Implementation of an endoscopy safety checklist

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ABSTRACT

Patient safety and quality improvement are increasingly prioritised across all areas of healthcare. Errors in endoscopy are common but often inconsequential and therefore go uncorrected. A series of minor errors, however, may culminate in a significant adverse event. This is unsurprising given the rising volume and complexity of cases coupled with shift working patterns. There is a growing body of evidence to suggest that surgical safety checklists can prevent errors and thus positively impact on patient morbidity and mortality. Consequently, surgical checklists are mandatory for all procedures. Many UK hospitals are mandating the use of similar checklists for endoscopy. There is no guidance on how best to implement endoscopy checklists nor any measure of their usefulness in endoscopy. This article outlines lessons learnt from innovating service delivery in our unit.

BACKGROUND

More than a decade ago, the landmark Institute of Medicine’s report, ‘To Err is Human: Building a Safer Healthcare System’1 revealed that between 44 000 and 98 000 patients die each year in the USA as a result of preventable medical error. The cost of this is estimated at $17–29 billion per year. This was mirrored in the UK: a retrospective review of patients records by Vincent et al2 showed approximately 10% of UK patients underwent a medical error, with half deemed to be preventable and a third of patients suffering significant disability or death. These errors within the National Health Service (NHS) amount to a cost of £1 billion a year in extra bed-days alone.2 These findings are corroborated internationally by a recent systematic review.3

Endoscopy is no exception. In 2004, the Report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ‘Scoping our Practice’4 investigated 1818 deaths within 30 days of a therapeutic gastrointestinal (GI) endoscopy. It found that 14% of endoscopic procedures were inappropriate and 9% were futile and made 21 recommendations aimed at improving identified deficiencies in organisational structure, training and education, endoscopists’ technical skill and patient information and monitoring. Although the recent British Society of Gastroenterology (BSG) audit5 shows significant improvements in certain technical aspects such as caecal intubation rates, other aspects of endoscopy patient safety have not been re-evaluated on a large scale.

Several factors make endoscopic procedures increasingly at risk of causing adverse events and patient harm. First, population-based bowel cancer screening exposes healthy, asymptomatic individuals to bowel preparation, sedation as well as an invasive endoscopic procedure, which may also involve high-risk therapy. Second, our ability to perform more numerous and more advanced therapeutic procedures throughout the GI tract has developed the field into much more of a surgical specialty with the associated inherent risks and complications. Surgical specialties have been identified in the evidence base as the most at-risk clinical areas for patient harm— which is perhaps not surprising given the invasiveness and complexity of the procedures. Other drivers increasing the demand for endoscopic procedures estimated to be 10–15% per annum6 include our ageing population; an increase in conditions requiring endoscopy, such as liver disease and advancing technology allowing endoscopists to perform more and more invasive ‘endo-surgical’ solutions.7

In addition to increased volume of endoscopic procedures, there is also...
increased emphasis on safety at a national level. In 2008, The Department of Health’s National Patient Safety Agency issued guidance on a series of so-called ‘Never Events’9 defined as a ‘serious but preventable patient safety incidents’. This list started as eight serious incidents resulting in significant harm to patients and expanded to 25 in 2012. Reporting of Never Events is mandatory to encourage learning and implement preventive strategies. There are significant financial disincentives associated with Never Events, as commissioners can recover the cost of the care episode. In 2009–2010, Never Events cost the UK an estimated £3.9 million. A number of the 25 Never Events are directly relevant to endoscopy:
- Overdose of benzodiazepine during conscious sedation
- Failure to monitor and respond to oxygen saturations during a sedated procedure
- Patient misidentification
- Wrong site surgery (or wrong endoscopic procedure)
- Misplacement of a nasogastric tube

Quality and safety cannot be compromised in our expanding specialty and proactive measures to maintain and improve safety should be sought. Most medical tasks are complex and any intervention involves numerous steps at which an error can occur. In the vast majority of cases, these errors are corrected or compensated for and patients do not come to any harm. However, if errors align and are not captured as the patient goes through the care pathway as in Reason’s9 ‘Swiss Cheese’ phenomenon, significant harm may occur. So, errors can be ‘with or without consequence’ and near misses may be an opportunity to intervene, thereby avoiding a more serious event in future.

HOW CAN ERRORS BE PREVENTED FROM OCCURRING? A CHECKLIST FOR ENDOSCOPY

In the past decade, the evidence base on how to prevent errors from occurring in healthcare has expanded dramatically. We now know that errors can be prevented through better team working and safety culture in healthcare,10 and that team training and organisational leadership for safety and quality improvement initiatives are important factors.11 The safety intervention that has captured the attention of all surgical and interventional specialties is the WHO surgical safety checklist. In 2009, a landmark paper described the development and application across eight hospitals worldwide of the WHO checklist.12 This simple tool, a checklist, demonstrated the ability to significantly reduce mortality from 1.5% before the checklist was introduced to 0.8% after the checklist implementation.

How can we apply this checklist to endoscopy? The premise of a checklist is to provide an opportunity moments before a procedure starts to check that vital information is shared with the whole team.13 As with surgery, a patient will usually have been admitted by a health professional (usually a nurse) outside of the endoscopy room. In some cases, the consent may even have been completed or partially completed by a different member of the team. In almost all cases, there will be endoscopy nurses within the room who have no prior knowledge of the patient. A checklist allows sharing of information pertinent to the individual patient and to their case. It is not meant to be a repeat of the entire admission document.

