Quality Connections

Sharing Best Practices and Lessons Learned

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"Checklists"

That's the word for January.

People are abuzz about Boston physician Atul Gawande's new book "The Checklist Manifesto." Gawande speaks of the complexity of life and the limitations of the brain. He says humans are set up to fail unless we use checklists to help us. But checklists, especially the Surgical Checklist, can bring pushback because they represent change. In large and small hospitals, some surgeons think using a checklist is an insult to their competency. "You take something as complex as surgery, and you think there isn't a lot that can be done to make it better," said Gawande. "A checklist seems like a no-brainer, but the size of the benefit is dramatic. According to a year-long, eight-nation project done in rural and urban hospitals with diverse populations, the checklist reduced deaths and complications by one-third."

After talking to many of you about implementing the Surgical Checklist in our RHQN hospitals, I am not surprised that the original study found the major barrier to widespread adoption is physician attitudes.

"If you ask surgeons, they'll say, 'Oh, we do this stuff,'" Gawande said. He himself was skeptical that the checklist would affect the eight to ten operations he performs each week. But Gawande says many of the improvements come from the intangible benefits of having doctors and nurses work as a team, communicating every step of the way. "You can't really measure the benefit of having the surgeon and anesthesiologist talking to each other and coordinating care."

Several nations and at least five states, including Washington state, have launched programs to promote widespread use of a checklist. As David Flum, MD, MPH from the University of Washington Surgery Department put it: "When I have an operation, please use a checklist on me." (Washington Post, January 15, 2009)

A speaker at a recent Safe Table Web call said "We tell our surgeons and staff that if they don't like the Checklist, try going anywhere else in the country. Everyone is using it. It is the Standard of Care."

Implementing the Checklist: Living a PDSA

Change isn't easy. You've all been living in the land of multiple PDSAs as you implement the Surgical Checklist. **Plan-Do-Study-Act: Planning** how to use the Checklist, **Doing** the Checklist, **Studying** the results, and **Acting** by either *adopting* what worked, making slight *adaptations* to your approach in additional PDSAs, or *abandoning* the first approach and starting all over.

Where is your hospital on the Change Continuum?

Ideally, the surgeon leads the use of the Surgical Checklist. While many RHQN members report new surgeons accept and champion their use, others are finding it difficult to find a physician champion at all. However, even Gawande recognizes that the surgical staff is often the best option to instill use of the Checklist.

Where is your hospital on the Adoption Scale?

- Physician champion adopts
- Surgeons adopt
- Spread to all invasive procedures
- Circulators adopt
- Noted in/part of the chart

RHQN Hospitals Share Best Practice Ideas:

Barbie Dailey in Othello shares that their circulating nurses met and decided to adopt the Checklist. They agreed to have a paper copy in each chart pack with a place for the patient ID sticker at the bottom. The circulators lead the use and engage surgeons by asking the Checklist questions. The circulator signs the form and it is a permanent part of the chart. Barbie reports they like the new Surgical Checklist with the "Less than" and "Greater than" 1 hour format. (Click here for a Link to the Surgical Checklist.) When a surgery lasts longer than the projected 1 hour, they draw an arrow to the 2 hour checklist, note the time, and continue using the 2 hour format. Othello also continues to use a whiteboard in surgery with the patient name, site, allergies, and important information.

Wayne Cantwell at Chelan reports they are also using the Checklist, having the seemingly normal…in large hospitals and small throughout the state…challenges. The Chelan staff "is very proactive with the Surgical Checklist and uses it on all procedures, including endoscopy. Checklist posters are on the wall in each of the OR rooms. Staff is active in directing the Checklist process before the incision is made or a procedure is started. Everyone on the team has to acknowledge the Checklist process before the incision is made." (Please note that SCOAP reports they are working on checklists for specific outpatient procedures at this time.)

Another great idea shared at the January 21st Safe Table Web Conference: Modify your check process to accommodate prone procedures. Mistakes can easily happen when "what is left is now right" and vice-versa. A hospital reported that following several near-misses, they do the surgical checklist after the prone patient is draped.

Please let me know your Lessons Learned and Helpful Hints for adopting the Surgical Checklist so we can spread your ideas to other RHQN members.

