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State hospitals to use checklist to reduce surgery problems

By Liv Osby • Staff Writer • Published: September 19, 2010 2:00AM

Surgical complications injure and kill thousands of people in the Palmetto State every year but many could be saved if hospitals used a simple safety checklist.

Now the state's hospitals are embarking on a pilot project championed by international patient safety guru Dr. Atul Gawande to bring that checklist to every operating room.

"In South Carolina, more than 700,000 operations are done in hospitals every year," Gawande told *The Greenville News*. "Our estimate is that if we get just a 10 percent reduction in complications, more than 4,000 people in South Carolina would be saved serious complications."

And because every avoided complication saves more than \$13,000 on average, the checklist would also cut annual health care costs statewide by more than \$50 million, he said.

South Carolina Hospital Association vice president Dr. Rick Foster announced the project Friday, saying the goal is for 100 percent of hospitals to use the list in every operating room on every patient.

"We feel like if everyone implemented this checklist, we could save the lives of at least 500 patients a year," he said.

The list was tested in eight hospitals from Seattle to Tanzania, said Gawande, a surgeon and professor at the Harvard School of Public Health and Brigham and Women's Hospital and director of the World Health Organization's Safe Surgery Safe Lives program.

It reduced serious complications such as blood loss and infection more than 30 percent on average, he said. In fact, deaths were almost halved.

Gawande said basic safety problems exist everywhere. Infection prevention is not consistent, for instance, and surgical teams don't always communicate.

"Surgery can go wrong in hundreds of different ways," he said. "As we started looking at the evidence, we believed this could save many thousands of people from harm."

Modeled on the checklist used by pilots prior to takeoff, the list checks 19 functions, including identifying the patient, marking the site to be operated on, and discussing any special risks, such as a need for blood, Foster said.

The surgical team also reviews the procedure beforehand and conducts a debriefing afterward that includes the instrument count and post-op instructions. In total, it only adds about three minutes to the procedure, he said.

But only about 20 percent of American hospitals use the list, Gawande said. So he proposed the pilot program and chose South Carolina to initiate it because it has led quality improvement efforts and represents "middle America."

"If I improved something in Boston or in California, I'm not sure middle America would believe it," he said. "But if we can demonstrate this is a sensible thing to do ... it's a model that can be brought to every other state in a couple of years."

The average hospital has a serious surgical complication rate of 3 percent, said Gawande.

"I do about 300 operations a year and that means I have about 10 patients I seriously harm," he said. "And at least half the time, the harm was avoidable."

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Since using the list in his own OR, Gawande said an error is caught each week. In a Thursday procedure, for example, the check revealed the anesthesiologist was planning for a two-hour surgery instead of 30 minutes. Had that not been discovered, the patient would have gotten extra anesthesia, extending her recovery time and cost, he said.

Foster said the checklist has been piloted to some degree in 80 percent of the state's hospitals.

Among them is Greenville Hospital System. Since last year, GHS has used another SCHA initiative called a time-out, where the surgical team goes over a short list just before surgery, said Dr. Thomas Diller, vice president of clinical effectiveness and quality. The more extensive WHO checklist will be expanded over the next year as ORs get digital monitors to display it.

"Some of these things have been done, but not necessarily consistently," he said. "Having a visual in the OR helps people so you don't forget. That's where some of these errors come from."

And Dr. Thomas C. Mann Jr., a surgeon with Bon Secours Medical Group, said St. Francis hospitals have been using the time-out since last year and incorporated the WHO checklist as well. This focus on safety eliminates unexpected scenarios, such as wrong-site surgeries, he said.

"We do it 100 percent of the time," he said. "I don't think there would be any question that surgical complication rates are impacted by this. Hopefully we can have 100 percent participation (among hospitals). It's a good thing to decrease complications and make sure we're doing the right thing for the patient."

Helen Haskell, founder of Columbia-based Mothers Against Medical Error, said the checklist just makes sense.

"Surgery is where most complications occur," she said. "This is an important measure to get people focused on safety and I think it's critical. Hopefully, it will quickly spread across the state."

Gawande said surgical teams weren't enthusiastic about the list in the initial WHO trial, viewing it as an intrusion. But in the end, 80 percent said it was easy to use and improved safety, and actually saw it prevent an error in their own cases.

Moreover, 93 percent said they'd want the list for their own surgery.

The author of several books, including "The Checklist Manifesto: How to Get Things Right," Gawande said he began thinking about safety by pondering how he could be the best surgeon he could be. Eventually he realized that was impossible without an aid to ensure things aren't missed.

"I see the mistakes we make, the mistakes I make. And I wanted to know how to avoid them," he said. "So if we're interested in understanding how we provide great care, we have to start confronting the reality that our brains can't hold it all, that we forget stuff, that things fall between the cracks."



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NO, I have some rules!

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