

Refusing access to surgery recovery area at a UK hospital unless WHO Safe Surgery Checklist is fully complete

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New research showing that refusal to allow surgery teams to take the patient to the recovery room after surgery unless the full *WHO Safe Surgery Checklist* has been complete is a highly effective way to improve use of the checklist. The study is being presented at Euroanaesthesia 2016 (London, UK, 27-30 May), and is by Dr Rajkumar Rajendram, King's College London, United Kingdom (and formerly of the Royal Free Hospital, London, UK, where the research was carried out) and colleagues.

The WHO surgical safety checklist has been proven to improve compliance with [safety standards](#) and decreases complications from surgery. The 19-item checklist includes a variety of checks designed to improve safety, including the surgical team introducing themselves and their individual roles through to use of antibiotics and pulse oximeters. The checklist was introduced at the Royal Free Hospital, North London in 2010. However, in 2011 an audit of 520 patients over 3 weeks (15 April-6 May 2011) revealed poor compliance (57% complete; 6% not started). Although several serious untoward incidents highlighted the potential benefits of using the checklist, compliance remained poor. The aim of this audit was to improve use of the WHO checklist.

In this study, the key stakeholders within each operating theatre team were identified and surveyed informally. The key reasons cited for the failure to complete the WHO checklist were: lack of understanding,

perceived lack of time and overall lack of communication, co-ordination and defined responsibility. Education on the checklist was delivered to theatre staff. After this, various initiatives were implemented using plan, do, study, act (PDSA) cycles to gauge their effectiveness. After each intervention the effect was assessed by a spot audit of 50-100 patients over a week.

In October 2011 a spot audit of 50 patients over a week found that utilisation of the checklist was still low (67% complete). Repeating the 50 patient spot audit unexpectedly detected a fall in use of the checklist (50% complete). The greatest deficiency was in completion of the surgical time out. However, highlighting this to theatre staff and allocating responsibility for the sign in, time out and sign out to the anaesthetists, surgeons and circulating scrub staff respectively resulted in an improvement (100 checklists; 94% complete). However this was unlikely to be sustained without the repeated audits which could not be continued indefinitely.

The authors found that, of the many initiatives that were tried, the most successful was to refuse the surgery team access to take the patient to the theatre recovery area post-surgery without a complete checklist. A month later a spot audit of 100 patients found that the WHO checklist had been completed for all cases. Subsequent spot audits have confirmed that this improvement has been sustained.

The authors conclude: "Despite clear evidence of benefit of the WHO surgical safety checklist human factors still limited use this checklist. The 'stick' philosophy of refusing entry to the theatre recovery area without a complete checklist was the key to its successful implementation at the Royal Free Hospital."

Dr Rajendram adds: "Behaviours will be repeated if they are rewarded with incentives, and stopped if they are penalised. Refusing transfer of

the patient from the theatre to the recovery area if the checklist is incomplete prevents the progression of the operating list. This penalises the whole team rather than any one individual. The whole team is therefore incentivised to complete the checklist."

However, he adds there is no 'magic bullet' that is applicable in all circumstances for changing professional behaviour. Many barriers obstruct the implementation of evidence-based practices. To successfully implement new ways of working, the barriers must be recognised and addressed. Individuals, teams and organisations go through various stages in the process of change. Different interventions will be effective at different stages.

He concludes: "Although passive forms of education are generally considered ineffective, they formed part of our successful multifaceted change strategy. It is important to raise awareness of desired changes before providing incentives and penalties. The needs of stakeholders should be determined before behaviour change interventions are designed, so the intervention is tailored to their specific needs. Otherwise completion of the checklist will be simply reduced to a box ticking exercise and the effectiveness of the intervention will be greatly reduced."

Provided by European Society of Anaesthesiology

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