Rural Healthcare Quality Network

A Checklist for Perinatal Care

Heads Up! In the Fall of 2008, the National Quality Forum created 17 consensus standards for perinatal care. Washington State OB leaders are now creating OB-COAP which will include measures from this list. It is interesting there is no VBAC measure, and no maternal morbidity measure. Many expect the NQF to change that in the future. Please go over this list of 13 Obstetric and Neonatal measures with your OB lead: Celebrate if you are collecting this information and/or identify areas for improvement for your patients.

Check if measuring	Obstetric Measures	Details
☐	****PN-007-07f** Elective Delivery Prior to 39 Completed Weeks Gestation	All singletons delivered at term (> or equal to 37 completed weeks gestation) that are electively delivered prior to 39 completed weeks gestation
☐	****PN-013-07** Incidence of Episiotomy	Number of vaginal deliveries with episiotomy procedures performed
☐	**PN-010-07** Cesarean Rate for Low-Risk First Birth Women	Proportion of live births born at or beyond 37.0 weeks gestation to women having their first delivery, that are singleton (no twins or beyond) and vertex presentation (no breech or transverse positions) that had a cesarean birth.
☐	**PN-011-07** Prophylactic Antibiotic in C-Section	All women undergoing cesarean section without evidence of prior infection or already receiving prophylactic antibiotics for other reasons who received prophylactic antibiotics within one hour prior to surgical incision or at the time of Delivery
☐	****PN-006-07** Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	Women undergoing cesarean delivery who receive either fractionated or unfractionated heparin or pneumatic compression devices prior to surgery.
☐	**PN-002/019-07** Birth Trauma Rate measures	Number of infants with specific birth traumas
☐	**PN-016-07** Appropriate Use of Antenatal Steroids	Total number of mothers who delivered preterm infants (24-32 weeks with preterm premature rupture of membranes or 24-34 weeks with intact membranes) who received antenatal steroids at any time prior to delivery.
☐	**PN022-07** Infants Under 1500g	The number per 1,000 live births weighing less than 1500g delivered at hospitals not appropriate for that size infant.
☐	**PN-021-07** Exclusive Breastfeeding at Hospital Discharge	Live births not discharged from the NICU who were fed by "breast only" since birth.
	Neonatal Measures:	
☐	**PN-001-07** Hepatitis B Vaccine Administration to All Newborns Prior to Discharge	Number of live newborns discharged from the hospital who were administered hepatitis B vaccine.
☐	****PN-003-07** Nosocomial Blood Stream Infections in Neonates	Selected bacterial blood stream infections per 1000 qualifying neonates.
☐	****PN-025-07** Birth Dose of Hepatitis B Vaccine and Hepatitis Immune Globulin for Newborns of Mothers with Chronic Hepatitis B	Percentage of neonates born to hepatitis B surface antigen-positive mothers who receive a birth does of hepatitis B virus vaccine and hepatitis B immune globulin.
☐	**PN-024-07** Obstetrical Anesthesia Complications Rate	OB Anesthesia Complication Rate

**Recommended for time limited endorsement

While the 4 NICU measures are not applicable to RHQN hospitals, I am including them for your information:
PN-029-07a: First Temperature Within One Hour of Admission to NICU; **PN-029-07b:** First NICU Temperature within one hour and <36°C **PN-030-07:** Retinopathy of Prematurity Screening **PN-031-07**: Timely Surfactant Administration to Premature Neonates (Number of infants born at 22 to 29 weeks gestation who were treated with surfactant at any time who received the surfactant within 2 hours of birth).

Please let me know if you have any questions or need any help in implementing these OB quality measures.

What's Happening @ RHQN:

The next RHQN Members Conference call is on February 9th at 10:30 a.m. Please alert your ED staff so they can attend. We will review the new RHQN "Emergency Department Wound Care Management Guidelines" and find out how your "early adopter" peers are using this in their EDs.

Musings: Having heard Atul Gawande speak and after reading "The Checklist Manifesto," I'm ready to make a change and accept the limitations of my brain in this complex world. So, I'm off to create a checklist for packing my suitcase to come visit your hospital. I look forward to seeing you soon.

Bev

If you have ideas, comments, questions, need additional resources or a consultation, please contact Bev McCullough, RHQN Quality Improvement Manager, at (206) 216-2862 or by email at bevm@wsha.org.