Expedition Coordinator

Chris Chue, Project Coordinator at the Institute for Healthcare Improvement. Chris has worked on organizing any care transition related activities through the State Action on Avoidable Rehospitalizations (STAAR) Initiative. He has also supported several webinars such as the Primary Care Coach Program: Wave 3, IHI’s Expedition on Reducing Readmissions, and many others. In addition, he is an avid Boston Celtics fan, go Celtics!
Welcome to today’s session!
Please use Chat to “All Participants” for questions
For technology issues only, please Chat to “Host”
WebEx Technical Support:
866-569-3239
Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…
Please send your message to All Participants
Let’s Practice Using “Chat”

Please take a moment to chat in your organization name and the number of people on the call with you.

Ex. “Institute for Healthcare Improvement – 2”

Expedition Director

Kathy D. Duncan, RN, Faculty, Institute for Healthcare Improvement (IHI), oversees multiple areas of content and is the clinical lead for IHI’s National Learning Network. Ms. Duncan also directs content development and provides spread expertise for IHI’s Project JOINTS as well as additional content direction for the Hospital Portfolio, directs a number of virtual learning webinar series, and manages IHI’s work in rural settings. Previously, she co-led the 5 Million Lives Campaign National Field Team and was faculty for the Improving Outcomes for High Risk and Critically Ill Patients Innovation Community. In addition to her leadership on the field team during the Campaign, Ms. Duncan was the content lead for several interventions in IHI’s 100,000 Lives and 5 Million Lives Campaigns. She also serves as a member of the Scientific Advisory Board for the American Heart Association’s Get with the Guidelines Resuscitation, NQF’s Coordination of Care Advisory Panel and NDNQI’s Pressure Ulcer Advisory Committee. Prior to joining IHI, Ms. Duncan led initiatives to decrease ICU mortality and morbidity as the Director of Critical Care for a large community hospital.
Expedition Objectives

By the end of this Expedition, participants will be able to:

- Identify specific opportunities to improve safety and reliability during the patient’s surgical experience
- Improve reliability of key processes identified during each step of the surgical suite
- Identify and test strategies to decrease risk of surgical site infection
- Describe strategies to identify failures during the surgical process

Expedition Schedule

<table>
<thead>
<tr>
<th>Session</th>
<th>Date/Time</th>
<th>Lead Faculty: Summary</th>
</tr>
</thead>
</table>
| Session 6: Post-operative | Thursday, 2/6 @ 1:00 – 2:00 PM ET | William Berry, MD, MPA, MPH, FACS  
Harvard School of Public Health  
Post-op Procedures  
Standardizing the end of the surgical process |
Today’s Agenda

- Assignment #4
- Perioperative Processes
- Q&A – SAVE all questions for the end

Assignment from Session 4

- Determine the core elements of a patient friendly and safe pre-op system
- If utilizing a PAT clinic, collect data on the visit:
  - Total visit: door to door
  - Time (mins) with each provider
  - Wasted time: i.e. total minus provider
- Evaluate cause for wasted time, considering:
  - Scheduling – visits and add-ons
  - Provider sequencing
- Collect data on same day cancellations, categorize:
  - Preventable vs. unpreventable
  - For preventable, assess impact of PAT
    - i.e. need for better instructions or medical work up
- Assess current system for preoperative lab testing
  - Is it patient specific – or is there opportunity to reduce lab testing?
  - Are routine order sets being used, if yes; are they appropriate?
Assignment from Session 4

- For the next 10 patients in your clinic measure total visit lengths and time with each provider
  - Is the total more than one hour?
  - What is the fraction of provider time / total time?
- For your 2 highest volume surgeons review their blood ordering practices
  - Do your surgeons use routine orders? If yes, are these age related?
  - Approach one surgeon with routine orders for EKGs or labs and ask if you can eliminate EKGs or labs that are based solely on age, with no active clinical indications
  - Count how many EKGs and labs would be eliminated in 10 patients

William R. Berry MD, MPA, MPH, FACS

William R. Berry, MD, MPA, MPH, FACS, the Chief Medical Officer of Ariadne Labs: a joint center for health system innovation and a Principle Research Scientist at the Harvard School of Public Health. He also serves as the Program Director for the Safe Surgery 2015 initiative. Prior to this, he was the Boston Project Director of the Safe Surgery Saves Lives initiative with the World Health Organization’s Patient Safety Program. He attended Johns Hopkins University School of Medicine and achieved board certification in General Surgery, Thoracic Surgery and Surgical Critical Care. After 17 years in practice as a Cardiac Surgeon, he attended the Kennedy School of Government and the School of Public Health at Harvard. He serves as an Associate Medical Director to the CRICO/Risk Management Foundation of the Harvard Medical Institutions.

