

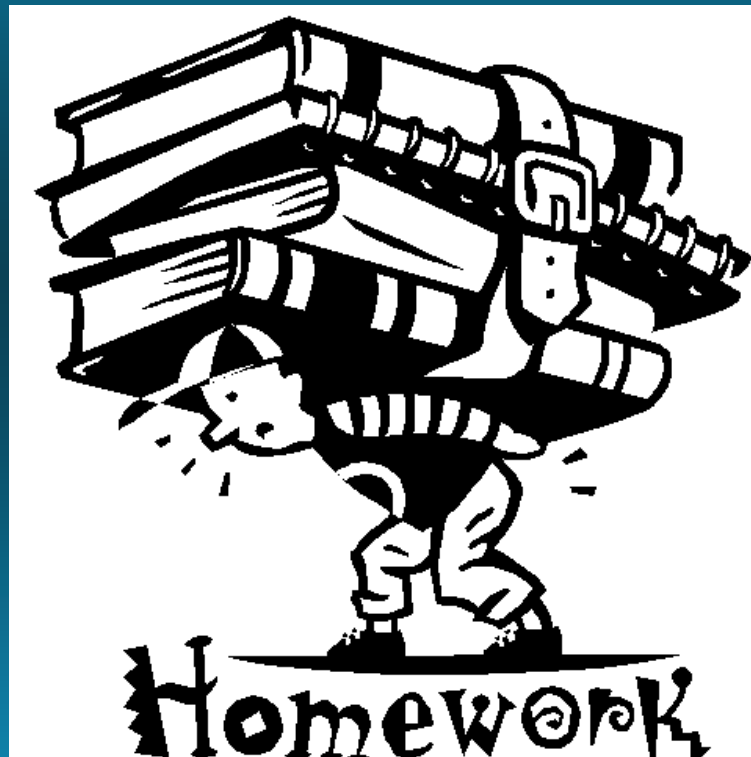


Call 2: Measurement of the Checklist

Summary of Last Week's Call

- The checklist is a checklist but it is also more than a list of checks
- It is a list of things that we should do for every patient every time
- It is a powerful tool to help us communicate
- It is going to take time for us to do this work the way that it needs to be done

How Did the Homework Go?



Last Week's Homework

- Gather an implementation team
- Schedule a time and venue for a meeting to take place in 8-10 weeks
- Read background materials on the checklist. We will send you links to the documents following this call
- Create a list using the excel template provided to you of all of the OR staff, physicians, and techs
- Send us a picture of your checklist implementation team

