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Canadian Patient Safety Institute
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SURGICAL SAFETY CHECKLIST

www.safesurgerysaveslives.ca

HOW: THE HOW-TO GUIDE

May 2009

Building a safer health system

HOW-TO GUIDE

FOR IMPLEMENTING THE SURGICAL SAFETY CHECKLIST

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Implementing the Surgical Safety Checklist in your organization is both exciting and challenging. This quick How-To guide provides an overview of the steps you should consider in preparing to use the Checklist in your OR. Other tools that you might find useful are the Detailed Explanation of the Surgical Safety Checklist Items, The Human Factors Guideline and the Fact Sheet. Also visit the Community of Practice to learn from and discuss with organizations that have implemented the checklist. For more and up to date information and resources please visit www.safesurgerysaveslives.ca.

This document is an update of the previous How-to Guide, version 1.0, published by the Canadian Patient Safety Institute on March 2009.

This document is based on the WHO Surgical Safety Checklist, URL http://www.who.int/patientsafety/safesurgery/en/ and the Starter Kit (The condensed How-To Guide), © World Health Organization 2008, and adapted by the Canadian in-Country Working Group with support from the Canadian Patient Safety Institute.

PREPARE FOR IMPLEMENTATION

☐ Clarify what, why and how

The first thing you should do as an advocate for the Checklist is to become familiar with what the Checklist is, how it works and why it matters to your organization. On our website you will find the four versions of the Canadian Checklists, a Fact Sheet, a video and a news release. Engage your colleagues in a dialogue to create awareness of the Checklist and the significant impact it can have on patient safety and improved outcomes. It is important to emphasize that you do not need to take the Checklist 'as is' if it does not fit your own organization: you are encouraged to adapt the Checklist.

☐ Network and learn from others

You will also want to learn how other organizations have adopted and implemented the Checklist. We encourage you to join the Safe Surgery Saves Lives Community of Practice to connect with leaders like you, ideally from an organization to which you relate well, and talk to them. Consider signing up your organization for inclusion on the Surgical Safety Map (follow the links from our website www.safesurgerysaveslives.ca). This is an opportunity to be part of and network with others who have taken on the challenge to make surgery safer. Listen to patients and look to them to provide meaningful stories for the organization. Build partnerships.

You may also find it helpful to provide your surgeons, anesthesiologists and staff with various educational opportunities. For example, bring in a speaker who is respected by the OR team to discuss the Checklist and the research data. Engage early responders as mentors for other OR teams and have them use recent examples of their own safe and unsafe surgery and the consequences, as opportunities for review and to further understanding. You will soon be at a stage where your organization will have its own leaders who will spread the surgical safety forward by becoming mentors.

☐ Create a sense of urgency[1]

You can expect that "yet another patient safety project" may be received with reluctance by some individuals in your organization. This is normal. Try to meet with as many of your colleagues as you can and let everyone know what you are doing. To counteract this, provide important facts (relevant quality data and logic, like the research published in the New England Journal of Medicine) to win their minds and give them food for thought. The www.safesurgerysaveslives.ca website is a good resource for this and other published work relevant for implementing the checklist.

In addition, you must try to win your colleagues' hearts too by telling stories, sharing results, discussing cases and recent examples of safe and unsafe surgery and their consequences. Behave with urgency, show passion, walk the talk, and let everyone see what you are doing. Use crisis (errors and good catches) as opportunities.

[1] Kotter, J. P. (2008) Asense of urgency. Boston, Mass.: Harvard Business Press.

IMPLEMENTATION STRATEGIES

☐ Prepare and educate all stakeholders

Your next step is to build on the awareness already created. You can now start educating everyone who will use or be affected by the checklist. Identify those who you think are likely to be most supportive of the checklist first. You must include colleagues from other clinical disciplines (surgery, anaesthesia, nursing, and providers in the perioperative settings) in these discussions.

☐ Develop champions at every level

At this early stage, work with those who are interested and willing to work with you, rather than trying to change the most resistant people. This is a very important step as this core group of enthusiastic interdisciplinary colleagues (both formal and informal leaders) will be the engine that drives this project. Debate together critical issues, barriers, opportunities and inspire each other. Build a vision of safe surgery. Imagine a strategy (think about a plan) that will help you move this project forward. Spread enthusiasm about the checklist in corridor talk, at the water cooler, reminders, vigilance, etc.

☐ Senior management endorsement *(not* decree)

Support of this initiative by leaders in each of the clinical disciplines is critical to its success. Emphasize to them the available facts: research findings from the pilot sites, benefits of lower complication rates and the potential for cost savings. Bring examples of other hospitals that are using the checklist now and their success. Think about what the hospital leadership can do to integrate the checklist with your other safety initiatives and how they can promote the use of the checklist. Share your vision, discuss metrics and communication strategies with key individuals in your organization. Be proactive in anticipating how people will react and prepare your responses in advance. Endorsement from senior hospital management, local health authorities, and provincial safety officers are important factors for success, although it must be stressed that at the outset, independent professionals such as surgeons and anesthetists cannot be told how to conduct their practice.

☐ Customize the checklist for your organization

You and your team are encouraged to adapt the checklist and make it fit in your organization. Encourage discussions about customization with all the relevant stakeholders and make the checklist yours. This promotes "ownership" of the checklist, and can act as a "signature" of Surgical Services in a hospital. We advise you to review the article regarding on how to adapt the checklist from a human factors perspective available on our website.

