When Is a Checklist Not a Checklist?

The primary function of a healthcare safety net is assuring safe and reliable care. However, like a safety net with holes, rote use of a checklist provides little protection against error. A case in point:

On the same day in an Oregon hospital, a 64 year-old and a 57 year-old were having the same two procedures on the same body part, performed by the same surgeon. The surgeon was to perform an additional procedure on the 57 year-old. Before surgery on the 64 year-old, the surgeon examined the patient, thought there was a switch in the OR schedule, and prepared to conduct the procedures intended for the 57 year-old. The surgeon discussed three procedures (instead of only two needed) with the 64 year-old, marked three sites, and performed the three procedures intended for the 57 year-old.

There were at least two opportunities to catch this wrong procedure surgery before it reached the patient. The Safe Surgery Checklist includes verification of patient, procedure, site, and consent prior to both anesthesia and the first incision. There may also have been another opportunity to notice the discrepancy if instruments for the third
Checklist, cont’d

procedure had to be added at the last minute. While these two Time Outs occurred in the example case, they did not occur with full and active participation of the entire surgical team. Neither the anesthesiologist nor the nursing staff fully focused on the information being reviewed, and the surgeon—captain of the surgical team—did not require the team’s attention.

When an event like the one described above happens, it is tempting to view it as an isolated issue—a lapse on the part of the surgeon, or the anesthesiologist, or the nursing staff. However, when the entire team fails to complete a necessary step correctly, a much more pervasive problem exists. Much has been written about strategies like checklists that healthcare can borrow from aviation to improve quality and safety. However, as shown in the adverse event above, strategies alone are insufficient. In the words of one CEO at an Oregon hospital, “Culture trumps safety every time.”

Two principal cultural issues underlie the case example. The most significant issue is a weak patient safety culture that normalizes risk, making risky acts not seem so risky and allowing care to drift away from safe practice. The second issue is a weak or absent sense of team. This is expressed as culture of hierarchy that may take the following shapes: non-surgeon members of the surgical team abrogate some of their professional responsibilities, surgeons accept when non-surgeon members abrogate some of their responsibilities, disconnects between surgeons and OR operations lead surgeons to not question or verify a schedule change, members of the surgical team may tacitly prohibit others from voicing concerns. All of these scenarios are symptoms of silos based on discipline and organization-specific responsibilities.

The first step in preventing future occurrences is to understand some of the deeper culture issues at play. Understanding these issues can then drive specific actions designed to assure reliable processes and strengthen the patient safety culture. One plan that the case example hospital developed to impact culture issues was to begin providing staff with regular feedback on how they were doing with the checklist Time Outs in a creative, non-punitive way.

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Coaching and Healthcare

A recent article in the New Yorker, Personal Best by Atul Gawande, describes a practice that we do not typically think of as a healthcare best practice or innovation—coaching. The idea that experts can become even more skilled with coaching is an intriguing one. Gawande, who is perhaps best known for his leadership in the WHO study of the Surgical Safety Checklist, has written extensively on healthcare and patient safety. Gawande applies the concept of

1 Followership is an interesting concept. For more information see Followership from Warren Bennis, Kellerman’s and Chaleff’s followership typologies, and The Ten Rules of Good Followership for a concise description.
Coaching cont’d

coaching—common for world-renowned athletes and singers and increasing among teachers and musicians—to surgical practice. Gawande describes his experience with having a recently retired senior surgeon observing his operations and providing insights.

“...He saw only small things, he said, but, if I were trying to keep a problem from happening even once in my next hundred operations, it’s the small things I had to worry about... That one twenty-minute discussion gave me more to consider and work on than I’d had in the past five years... Since I have taken on a coach, my complication rate has gone down. It’s too soon to know for sure whether that’s not random, but it seems real. I know that I’m learning again.”

While coaching would not work for everyone, and not everyone has the temperament to be a coach, the idea presents some interesting possibilities for healthcare.

Journal Brief: ICU Readmissions


Abstract

Objective: To examine which patient characteristics increase the risk for intensive care unit readmission and assess the association of readmission with case-mix adjusted mortality and resource use.

Design: Retrospective cohort study

Setting: Ninety-seven intensive and cardiac care units at 35 hospitals in the United States.

Patients: A total of 229,375 initial intensive care unit admissions during 2001 through 2009 who met inclusion criteria.

Interventions: None.

Measurements and Main Results: For patients who were discharged alive and candidates for readmission, we compared the characteristics of those with and without a readmission. A multivariable logistic regression analysis was used to identify potential patient-level characteristics that increase the risk for subsequent readmission. We also evaluated case-mix adjusted outcomes by comparing observed and predicted values of mortality and length of stay for patients with and without intensive care unit readmission. Among 229,375 first admissions that met inclusion criteria, 13,980 (6.1%) were eventually readmitted. Risk factors associated with the highest multivariate odds ratio for unit readmission included location before intensive care unit admission, age, comorbid conditions, diagnosis, intensive care unit length of stay, physiologic abnormalities at intensive care discharge, and discharge to a step-down unit. After adjustment for risk factors, patients who were readmitted had a four-fold greater probability of hospital mortality and a 2.5-fold increase in hospital stay compared to patients without readmission.

