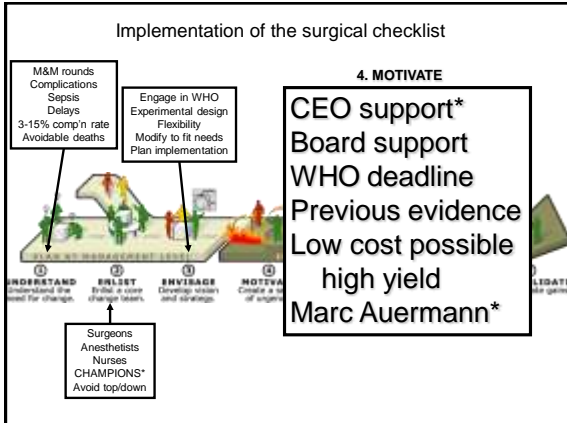
Surgeons
Anesthetists
Nurses
CHAMPIONS*
Avoid top/down

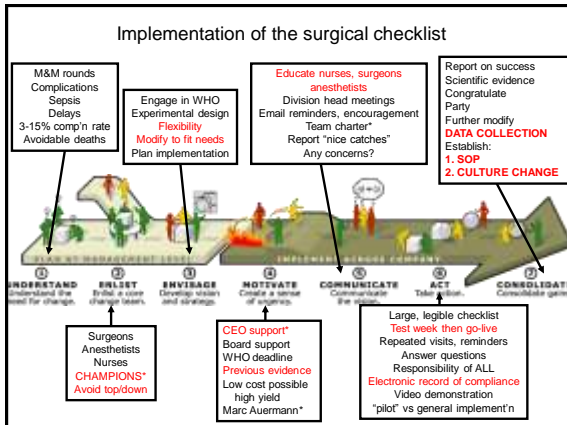
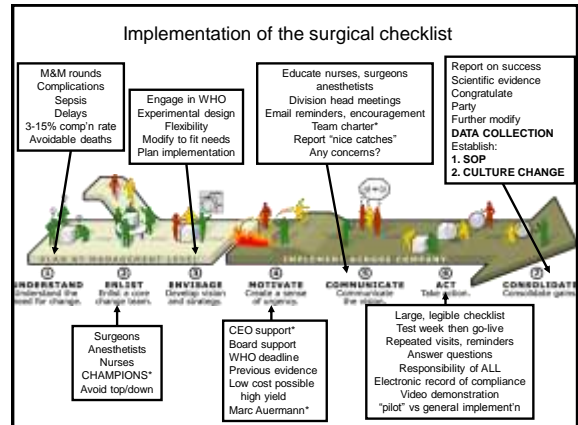
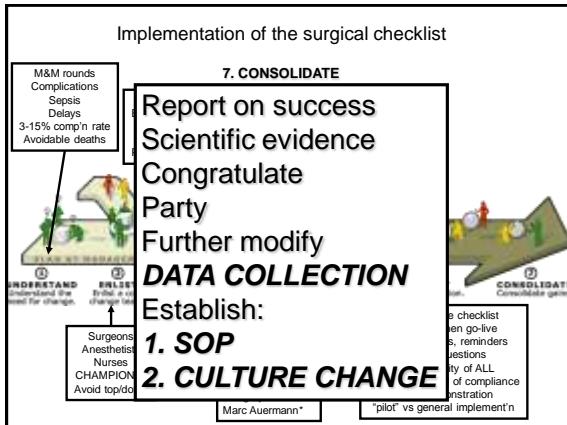
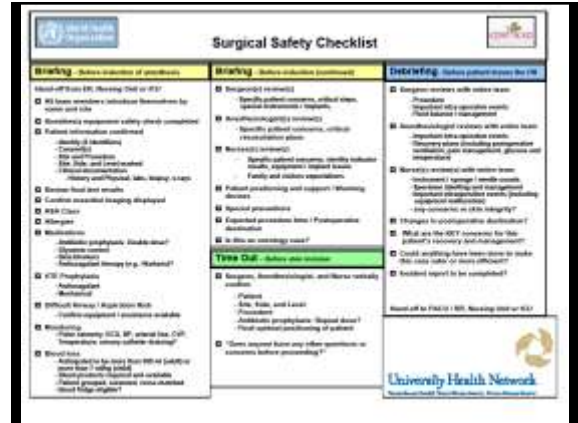
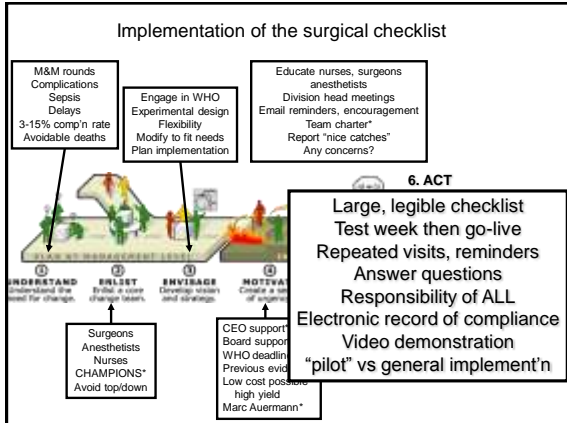
Implementation of the surgical checklist