☐ Implement after a brief practice run

Early adopters have found it useful to have a week of "practice runs" with a "go-live" date, so that all practitioners can become familiar with using the checklist. This will help reduce reluctance to implement because you have the opportunity to try it out before making a more significant and broad-

reaching commitment. It is also critical during this period that the champions are visible and present to offer advice, reminders, etc.

☐ Start small, and then expand

With the help of hospital leadership, run a campaign to get the checklist implemented in specific settings, for example a single operating room or within a single department. After testing it out, addressed the issues that came up, and when there is enough enthusiasm, you can plan the best strategy to expand. During the original evaluation by WHO, sites that tried to implement the checklist in multiple operating rooms simultaneously or hospital wide faced the most resistance and had the most trouble convincing staff to use the checklist effectively.

☐ Use the checklist

Make sure your core team members are always using the checklist in their own operating rooms. Slowly encourage others to adopt the checklist and work through potential concerns with them. Do not hesitate to customize the checklist for your setting as necessary, but do not remove safety steps just because you are unable to accomplish them. Share your enthusiasm, your vision, ask questions when in doubt, and communicate with your core team. Empower others and remove obstacles in their path.

MAINTAIN SUCCESS, SHARE LEARNINGS

☐ Monitor and record compliance

Whether compliance is registered on paper or electronically, it should be recorded and those who do not comply must be reminded that compliance is expected, and the innovation represents a new standard of practice. This requires ongoing vigilance from champions and leaders. A quick compliance tool is available with the "Checklist with Scorecard" version of the Canadian checklist.

☐ Track changes

Collect data to see if the standards are being followed as the checklist is implemented in more operating rooms. Follow both process and outcome measures—e.g. in what percent of operations are we giving antibiotics at the correct time? How many patients get surgical site infections? A Data Collection Tool is under development and will soon be available for organizations wishing to use it. The most significant message of checklist use has been that in the surgical domain, we must collect better and more comprehensive data about what we do, how we are doing it, and the resultant patient outcomes. To the extent that this is possible, it should be encouraged as a foundation for progress.

☐ Set public goals

Once you have a sense of your data, try to improve your numbers by letting your whole hospital know about improvement goals you hope to achieve. This will help you not only to stay on track with your project, but also to get support from stakeholders when needed. Relentlessly communicate your vision and strategy to relevant people to obtain buy in and generate still more urgency.

In some jurisdictions, the data collection has been sophisticated enough that public reporting of compliance has been achieved. This trend in surgical practice will continue, and all hospitals in future will want to be prepared to report on their acceptance of this important advance.

☐ Monitor and record "nice catches"

During the course of the checklist operation, many have found that issues in fact have been picked up before an error of commission or omission is made. These should be regarded as "close calls" or "nice catches" and should be recorded and publicized. Positive reinforcement of the use of the checklist is of great value. In some organizations, these can be recorded in incident reports, so that the information can be disseminated through the quality committees.

☐ Celebrate and reward successes

All changes of practice which are successfully implemented should be rewarded, and the particular steps taken may vary depending on your setting. This may involve general celebrations or rewards for those groups in the operating room setting who have achieved 100% compliance. Competition between teams is most often a good motivator to change; therefore it is important to make public the teams who worked hard to raise your organizational bar. Often, simply posting the results prominently in the operating room is an effective way to maximize compliance. Thank you notes and other way of appreciation from leaders and quality teams are always an effective way to positively reinforce success.

☐ Update the hospital on progress

Make the progress on both process and outcome measures publicly available so that hospital staff can witness improvement. The Data Collection Tool provides a good starting point for sharing information. Highlight the short term wins your organization achieved and project future expectations (your best case scenario). This will silence critics and disarm cynics.

☐ Continuity is essential

Continue to use the checklist. Data collection may become less frequent as the checklist is accepted. A periodic check on progress will ensure that process measures stay on track and complications are minimized. Do not let your team and the others involved slide back into complacency. Expand your efforts continuously based on your strategy and your vision. Your successes and lessons learned are a strong foundation together with the successes of everyone in your network and in Canada.

☐ Make change stick

Find ways to incorporate the use of the checklists with other safety initiatives in the hospital. Institutionalize its use into the structures, systems and culture of your organization. Ideally, this should be regarded as "best practice" or "standard operating procedure".

Often, the use of questionnaire follow up after 6-12 months, asking all involved staff for acceptance, suggestions, and barriers show everyone that their opinion matter in the change. Ideally, the results should be made public and also the actions that will be taken based on the answers.

Anticipate possible downturns in the implementation and expansion strategy and try to find solutions. If that happens, try to raise urgency again by bringing outsiders in (mentors, successful organizations that relate well to), deal with the nay-sayers one by one, show your successes.

☐ Data collection outcomes

Ideally, the best way to sustain change is to record and report outcomes on an ongoing basis, specifically the anticipated reductions in specific complication rates. However, the present cost of following these outcomes is prohibitive for most hospitals, and until that is possible, the confirmation of the checklist implementation is the most cost-effective first step in improving patient safety.

☐ Share your experience with the Safe Surgery Saves Lives program

The Safe Surgery Community of Practice is one easy way to discuss and learn about how others are implementing the checklist. From there, you can access experts and mentors that can give you personalized advice.