Continued ➤

Return to Top
ICU Readmissions cont’d

**Conclusion:** Intensive care readmission is associated with patient factors that reflect a greater severity and complexity of illness, resulting in a higher risk for hospital mortality and a longer hospital stay. To improve patient safety, physicians should consider these risk factors when making intensive care discharge decisions. Because intensive care unit readmission correlates with more complex and severe illness, readmission rates require case-mix adjustment before they can be properly interpreted as quality measures.

**Pub Med Citation**

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**In the News**

‘Alarm fatigue’ was a factor in a second Massachusetts hospital death according to a September article in the Boston Globe. According to the article, this event “...has pushed the hospital to intensify efforts to prevent nurses from tuning out monitor warning alarms...including holding monthly drills in the ICUs timing how long it takes nurses to respond to alarms; and arranging seminars and webinars on reducing false alarms and guarding against alarm fatigue...” Patient safety experts will recognize these action plans as somewhat less than ideal. Perhaps a better approach is detailed in a 2010 paper in the American Journal of Critical Care. This quality improvement study showed a reduction in critical monitor alarms of 43% from baseline data. The authors attributed the reduction to several factors, including careful assessment and customization of monitor alarm parameter limits. The complete article is available free of charge [here](#).

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**Resources**

**DICE tool** can provide insight and predict chances of success for improvement projects. The tool factors in the **Duration**, performance **Integrity** (team’s ability), **Commitment** of leadership, and any extra **Effort** required. For a complete description of the tool and scoring see Sirkin HL, Keenan P, & Jackson, A. (2005). The hard side of change management. *Harvard Business Review* October p109-118. If you decide to use the tool after purchasing the article ($6.95 [HBR reprint](#)), contact Leslie Ray for an Excel scoring spreadsheet.
The Director’s View

Moving Reporting and Learning to the Next Level

It is my sincere pleasure to announce that, as of September 30th, all 58 of Oregon’s acute care hospitals are participating in Oregon’s voluntary adverse event Patient Safety Reporting Program. With full participation, the Commission’s vision of making healthcare safer for all Oregonians is closer to becoming a reality. We are committed to maintaining a safe environment for reporting so that our hospitals can confidently share information that produces real change and a better experience for patients in Oregon.

Reporting Standards
While Oregon hospitals have achieved reporting numbers somewhat similar to those in states with mandatory reporting, full participation increases the Commission’s ability to identify lessons from across the state and provide information that will decrease the risk of future events. We now need to continue to improve the number of hospitals submitting reports. To do this, we must increase the quantity and improve the quality and timeliness of adverse event reports currently being submitted to the Commission.

Earlier this year, we presented our plans to develop state standards for reporting in Progress Toward Robust Reporting and asked for comments regarding both the overall plan and the specific goals we developed. In summary, the standards set goals for 2011 through 2015 that gradually:

1. Increase the number of reports required based on the number of discharges
2. Increase the percent of reports that are of high quality
3. Decrease the overall mean time between discovery of the event and submission of the report

In developing the standards, we are providing a way to recognize reporting hospitals that are meeting, and in some cases exceeding, expectations. For 2011, the first year for the standards, we will consider only the quantity of reports. Beginning in 2012, standards will also include report quality and timeliness.

Online Reporting System
Commission staff are working hard to internally test and validate our newly designed online reporting system. Thank you again for your patience during this important time. We anticipate external quality assurance testing of this system very soon. We would value your feedback and input regarding our new online reporting system before we make it public for all hospitals.

Please contact Leslie Ray if you would like to volunteer your hospital to be a part of testing the NEW online system or if you have any additional questions related to the new reporting standards mentioned above.

Bethany Higgins, Executive Director
Upcoming Events

Commission Meeting
December 13th from 12:30 to 3:30pm at the Wilsonville Training Center of Clackamas Community College. To request an agenda, please contact Carrie Parrish. All Commission meetings are on the second Tuesday of even-numbered months. Click here for a listing of meeting dates.

Patient Safety Rounds
November 4th from 12:10 to 12:55 – “Making Sense of Data Part II: Measurement.” A monthly, 45-minute case presentation and discussion of best practices in webinar format provides an opportunity to learn what others around the state are doing and share information. Click here for registration information.

Other Events
November 16, 2011 from 1:30 pm- 3:00 pm (ET) — The New Kid on the Patient Safety Block: Diagnostic Error in Medicine from NPSF. Webinar Information

November 17, 2011 from 1:30 pm- 3:00 pm (ET) — When Caring Hurts: Understanding the Second Victim Experiences from ISMP. Webinar Information

March 4-10, 2012 Patient Safety Awareness Week: Be Aware for Safe Care. More Information

Contact Us

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http://oregonpatientsafety.org

This newsletter is sent to interested parties and participants in the Oregon Patient Safety Commission’s adverse event reporting program for hospitals. Your E-mail address will not be shared or used for any purpose unrelated to the Commission’s activities. If you wish to unsubscribe, please send an E-mail to carrie.parrish@oregonpatientsafety.org with subject “Hospital Unsubscribe.”