The key features of an endoscopy checklist to be completed immediately before a procedure starts (ie, the equivalent of the WHO surgical checklist ‘Time Out’ section) are listed in box 1. These are neither exhaustive nor mandatory and we take the view that every endoscopy unit ought to develop one that they feel best works for their team. However, effective checklists should be as concise and as user-friendly as possible,14 while covering the main issues that could give rise to an adverse event, Never Event or patient safety incident. The proposed checklist is based on observations of errors across endoscopic procedures in our unit and hence is applicable to upper and lower GI endoscopy. The rationale behind each of our suggested parameters is given in box 1.

Regarding the practical application of an endoscopy checklist, we believe that it is vitally important that one individual takes the lead for the completion of the checklist and is responsible for ensuring ‘Time Out’ does occur. This does not necessarily need to be the endoscopist and could equally be the lead nurse. Whoever leads, however, must ensure the entire team are engaged in the process.

As with the WHO surgical checklist, we propose that there is a section to be completed immediately after the procedure and before the patient leaves the room—a ‘Sign Out’ section. This would include the information listed in box 2.

IMPLEMENTATION OF A CHECKLIST WITHIN THE ENDOSCOPY DEPARTMENT

Any new intervention requires input from key members of the team to ensure buy-in from all stakeholders.15 Each endoscopy unit will have their own ideas about how best to incorporate a checklist into their protocols. Some may choose to have a paper-based version, either as part of the admission booklet or a separate dedicated form. Others may be able to incorporate it into the electronic endoscopy reporting system, some of which have the facility either for all checklist items to be included in their programme or to customise fields to include a checklist.

Once the checklist template has been agreed by the endoscopy users, a period of training and implementation should be planned. Most endoscopy units in the UK have two pools of staff: the endoscopy nurses who are a constant presence in the unit and several (indeed many in some cases) endoscopists from different disciplines (surgical, medical and nursing) who
A carefully planned implementation programme with suitable notification is a prerequisite for the successful adoption and long-term sustainability of a checklist. A multipronged approach will help and this can be achieved by presenting the evidence for its utility in governance, endoscopy user group meetings, grand rounds and departmental meetings. Simply launching the checklist without training and familiarisation is likely to be unsuccessful as it may become a ‘tick-box exercise’ if team members do not understand the rationale behind its use.

Ideally we would recommend that several staff are invited to champion the use of the checklist and that they act as leads in the implementation of change. This may include a lead nurse, endoscopist and even trainees. If possible, some or all of these could have dedicated time to support users during the first week(s) of its introduction to help troubleshoot, remind the teams and to facilitate usage. Strong leadership is required from within the nursing and medical team, including from the medical and nursing directors of the institution to establish a change in practice. If done poorly, evidence suggests that the patient may be at more risk, especially if everyone may come to the unit as little as once per week.
assumes someone else has completed the necessary checks. Interim feedback (eg, at about 4–6 weeks) after the introduction of the checklist will allow staff to contribute ideas as to how to improve and adapt the checklist. Sharing ‘in-house’ clinical examples of where the checklist mitigated an error may also facilitate uptake (box 3).

Audit of checklist completion is also advised so that the leads can understand the challenges, target poor uptake and support those who do not appear engaged or who do not see its relevance. Our checklist implementation strategy is summarised in box 4.

WHAT ARE THE ENABLERS AND BARRIERS TO CHECKLIST IMPLEMENTATION?

In our unit, a checklist was developed to address common and significant patient safety issues we encountered (figure 1). Sequential multidisciplinary expert focus groups were convened to draft the initial checklist and subsequent versions revised following feedback from team members. The checklist has been in place for over a year now and has since become mandated by the hospital’s medical director. We have learnt several lessons in optimising checklist application in the process. In our experience, there are several barriers and enablers to successful implementation of a checklist within an endoscopy department—these are not very different from those that have been identified previously in relation to the WHO surgical checklist. These are summarised (table 1).

WHAT WILL YOUR PATIENTS THINK?

One concern may be that patients would be made anxious by being asked repeated questions once in the endoscopy room. In our experience, if it is explained to the patient that this is a final safety check as a
measure to ensure all members of the team in the room know their case and that all documentation matches up, patients are reassured. In auditing, the uptake of the checklist and patients’ views should be sought, as part of the patient feedback/satisfaction surveys required for the Global Rating Scale.19 20

CONCLUSION
In a medical world where safety and quality is paramount and under rightful scrutiny, medical error will still occur but will be less well tolerated. A checklist will not prevent every error in endoscopy—it cannot achieve this, nor should it be intended to do so. If it could, however, prevent even a small number of errors and promote an enhanced culture of safety through improved teamwork in the endoscopy room, we strongly believe its use will be justified. In those cases where error does occur and a checklist has not been used, there is likely to be room for criticism. The checklist is a simple, inexpensive, effective tool that has the potential to promote reliable safe endoscopy partly through a system of robust checks, but also by enhancing teamwork in endoscopy.

REFERENCES
6 UK BC. Bowel Cancer UK: Improving capacity saving ilves: Endoscopy in the UK.