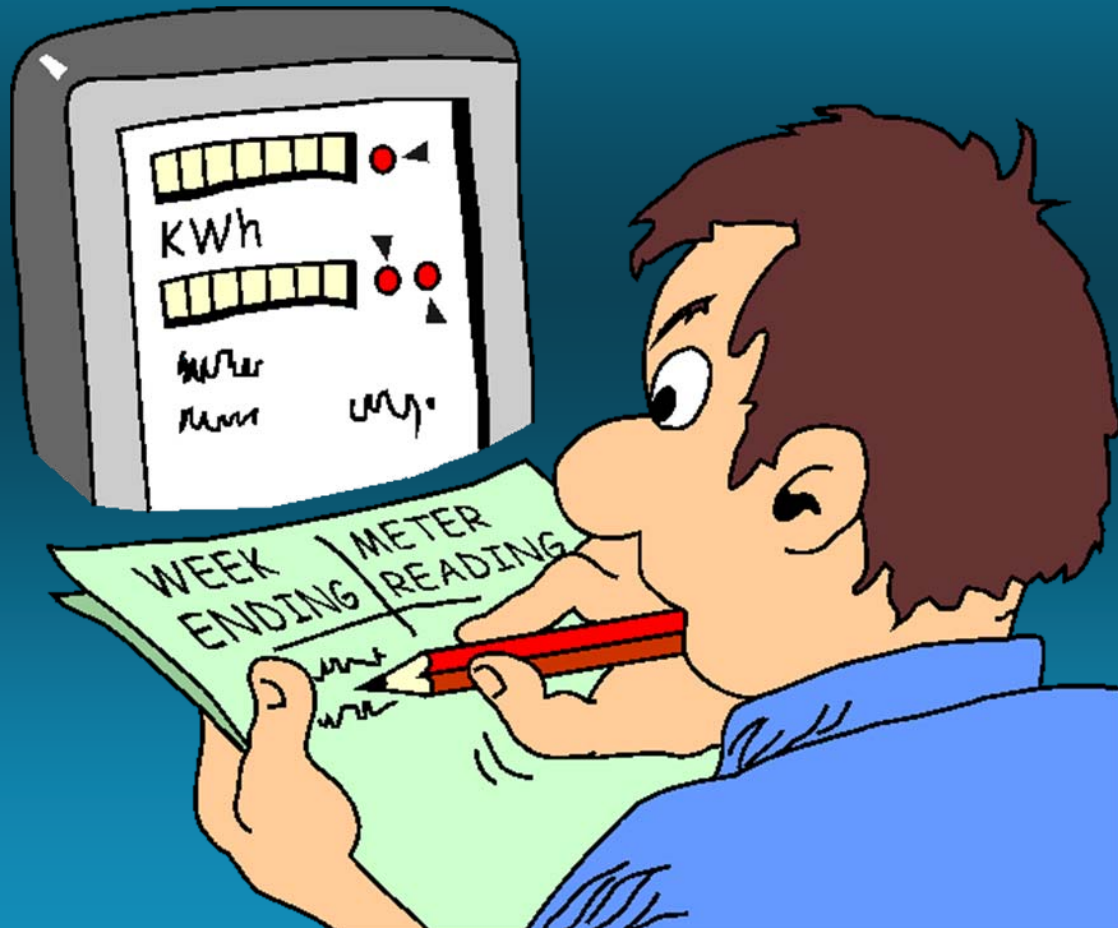
Why Measure?

Structure

Process

Outcome

The Burden of Data Collection



Why Measure?

Structure

Process

Outcome

State Measurement

Elements of Data Collection

- Surgical Mortality
- Surgical Site Infection (SSI) Rate
- Overall measurement of surgical complications

What Do We Already Know?

Results – All Sites

	Baseline	Checklist	P value
Cases	3733	3955	-
Death	1.5%	0.8%	0.003
Any Complication	11.0%	7.0%	<0.001
SSI	6.2%	3.4%	<0.001
Unplanned Reoperation	2.4%	1.8%	0.047

Site C

	Baseline (n=524)	Checklist (n=598)
Abx Given 0-60 Mins Except Dirty Cases	98.1%	96.9%
Adherence to All Six Safety Indicators	94.1%	94.2%
SSI	4%	2.0%*
Death	1.0%	0.0%*
Any Complication	11.6%	7.0%*

*p<0.05

Stanford University, United States

- E/O Mortality declined from .88 to .80
- Reported Patient Safety Never Events (PSN) rose from 559 to 637
- Reported events due to errors/complications decreased from 35.2% to 24.3%
- Mean OR start to incision time was shorter
- There was improvement in the belief (SAQ) that all personnel take responsibility for patient safety

(N=12,247)

SURPASS Checklist, The Netherlands

- 100 item checklist implemented in 6 high performing hospitals
- Compared to controls the test hospitals had a greater than one-third reduction in complications and achieved an almost 50% reduction in deaths (from 1.5% to 0.8%)

(N=7,580)

Veterans Health Affairs, United States

- Implemented a surgical team training program incorporating a modified version of a surgical checklist in the operating theatres of 74 facilities
- Experienced a mortality reduction of 18%

What Do You Collect Already?

- Unplanned Return to the OR within 24 hours
- Specimen Labeling Errors

Why Measure?

