

Using a collaborative approach to implementing the WHO Safer Surgery Checklist in Wales

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Context and Problem

The WHO Safe Surgery Saves lives Safer Surgery Checklist was launched by the WHO in Europe in January 2009. The National Patient Safety Agency issues an alert at the same time mandating the introduction of the checklist in England and Wales. In Wales the 1000 Lives Campaign gave its support to the implementation of the alert by bringing together all the operating departments across Wales to work together in a collaborative.

Assessment of the Problem:

- While surgical procedures are intended to save lives, unsafe surgical care can cause substantial harm.

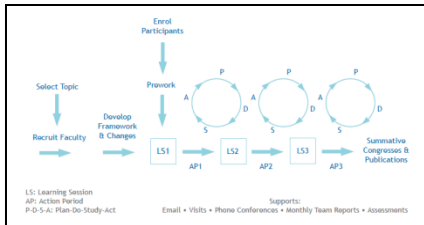
- About 234 million operations are done globally each year with a rate of 0.4-0.8% deaths and 3% to 16% complications. This means that at least 1 million deaths and 7 million disabling complications occur each year worldwide (WHO).

- It is difficult to translate these figures to a country like Wales, but we know we have a 5.3% infection rate which could be improved and using the figures associated with developed countries there is the potential for a reduction in complications of over 17,000 in a year.

Strategy for Change

We used the model for improvement (PDSA) and supported organisations using IHI's breakthrough series collaborative model. A specific collaborative was launched in March 2009 and finished in late September 2009.

The collaborative provided education on the Model for Improvement, a tool to collect measures, an environment to share good practice, challenges and success.



Measurement of Improvement

Organisations were tasked with collecting data on the compliance against using the 'time out' section of the checklist, collected via an extranet web based tool supported by IHI.

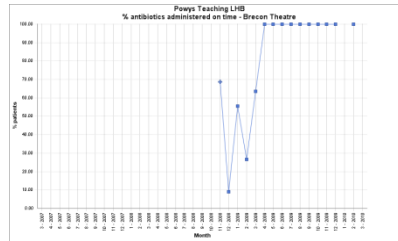
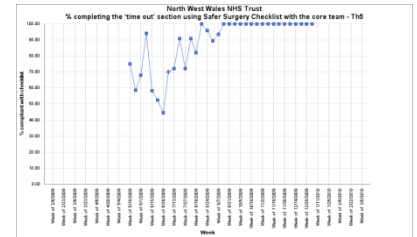
Within the year since the release of the NPSA alert being issued, a majority of the organisations in Wales have managed to introduce the WHO checklist in all of their operating theatres and demonstrate through data collection, reliable processes.

Although organisations were able to adapt the checklist, on the whole very little changes were made, so we now have a whole country working with the same standardised approach.

Effects of Changes

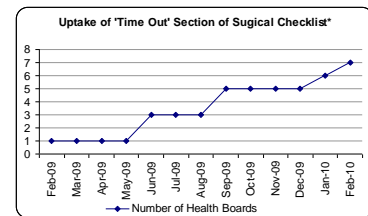
- Increasing compliance with surgical site infection care bundles e.g. on time antibiotics.
- Avoiding adverse incidents and even potential wrong patient surgery.

Examples of compliance:



Lessons Learnt

- A whole country can change its practice in a relatively short period of time. The "Time Out" section of the Surgical Checklist is relevant to 8 Health Boards in Wales. The chart displays uptake in terms of when data was first reported on the Extranet by a Hospital from a Health Board.



- The Checklist made a difference with not only improving compliance with on time antibiotics but also avoiding adverse events such as wrong site surgery, equipment problems, availability of cross matched blood and wrong patient surgery.

Conclusion:

- A collaborative approach to implement wide spread change not only provides the members of the group with a supportive framework but also shares change management learning widely.
- Using the model for improvement to implement a mandatory NPSA alert has ensured not only a rapid introduction but also a measured, reliable and sustainable change.