Additionally, he is the director of the surgical simulation program at the Center for Medical Simulation in Cambridge, MA with an interest in team training for surgeons. For the last eight years, he has also been faculty for the Institute for Healthcare Improvement in collaborative projects focused on improving the safety of surgical patients.
Discussion Topics

- The Surgical Safety Checklist as a teamwork tool
- Implementation challenges
- The One-on-One conversation

Building in Safety

7. Forcing Functions and Constraints
6. Automation and Computerization
5. Standardization and Protocols
4. Checklists and Double-Check Systems
3. Rules and Policies
2. Education/Information
1. Instructions to Be More Careful, Vigilant

The Checklist Doesn’t Work If You Don’t Use It

- The checklist has become a “tick the box” exercise
  - Minimal engagement
  - Not used by the “team”
  - Critical information is not communicated
- Team members memorize the checklist items
- Checklist compliance is measured not meaningful use
Site C

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n=524)</th>
<th>Checklist (n=598)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abx Given 0-60 Mins Except Dirty Cases</td>
<td>98.1%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Adherence to All Six Safety Indicators</td>
<td>94.1%</td>
<td>94.2%</td>
</tr>
<tr>
<td>SSI</td>
<td>4%</td>
<td>2.0%*</td>
</tr>
<tr>
<td>Death</td>
<td>1.0%</td>
<td>0.0%*</td>
</tr>
<tr>
<td>Any Complication</td>
<td>11.6%</td>
<td>7.0%*</td>
</tr>
</tbody>
</table>
Safe Surgery 2015: South Carolina Checklist Template

### Before Induction of Anesthesia
- Patient identification (name and DOB)
- Surgical site
- Surgical Procedure to be performed matches the consent
- Site marked
- Known allergies
- Patient Positioning
- The anesthesia safety checklist has been completed

### Anticipated airway or aspiration risk

### Risk of significant blood loss
- Two IVs/central access and fluids planned
- Type and crossmatch/-screen
- Blood availability

### Risk of hypothermia - operation > 1h
- Warmer in place

### Risk of venous thromboembolism
- Boots and/or anticoagulants in place

### Before Skin Incision

#### Entire Surgical Team:
- Is everyone ready to perform the time out?
- Please state your name and role
- Patient’s name
- Surgical procedure to be performed
- Surgical site
- Essential imaging available

#### Has antibiotic prophylaxis been given within the last 60 minutes?
- Plan for re-doing discussed

### Before Patient Leaves Room

#### Nurse reviews with Team:
- Instrument, sponge and needle counts are correct
- Name of the procedure performed
- Specimen labeling:
  - Read back specimen labeling including patient’s name

#### Briefing

#### Surgeon Shares:
- Operative Plan
- Possible difficulties
- Expected duration
- Anticipated blood loss
- Implants or special equipment needed

#### Anesthesia Provider Shares:
- Anesthetic plan
- Airway concerns
- Other concerns

#### Circulating Nurse and Scrub Tech Share:
- Sterility, including indicator results
- Equipment issues
- Other concerns

### Surgeon says:
"Does anybody have any concerns? If you see something that concerns you during this case, please speak up."

---

*This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Based on the WHO’s Safe Surgery Checklist, 2009. [http://www.who.int/patientsafety/safesurgery/en/](http://www.who.int/patientsafety/safesurgery/en/)*
Teamwork vs. Process

### Before Induction of Anesthesia

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<td>- Patient identification (name and DOB)</td>
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<td>- Surgical site</td>
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<tr>
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<tr>
<td>- The site has been marked</td>
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<tr>
<td>- Known allergies</td>
</tr>
<tr>
<td>- The anesthesia safety check has been completed</td>
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### Anesthesia Provider discusses patient specific information with the team:

- **Anticipated airway or aspiration risk**
- **Risk of significant blood loss**
  - Two IVs/central access and fluids planned
  - Type and crossmatch/screen
  - Blood availability
- **Risk of hypothermia - operation >1h**
  - Warmer in place
- **Risk of venous thromboembolism**
  - Boots and/or anticoagulants in place
Before Skin Incision

