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A Surgical Checklist for the Office Setting

by Tinker Ready

A checklist designed for an office-based plastic surgery practice improved documentation of key safety measures, researchers have found.

Despite being used routinely in many hospitals and ambulatory surgery centers, checklists have neither gained the same attention nor have been extensively tested in the office-based surgery settings, said co-author Richard Urman, MD, MBA, staff anesthesiologist at Brigham and Women's Hospital in Boston, who led the study.

"This is an area that has not been explored enough. There is a huge need, given all the safety concerns in office-based settings," Dr. Urman said.

Dr. Urman and co-author Fred Shapiro, DO, staff anesthesiologist at Beth Israel Deaconess Medical Center, also in Boston, presented their findings at the 2012 annual meeting of the International Anesthesia Research Society (abstract NO S-03). Drs. Unman and Shapiro are the co-founders of the Institute for Safety in Office-Based Surgery, a Boston-based nonprofit group.

The researchers reviewed charts for 219 patients treated at the plastic surgery clinic to determine baseline rates for each checklist item, as well as various adverse outcomes of surgery. The baseline rate of adverse events was 15%, suggesting a need for the checklist approach, they said.

The researchers customized the list, based on the World Health Organization's model checklist, after meeting with the practice's surgeons, anesthesiologists and nurses.

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"The prerequisite is that all members of the office, both medical and nonmedical, are willing to adapt the checklist to their setting," said Dr. Shapiro, who has studied office-based anesthesia extensively.

Dr. Shapiro said it is equally important that staff understand the rationale for the various items in a checklist. These might include the following:

- Has the procedure complexity and sedation/analgesia been reviewed?
- Is the case-specific equipment available?
- What critical events are likely?
- Has a policy for emergency medical service (EMS) been confirmed on the day of the procedure?
- Are there concerns about local anesthetic toxicity?
- Have written instructions been given to the patient for postoperative medications, care and follow-up?

The increased anticipation of critical events demonstrates a subtle but important change in the operating room environment because improved communication and teamwork are critical for patient safety, Dr. Shapiro noted.

The researchers tallied prechecklist documentation rates for each item, as well as postsurgery adverse outcomes, through a review of 219 charts. After an education program, the researchers performed a chart review.

At baseline, 90% of charts were missing documentation of three or more checklist items. The adverse event rate was 15%, and included cases of uncontrolled pain (3.7%) and bleeding/bruising (3.2%). The measurable rate of adverse events "suggests potential for improvement," the researchers concluded.

After the introduction of the checklist, several key safety indicators and practices increased to 90% to 100%. These included the presence of case-specific equipment, confirmation of EMS policy and precautions for local anesthetic toxicity.

Use of the checklist also resulted in improvement of surgical site and side markings and the discussion of patient preparation and critical events, which "demonstrate an important change in the operating room environment because improved communication and teamwork are critical to any patient safety endeavor," according to the researchers.

John A. Dilger, MD, president of the Society for Ambulatory Anesthesia, noted that even in hospitals, where standards of practice are in place and should be followed, items may be missed.

"The checklist may be even more important in an office setting where Joint Commission standards may not be in place," said Dr. Dilger, assistant professor of anesthesiology at Mayo Clinic, in Rochester, Minn.

The checklist is a good idea, he said, but added that the study does not measure whether missed and unchecked items led to an increase in near misses or morbidity.

Dr. Shapiro said the goal of this study was to determine if the checklist increased the

documentation of the use of quality and safety indicators. Larger, prospective studies will be needed to determine if the list improves mortality and morbidity and reduces cost. The researchers also plan to adapt the checklist for other specialties, including interventional radiology, podiatry and dentistry.

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