3. ENVISAGE

Engage in WHO
Experimental design
Flexibility
Modify to fit needs
Plan implementation

Surgeons
Anesthetists
Nurses
CHAMPIONS*
Avoid top/down



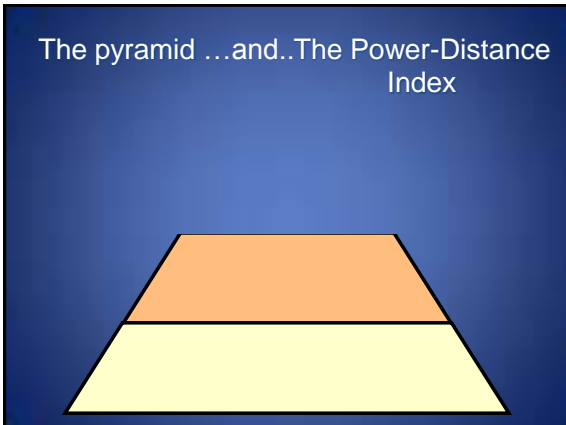
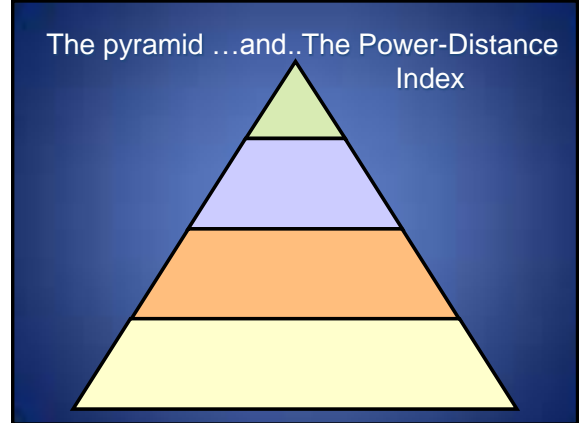
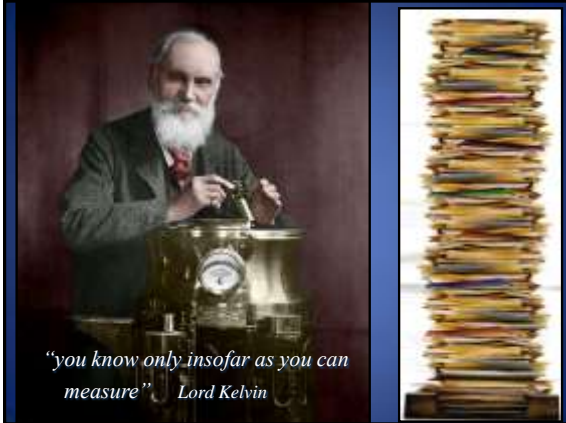


