There’s evidence that using a surgical checklist makes a difference in patient outcomes. A worldwide pilot study at 8 hospitals, published in January, found patient deaths and complications lower after OR teams used the World Health Organization’s Surgical Safety Checklist. Yet some OR teams struggle to consistently perform the surgical site verification process required by the Joint Commission’s Universal Protocol.

How do you bring about the culture change needed for successful timeouts and briefings? One model ORs have used is aviation. LifeWing Partners, founded by pilots and physicians, works with hospitals around the country to help them build team-based cultures.

*OR Manager* interviewed LifeWing’s President Steve Harden, a former US Navy Top Gun instructor, and Steve Montague, a 26-year aviation veteran, about getting surgical teams on board.

Harden will keynote the Managing Today’s OR Suite Conference Oct 7 to 9 at Caesars Palace in Las Vegas. His talk will be titled From Aviation to Health Care: A Culture of Safety.

**Q** What are the pitfalls of getting the timeout in place and practiced appropriately?

**Harden:** One of the biggest pitfalls is that many people have never seen the timeout done correctly. So they don’t have a vision of what it should look like when it’s done properly and what they should be striving for.

Sometimes the timeout becomes longer and more involved than it should be. If it slows the work flow, you definitely won’t get the support of the physicians.

Also, if people don’t know how to do it well, you may not prevent the very thing you are trying to prevent—wrong site surgery. When this happens, everyone becomes demoralized. They say, “We had a wrong surgery, but we were doing the timeout.”

Embedding the checklist in your workflow is nothing short of a culture change. Changing the culture is primarily a leadership issue.

When we go into a hospital, an initial reaction we often hear from physicians and nurses is that leadership dropped the checklist on them and said, “Here it is. Do it.” Then they walked away, assuming it would be done. Leadership didn’t persistently follow up to make sure it was used correctly.

**Q** How can you get past the pitfalls?

**Harden:** When administrators want to use a checklist for the Universal Protocol, many go and get a checklist from another institution. That never works. Checklists need to be developed by the people who will use them. As long as you comply with the Joint Commission’s requirements, there’s a
lot of freedom in how you structure the checklist in your culture. The people who actually will use the checklist are the ones who should create it and are responsible for making sure it gets accomplished.

Montague: If physicians and staff understand the “why” of a preprocedure checklist, it’s much easier to embrace. They’ll understand that this is not an external requirement. They’ll want to do it because their life is going to be better, and they are going to be more effective as a team. As pilots, we can say, “My life is better as a professional because we do this.”

But don’t people already understand why they should use a checklist? The Joint Commission says you have to do this to prevent wrong surgery.

Harden: Most of the hospitals we work with aren’t using a checklist when we begin our work. Most are trying to do the required steps from memory, and there is a great deal of variation from team to team. It’s the variation that allows fertile ground for errors. Most OR teams do not understand the benefits they can gain from adopting a checklist approach.

One complaint is that a team briefing with a checklist takes too much time. What have you seen?

Harden: We’ve had success by pointing out the efficiencies to be gained. Teams are investing a minute to a minute and a half on the front end of the case but are likely to gain 5 to 10 minutes and maybe more on the back end. Over time, that can a considerable gain. Data from our clients shows decreases in the number of cases with unexpected delays. Case lengths also improve. The efficiency gains are what get the physicians on board. But a checklist can’t be completed in minute to a minute and a half unless the tool is well designed, aids the workflow, and was designed by the people who actually use it. The people who use it must also constantly tweak it to make it better.

Montague: In the literature, there are reports that cases are disrupted when you don’t have all of the needed people in the OR, the equipment isn’t ready, and the circulator has to make trips out of the OR to find missing items. If you ask people, “Does this happen in your OR?” They say, “It happens all the time.”

This inefficiency has been accepted as a way of doing business. With a team briefing, there is a way to discuss these things in a concise format. It’s an investment. You are reducing time in the long run and reducing the risk to the patient.

Over time, the timeout can become rote, and team members tend to tune out. How do you avoid that?

Montague: We offer 2 specific suggestions. One is responsibility. Everyone in the OR is responsible for ensuring the checklist is done correctly. Just as important is designating one person with the final responsibility and accountability. There should be a policy in writing that says: “You have to make sure the briefing or checklist is done correctly. You have the power and responsibility to ‘stop the line’ if it is not being done correctly.”

