## Checklist Case Example: Surgical safety checklist

**Section A: A case example on 6 stages of developing a checklist in practice.**

Checklists are developed to assist teams in their day-to-day work. They are a list of verifications or actions which need to be completed before, during or after a procedure or task.

1. **Highlight an area of practice that requires improvement**

**You may find through significant event audit (SEA), or clinical audit, that specific areas of your practice would benefit from the introduction of a checklist. For example, a human error such as forgetting to turn on the oxygen supply, or from a clinical audit where a step in a protocol is routinely missed or performed incorrectly. Instances where the implementation of a checklist could reduce the likelihood of these in the future.**

After a significant event audit after a swab was left inside of a Chihuahua during a routine spay, it was decided that a surgical safety checklist (SSC) would be introduced.

2. **Hold a meeting to involve and engage the team**

**It's important to engage all members of the team, who will use the checklist once it has been introduced into practice. A team meeting can be effective in establishing ownership of the process, and ultimately the checklist. Ask a team member volunteer as the Checklist Champion.**
**In the meeting, ask the team to outline each individual step of a process in its entirety. Once you have a list, work your way through and highlight any steps that are critical, or require special tasks or preparation. This will form the basis of the checklist.**
**The steps included on the checklist should be specific and unambiguous, and ordered chronologically to allow smooth progression.**

The entire practice team were gathered to discuss the steps that should be on the SSC.

3. **Create and circulate the checklist**

**Following the meeting the checklist should be written up and circulated amongst the team.**
**When the checklist is circulated it should include a timeframe of which to provide feedback and an anticipated date of implementation.**

4. **Introduction of the checklist and the Checklist Champion**

**In the initial meeting, once the checklist has been introduced, the Checklist Champion will ensure that all members of the team are using the checklist, providing training where required and ensuring the checklist is used consistently in all relevant procedures. Any questions that arise will be directed to the Checklist Champion, who will be open to giving and receiving feedback.**

The Deputy Head Veterinary Nurse was allocated as the checklist champion.

### 5.   Discuss the checklist

**Shortly after checklist implementation, discuss the checklist in a team meeting to see how the team are finding it. Was it awkward? Was it too long?  Finesse the checklist to make it more convenient and usable. You may need to repeat this occasionally to ensure the team are happy; if the checklist doesn't help assist daily practice, no one will use it!**

Suggestions were made to the checklist by the team members that had been using it.

### 6.   Audit the checklist

**Conducting an audit on the use of the checklist is beneficial to the implementation of the checklist.  It helps to ascertain that the checklist is being used by all members of the team.**
**It is important to take note of what works in the checklist, as well as areas that might require revision for an updated version. Regardless of whether any changes were needed it is important to review the checklist on a regular basis. This can be done by repeating the audit in the future, six months or one year later, to check that the efficacy and quality of care have been maintained.**

Internal audit showed that the surgeries had been more streamlined since the introduction of the SSC.

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Section B: Development of a surgical safety checklist in practice

### Checklist topic

A client brought their pet Chihuahua in for a routine spay. The operation went smoothly, other than a reasonable amount of bleeding from the ovarian stump. A few months later, the client returned to the practice stating that the animal has lost her appetite and was lethargic. Following examination, X-ray and ultrasound, a suspicious mass was found in the abdomen. The patient was booked in for surgery the next day, which revealed a retained surgical swab in the abdomen. The veterinary surgeon removed the swab and the patient made a full recovery.

The practice team noted this as a significant event, and decided to conduct a significant event audit, to reduce the likelihood of the event re-occurring in the future. The audit suggested that this issue, as well as many others, could easily be avoided with the introduction of a Surgical Safety Checklist.

### Checklist development meeting

The entire practice team participated in a meeting to discuss the crucial steps that should be carried out in every surgery performed, specifically pre- and post-operative checks that are essential for ensuring a safe surgery. One staff member noted that steps such as counting swabs in and out, are occasionally missed due to human error such as slips, lapses and mistakes but also external factors such as time constraints and unexpected complication/s during the surgery.

The team agreed that the nomination of a Checklist Champion for the surgical safety checklist would help ensure its uptake and success. The ideal individual to act as the champion was the Deputy Head Veterinary Nurse, as he is present for the majority of surgeries that occur within the practice.

### Draft and circulate the checklist

The Checklist Champion then created the checklist (example provided below), including the key points that were highlighted by the team within the meeting. He circulated the document around the team, to allow any further amendments to be discussed.

### Introduce the finalised checklist

In his circulation, the Checklist Champion specified that in his absence, the Veterinary Assistant would take on the role of champion, ensuring the checklist is used in every surgery

Implementation date: 1st February 2017

On implementation, the team were reminded that the holder of the checklist has the authority to stop a procedure if the checklist is not being used fully or appropriately.

A second team meeting was held on the 1st March 2017, in which the team discussed the checklist implementation in both its successes and downfalls.

The team agreed that:

⇒ Changes were needed to improve compliance
⇒ The checklist should be separated into three categories:
  o Prior to induction of anaesthesia
  o Prior to skin incision
  o Prior to leaving the operating room
⇒ A checkpoint should be added to the end of the checklist regarding management of the patients after discharge

It was emphasised that the checklist is not just a box-ticking exercise, but a communication tool to ensure that a list of critical tasks are performed before a procedure continues.

## Audit the checklist

An initial audit was performed to ensure the checklist was being used by all members of the team and to identify reasons why it was not used. The team agreed that surgeries were more streamlined since the implementation of the reviewed checklist. New members of the team reported feeling more confident in their abilities, and their provision of care. Two further changes were flagged by the team and the checklist was amended accordingly.

Amendments were:

⇒ Reformatting the checklist so that it fits on a single side of A4 paper.
⇒ Specifying who each section of the checklist refers to (nurse, surgeon, etc.).

A subsequent audit date was set for a month later to confirm the efficacy of the changes.

Date of next audit: 1st July 2017

On re-audit, the team found that the amended checklist was now successfully used by the whole team. All clinical staff members felt comfortable using the checklist as part of their surgical routine. No further amendments were suggested and a review was scheduled for one year later.

Date of next audit: 1st July 2018

Interested in submitting your own case example? Email us at ebvm@rcvsknowledge.org