- ### Implementation of the surgical checklist
- The key points of the "toolkit"**
 (use project management if desired)
1. Prepare and educate *all* stakeholders
 2. Use evidence to engage OR staff
 3. Develop champions at every level
 4. Senior management endorsement (*not* decree!)
 5. Customize for your hospital (input from all)
 6. Implement after a brief 'practice run'- persist!!
 7. Monitor, record and publicize compliance
 8. Monitor and record 'nice catches', 'learnings'
 9. Celebrate and reward successes
 10. Public reporting (in Ontario)***



In the last year at UHN
We have found....

- Takes little time, patients satisfied
- Reminders required less frequently with time
- Details *are* important, and potential problems and omissions *are* being picked up!
- Significant in start-up time and effort, but ...
- Costs virtually no money
- This is a *team-building* opportunity!
- It can always be changed...it's flexible!
- The two big issues are *culture change* and *data collection!*



An email to a UHN surgeon.... (this is for real)

"Alex" - it has come to my attention that you don't favour carrying out the Checklist, which is now a mandatory surgical process at UHN. The purpose of this reminder is to emphasize the need for doing this, and of the consequences of not participating. The checklist has proven in your own and other services to be not only useful in the promotion of patient safety, but also of team-building...an important ancillary effect. You will remember your own unfortunate incident in the OR a few months ago, which would have been avoided had we used the checklist at that time.

I am informing you that if I am told that you either refuse to use the checklist, or continue being sarcastic when you are reminded, I will be forced to take OR time away from you. If you continue to disregard the processes that all other surgeons, anesthesiologists and nurses have adopted, this may result in suspension of your privileges.

If you don't believe me, just try me.

Bryce





The ideal setting for change

- ✓ Clear recognition of a problem
- ✓ A desire to correct the problem
- ✓ Intervention to mitigate the problem
- ✓ Evidence that the intervention is effective
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- ✓ Passionate leadership and troops that buy in

What do the UHN OR staff think after one year of using the surgical checklist?

University Health Network

q1

- Do you think the use of the checklist has improved patient safety at UHN?