Structure

Process

Outcome

Why Monitor With Our Tools?

Monitoring will help your hospital...

- Track progress toward thorough and consistent checklist use
- Track improvements in surgical teamwork
- Enhance and sustain checklist use through site specific and comparative data.

TOOLS AVAILABLE

Tool	Completed By	Estimated Time to Complete Tool	Suggested Frequency of Administration	Training Required
Checklist Implementation Leader Survey	Members of the checklist implementation team	<10 Minutes	Twice (baseline and post-implementation)	Instruction Review
Surgical Safety Culture Survey	All OR Personnel, including anesthesia providers, nurses, surgeons, surgical techs, and other staff	<5 minutes	Twice (baseline and post-implementation)	Instruction Review
Surgical Teamwork Observation Tool	Surgical Nurse Manager, Quality Improvement / Patient Safety Officer or other staff member with appropriate clinical experience	≥ 1 hour, including observation time	At a minimum 5 cases/quarter	20 minute online training for observers and Instruction Review
Surgical Safety Checklist Observation Tool	Circulating Nurse	< 5 minutes	At a minimum 5 cases/quarter	Instruction Review

CHECKLIST OBSERVATION TOOL

Briefing

4. Which of the following individuals participated in confirming the patient's identity, procedure or operative site before incision? (Mark all that apply.)	<input type="checkbox"/> Nurse	<input type="checkbox"/> Anesthesia provider	<input type="checkbox"/> Surgeon	<input type="checkbox"/> Not confirmed
5. Did team members introduce themselves by name and role (e.g., "Lynn, the anesthesiologist.")?			<input type="radio"/> Yes	<input type="radio"/> No
5a. <i>If no</i> , is this team established (e.g., introductions performed earlier, regular surgical team)?			<input type="radio"/> Yes	<input type="radio"/> No
6. Before incision, did the surgeon discuss the operative plan?			<input type="radio"/> Yes	<input type="radio"/> No
7. Before incision, did the surgeon state the expected duration of the procedure?			<input type="radio"/> Yes	<input type="radio"/> No
8. Before incision, did the surgeon communicate the expected blood loss (EBL)?			<input type="radio"/> Yes	<input type="radio"/> No
9. Before incision, did the nurse discuss sterility, equipment, or any other concerns?			<input type="radio"/> Yes	<input type="radio"/> No
10. Before incision, did the anesthesia provider discuss the anesthesia plan (including airway or other concerns)?			<input type="radio"/> Yes	<input type="radio"/> No
11. Were all checklist items read aloud, without reliance on memory?			<input type="radio"/> Yes	<input type="radio"/> No

TEAMWORK OBSERVATION TOOL

On a scale of 1 – 7, with 1 being “STRONGLY DISAGREE” and 7 being “STRONGLY AGREE”, please indicate your agreement with the following statements regarding this procedure:

	Strongly Disagree			Strongly Agree				N/A
1. Clinical leadership was shared among disciplines depending upon the patient's condition or issues that arose during the operation.	①	②	③	④	⑤	⑥	⑦	○
2. Physician leaders were open to suggestions from all team members.	①	②	③	④	⑤	⑥	⑦	○
3. Physician leaders set a positive tone while performing the Checklist.	①	②	③	④	⑤	⑥	⑦	○
4. Physician leaders maintained a positive tone throughout the operation.	①	②	③	④	⑤	⑥	⑦	○
5. Verbal communication among team members was easy to understand (e.g., clearly articulated and spoken at an adequate volume).	①	②	③	④	⑤	⑥	⑦	○
6. Team members shared key information as it became available.	①	②	③	④	⑤	⑥	⑦	○
7. Speakers made a visual or spoken effort to confirm that important information was received.	①	②	③	④	⑤	⑥	⑦	○
8. Recipients made a visual or spoken effort to confirm that they understood the information communicated.	①	②	③	④	⑤	⑥	⑦	○