The second suggestion involves proper communication. The person leading the checklist needs to ask questions instead of making statements. When you ask questions, it is a dialog, and others are expected to respond.
You want to make it interactive as much as possible. Everyone on the team should have a speaking role; this keeps the team tuned in.

**Q** Who leads the checklist? Is it typically the physician, the circulating nurse, or someone else?

**Montague:** It’s probably evenly split between the physician and the circulating nurse. When the circulating nurse leads it, we think it’s essential to do the prompt to make sure the surgeon, the anesthesiologist, and others in the room are taking an active role.

My experience is that physicians are like pilots—we sometimes feel we’re invulnerable. We don’t think we are going to have an accident or a wrong-site surgery. I think you’re more successful engaging physicians if your checklist helps to fix the routine things they experience every day. Is the antibiotic on board? Do we have the equipment ready?

If your checklist helps fix everyday frustrations, it’s easier to get them to lead it and use it. That also gets into the last piece—the culture change.

**Q** Culture change seems like world peace. Everyone would like to get there, but how do you bring it about?

**Harden:** You change culture by changing what happens at the hundreds of moments of truth every day. For example, when it’s time to do the Universal Protocol, do you do it from memory, or use a checklist? That’s a moment of truth. Are you paying attention and focused, or are you half-listening? That’s another moment of truth.

We change what happens at the moment of truth by changing what people think at the moment of truth through good training. We reinforce the desired actions by using good tools like checklists. Ultimately, with training and tools we create good habits. Habits determine our character. The character of the team determines the culture. So the formula for changing culture is to change character by creating good habits through use of effective tools and good training. That’s exactly the model we followed in aviation.

**Q** How do you make it safe for everyone on the team to speak up if they see a problem? That’s key for patient safety.

**Harden:** I have never worked in a hospital where I did not hear a nurse say, “This is never going to fly with Dr S. Are you going to hold him accountable? Or is he going to bite my head off?”

Quite simply, this is a leadership issue. Behavior that gets rewarded gets repeated. Behavior that has negative consequences gets changed. This fear is going to persist until folks see something different happen. Words are not sufficient; they have to see different behavior. They have to know that Dr S has had a “performance coaching session” with the vice president for medical affairs about negative behavior.

Those who speak up also need to be rewarded. Someone needs to say to Nurse J, “I noticed that you spoke up during that case. A note is going into your personnel file to document that you have shown exactly the kind of behavior we want.”

When we work with a hospital, we spend a third of our time working with the leadership team, making sure they understand what is required and what standards they need to enforce.
Teamwork training can be difficult to achieve in a busy OR. How do you get everyone to attend?

Montague: To create a good checklist process, we strongly believe you must lay the groundwork with teamwork and communication training. That is one of the prerequisites for working with us. If you are not trained in how to listen and how to build a team, the checklist tool is not going to work.

If folks want to do it the right way, they need to make training happen. We do whatever it takes to work around the OR schedule. We have started as early as 6:30 am and as late as 7 pm, and we have done training on weekends.

We’ve had success in getting physician participation in training sessions. Once they hear from their peers that it is worthwhile, provides CME, and their attendance can earn them up to a 10% discount in their malpractice premiums, most physicians want to participate.

It seems like mistakes happen not in routine cases but in situations where there is an aberration. The patient’s position has been changed, or there is an emergency. How can a checklist help?

Harden: Our philosophy is that the more complex the case, the greater the need for a briefing. It is going to slow you down a bit, and that’s OK. That’s the time when you avoid harm. We in aviation say, “Once you get out of your normal behavior pattern, you are probably going to make a mistake.”

In an emergency, we use a different checklist; we may only review certain steps. You may only review 5 steps rather than the usual 10 steps. Then you go back when things slow down to review the other steps.

The important thing is to analyze those emergency steps on the front end, not to make it up as you go.

Montague: A hospital CEO told me, “When we have had an incident, we were slightly out of the normal pattern.” That’s what you need to build into your checklist and briefing: A pause to look around the room. Look people in the eye and say: “This is not what we normally do. These are the risk factors. I need you to watch for them.” It is essential to put a placeholder in the briefing to hold these kinds of discussions.

The Managing Today’s OR Suite Conference brochure is in this issue. You can also download the brochure and register online at www.ormanager.com

Learn more about LifeWings at www.saferpatients.com

Reference