**Process**

**Teamwork**

<table>
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<th>Entire Surgical Team:</th>
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<td>□ Is everyone ready to perform the time out?</td>
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<td>□ Please state your name and role</td>
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| Patient’s name |
| Surgical procedure to be performed |
| Surgical site |
| Essential imaging available |
| □ Has antibiotic prophylaxis been given within the last 60 minutes? |
| □ Plan for redosing discussed |

**Briefing**

**Process**

**Teamwork**

<table>
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<th>Surgeon Shares:</th>
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**Anesthesia Provider Shares:**

| Anesthetic plan |
| Airway concerns |
| Other concerns |

**Circulating Nurse and Scrub Tech Share:**

| Sterility, including indicator results |
| Equipment issues |
| Other concerns |

**Surgeon says:**

“Does anybody have any concerns? If you see something that concerns you during this case, please speak up.”

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Before Patient Leaves Room

**Process**

**Teamwork**

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</table>

**Debriefing**

**Process**

**Teamwork**

<table>
<thead>
<tr>
<th>Entire Surgical Team Discusses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Equipment problems that need to be addressed.</td>
</tr>
<tr>
<td>□ Key concerns for patient recovery and management</td>
</tr>
<tr>
<td>□ What could have been done to make this case safer or more efficient</td>
</tr>
</tbody>
</table>
What Is the Problem Here?

Surgeons Think Things Are Pretty Good . . .

Figure 2. The surgeon’s view of operating room (OR) teamwork by OR caregiver role. Anesthes., anesthesiologist; CRNA, certified registered nurse anesthetists.

Makary et al., J Am Coll Surg 2006; 202: 746-52
Not Everyone Agrees

Makary et al., J Am Coll Surg 2006; 202: 746-52

The Quality of Physician Leadership Depends on Who You Ask

Safe Surgery 2015 Preliminary Data
Evidence
“Driven” Behavior

Believing
Changing Minds and Changing Hearts

Physician Acceptance Is the Critical Factor in Successful and Meaningful Use of the Checklist
Physician Engagement Observed During a Surgical Checklist Implementation

The One-on-One Conversation: A Path to Meaningful Checklist Use
Methods of Engagement

- Posters
- Bulletin Boards
- Large Meetings
- Departmental Meetings
- Emails
- Hospital Newsletters
- One-on-One Conversations

Nothing Replaces this Conversation

- Staff meetings *don’t count.*
- Emails *don’t count.*
- Posters *don’t count.*
- Bulletin boards *don’t count.*
Principles Behind the One-On-One Conversation

- Each conversation may need to be approached differently
- The person that has this conversation needs to be respected and trusted
- You may need to have multiple conversations before they are willing to help with the work

Framing Your Conversation with a Colleague

- Schedule a time to meet with them
- Make sure that you have a copy of your checklist
- Highlight the items on the checklist that you would like them to lead
Points to Discuss (Part 1)

- Introduce the checklist and emphasize that the checklist is about communication and teamwork
- Explain how the checklist or your updated checklist is different from what you are currently doing
- Emphasize that everyone in your facility tries to be safe and you are building upon what you already do
- Tell them that they are a leader in your facility and that you can’t do this without their help
- Say, If you do it, other team members will follow your patterns of communication. . . . You are in the position of setting the tone

Points to Discuss (Part 2)

- Walk through the checklist and explain to tell them how to use it and what their part is
- The checklist gives you an opportunity to make your plan clear, answer questions, demonstrate openness, and professionalism
- Ask them to help with the project, “Will you help us with this work?”
- Thank them for their time
A Story from Texas

What This Work Is Really About. . .
This isn’t just about one person and what they need. Everyone is in the room for the patient and all of the people around you need your help, encouragement and leadership. Surgery is a team effort and the most effective and safe teams recognize that.

Safety is staying back from the edge

The Checklist can help you do that
Take Home Messages

- The checklist can be used as a teamwork and communication tool...most hospitals can get more out of their checklist
- Use One-on-One conversations as a way to get buy-in

Homework

- Observe 3 cases and complete the observation tool
- Observe before the induction of anesthesia, before skin incision, and before the patient leaves the room
Questions?

Raise your hand

Use the chat

Expedition Communications

- Listserv for session communications: surgeryexpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes
Next Session

Thursday, February 6, 1:00 PM – 2:00 PM ET
Session 6 – Post-Operative Processes

William Berry, MD, MPA, MPH, FACS
Harvard School of Public Health