Option 1: Self-Monitoring

- Use some or all of the surveys and observation tools
- We will provide training, instructions and real-time support in using the surveys and tools
- You will be responsible for collecting your data and analyzing it yourself

Option 2:

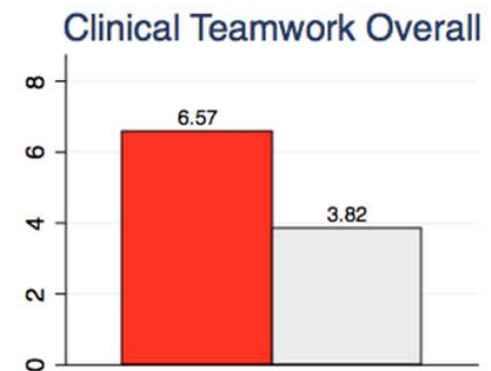
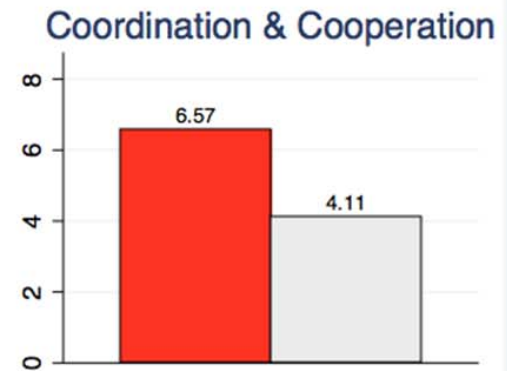
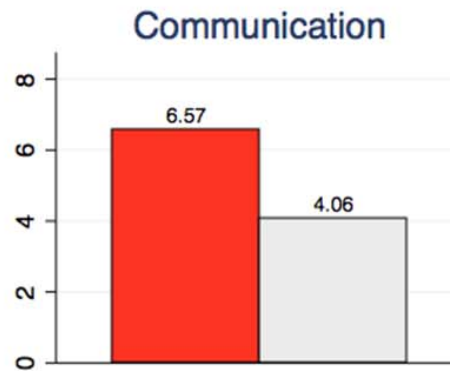
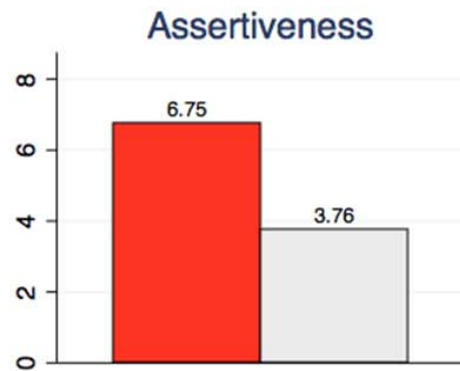
Participate in a Research Study

- Use all of the surveys and observation tools
- We will provide training, instructions and real-time support in using the surveys and tools
- Send data to HSPH where we will analyze it and provide feedback
 - No cost to you
 - Includes benchmarks with other SC hospitals

FEEDBACK EXAMPLE

Teamwork Summary:

Average score by dimension



Items are on a scale of 1-7. Higher numbers are better.

Benefits of Participation

- More accurate and detailed data to improve monitoring of the Checklist implementation process and targeting of opportunities for improvement
- Periodic reports and benchmarking at no cost to you
- Generate knowledge that will enhance surgical care worldwide

What to Take Home

- Measurement is important
- We encourage everyone to use the tools to monitor
- We would like everybody to participate in Option 2

Homework

- Continue to compile the spreadsheet of OR Personnel (anesthesia providers, nurses, surgeons, and techs)
- If you haven't already, designate if your hospital will be participating in the research portion of this study
 - Send an email to: Lizzie Edmondson at: safesurgery2015@hsph.harvard.edu



Questions

Resources

Website:

www.safesurgery2015.org

Email: safesurgery2015@hsph.harvard.edu