Profession	Response (0-10)
nurse	8
anesth	7
surgeon	7

q2

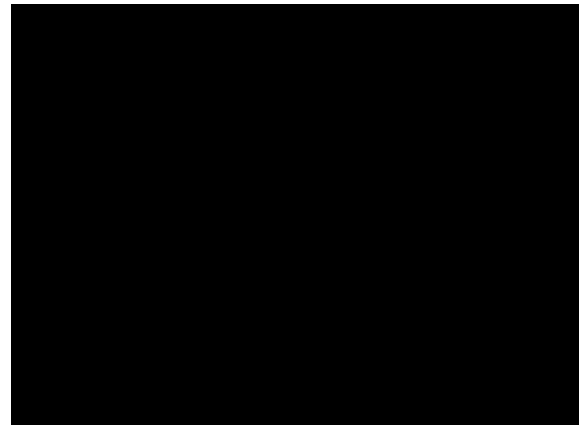
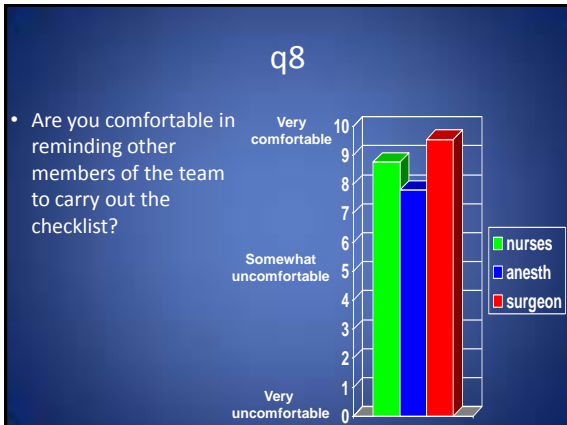
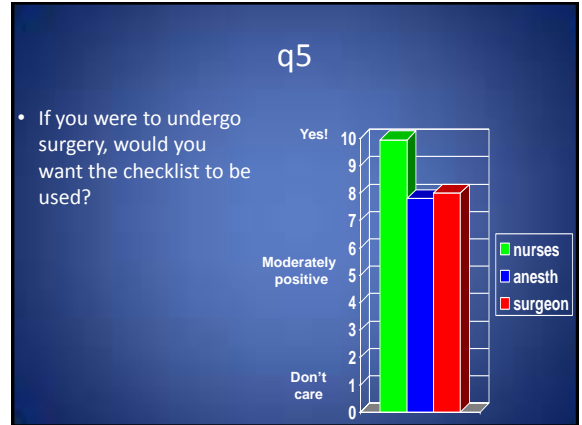
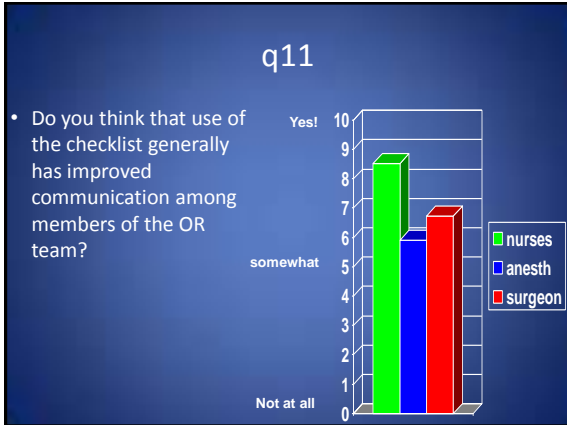
- Do you find the conduct of the checklist inconvenient?

Profession	Response (0-10)
nurse	2
anesth	3
surgeon	2.5

q3

- How much time does the checklist take?

Profession	Time (minutes)
nurses	2.5
anesth	2.5
surgeon	2.5



...what it is....

A Culture Change

Teamwork + Process/Details

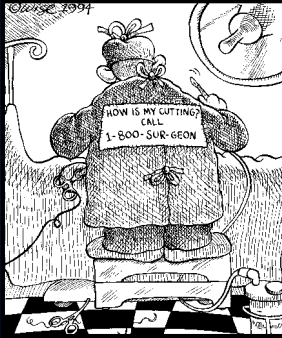
↓

↓ RISK





The Era of Accountability



© 2004

HOW IS MY CUTTING?
CALL
1-800-SUR-GEON

*"The Hawthorne effect
in action"*

A cartoon illustration of a doctor in a white coat and cap, standing in a room. The doctor is holding a sign that reads "HOW IS MY CUTTING? CALL 1-800-SUR-GEON". The doctor is looking at the sign. The cartoon is signed "© 2004" in the top left corner. To the right of the cartoon is the text "The Hawthorne effect in action".

*is it
Heroism?*

A photograph of a large commercial airplane floating in the water. The plane is tilted, and its wings are visible. In the background, there are several boats and a city skyline. In the bottom right corner, there is a small inset portrait of a man in a pilot's uniform. Below the portrait is the text "is it Heroism?".

Getting it done

Implementing the Surgical Checklist

Bryce Taylor, Dublin, October 2009

A photograph of a city skyline at sunset or sunrise, reflected in a body of water. The sky is a mix of blue and orange. The buildings are lit up, and their lights are reflected in the water. The text "Getting it done" is written in large, bold, black letters at the top. Below it, "Implementing the Surgical Checklist" is written in a smaller font. At the bottom, "Bryce Taylor, Dublin, October 2009" is written in a small font.