Surgical Safety HardStop Checklist
Summa Akron City Hospital

Overview
The Hospital Surgical Services Optimization Committee created a registry of initiatives related to patient safety and efficiency. To improve throughput, a discussion began involving the possibility of the Certified Registered Nurse Anesthetist (CRNA) assisting with the transport of patients to the Operating Room (OR). The RN Circulator had traditionally brought the patient to the OR. There was a concern regarding the RN Circulator having the opportunity to pause prior to moving the patient to the OR table in order to complete the surgery checks important for this team. Patient safety concerns from missed communication and poor handoffs were the basis for the development of the HardStop Safety checklist. The surgical volume has increased and activity level is high. Standardizing the checklist framework improves error and complication rates. HardStop does not mean “stop working so hard”. The team began to think of it as part of our safety behaviors. Practice with a questioning attitude and STOP the LINE for patient safety. A HardStop creates pauses for individual healthcare providers to review and validate patient readiness for surgery with safety at the center of care. Although a seemingly simple intervention, checklists have a sound theoretical basis in principles of human factors engineering and have played a major role in some of the most significant successes achieved in the patient safety movement.

Data/Metrics
The current data monitored includes: completeness of the HardStop Safety Checklist documentation and OR turnover time between cases. HardStop Safety Checklist documentation is reviewed each day. The data is reported to the HardStop Committee and the staff in all areas using graphs as a visual tool.

Implementation
The HardStop Safety Checklist Team included: divisional leadership, anesthesia medical directors, RNs from pre-op and the operating room, CRNAs, surgical services unit directors and RN educator and process improvement team members. Surgical Services goal of zero defects is to increase patient safety by performing a routine checklist, a team pause and improving communication between Preadmission Testing (PAT), Sameday Surgery (SDS), the Operating Room (OR), and Post Anesthesia Care Unit (PACU). The creation of the HardStop Safety Checklist provides these pauses with a single paper that follows the patient from the pre-op visit until surgery is complete. January of 2014, the HardStop committee began meetings to discuss the process for the HardStop and opportunities for continuous improvement. The HardStop Safety Checklist process began with two outpatient ORs. The pre-op nurse, CRNA, and OR RN Circulator were educated about the new process. May 2014 two more rooms began using the HardStop process. By June of 2014, the new process was implemented in all OR’s. Within weeks the pre-testing department was on board.

Results/Outcomes
The OR RN Circulator has reached 100% over the past 6 weeks (this stop is the last possible hole in the Swiss cheese before surgery). The pre-op teams are close to 100%. In October 2014, we began to track the CRNAs completion of the pre-op HardStop Checklist and they have continued to improve. Leadership messages and joint staff meetings have united the team. Turnover Time is an average of 23 minutes. This number reflects wheels out to wheels in for the next patient. This time is reflective of great teamwork as compared to national benchmarks through the Advisory Board. Compared to like-hospitals, we have been in the 90th percentile as our data will demonstrate; however our goal is 25 minutes at this time.

Barriers/Lessons Learned
Lessons learned included: clear communication to a large number of staff members using the checklist requires endless energy, misconceptions of how the checklist should be used must be addressed often, and reaching all learners for clear understanding of the importance of the checklist takes time.
Information clarification regarding day of surgery update of history and physical was reviewed in depth with the CRNAs who were not accustomed to looking for this information. Gaps in knowledge no matter the role should not be underestimated.
Surgical Services leadership engagement is important to the success of a safety project. Available resources like the Summa safety consultant providing a joint staff meeting helped the staff to connect the idea of using the HardStop Safety Checklist to the safety of our surgical patient. There will always be new concerns, as we are currently looking at how to improve the use of the checklist with inpatient, critical care and emergency room patients to standardize practice. The Endoscopy Department will be implementing a modified version of this checklist this year. We look forward to their success as we use the lessons we learned to help this department provide safer care for our patients.

Copyright © 2015 Ohio Patient Safety Institute, 155 E. Broad St., Suite 301, Columbus, OH 43215-3640, 614.221.7614, www.ohiopatientsafety.org