

# The Improvement Map campaign and Surgical Safety Checklist challenge

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In the past few years, hospitals, physicians, and other health care professionals have made unprecedented commitments to quality and patient safety, with many demonstrating impressive progress during the Institute for Healthcare Improvement (IHI)'s 100,000 Lives and 5 Million Lives Campaigns. During the 20th Annual IHI National Forum in December 2008, IHI President and CEO Donald L. Berwick, MD, announced the continuation of those campaigns with a new phase called the Improvement Map.

Unlike the previous campaigns, which concentrated directly on reducing needless deaths and injuries, the Improvement Map will focus on a set of process improvements designed to achieve the highest levels of performance in the areas that matter most to patients. It will help make sense of the many complex and competing demands of improvement by offering easy-to-follow guidance and reliable routes for improvement. It will enable quality improvement leaders to distill from hundreds of requirements and measures their own change agenda, in order to establish priorities, organize work, and optimize resources.

The Improvement Map will include 12 interventions contin-

ued from the 100,000 Lives and 5 Million Lives Campaigns. Three additional interventions are being added to the agenda:

- The World Health Organization (WHO) Surgical Safety Checklist
- Prevention of catheter-associated urinary tract infections
- Linking quality and financial management: Strategies to engage the Chief Financial Officer and provide value for patients

The remainder of this article discusses the first of these interventions.

The WHO Surgical Safety Checklist is a tool that was created over 2 years with international input from experts in surgery, anesthesia, infectious disease, epidemiology, nursing, biomedical engineering, and quality improvement to reduce the number of errors and complications resulting from surgery. Organizations from around the globe have endorsed the concept of the checklist, which was officially launched June 25, 2008. The checklist outlines essential standards of surgical care and is designed to be simple, to be widely applicable, and to address common and potentially disastrous lapses. Use of the checklist can identify gaps in perioperative practice and can establish or confirm adherence to proven standards of care that can improve surgical results and decrease death and complications.

The checklist has been validated in 8 pilot sites in diverse global settings. The initial data from these pilots show that key safety standards are rarely followed in their entirety and

use of the checklist improves adherence to them.

In order to jump-start the use of the Surgical Safety Checklist, Dr Berwick presented the Surgical Safety Checklist "Sprint" challenge to the National Forum audience in December. The goal of the challenge is for the WHO Surgical Safety Checklist to be adopted and used in **at least 1 operating room in every hospital enrolled in the Campaign by April 1, 2009**. Hospitals not currently enrolled in the Campaign are welcome and encouraged to enroll and join the challenge.

The Wisconsin Campaign Node, coordinated by MetaStar, is encouraging Wisconsin hospitals to rise to this challenge. It is a quick, simple way in which to test the Surgical Safety Checklist and to make rapid improvements that can be measured locally.

To learn more about the Improvement Map and to join the Surgical Safety Checklist "Sprint" challenge, go to [www.ihl.org/Programs/ImprovementMap](http://www.ihl.org/Programs/ImprovementMap). From here you can access information on the Campaign and obtain the Surgical Safety Checklist, a starter kit, and other resources to help you implement the checklist. The starter kit prepared by WHO provides a way to evaluate the current state of safety practices at your facility, to compare them with the objectives of safe surgical care established by WHO, and to identify areas for improvement. It also provides suggestions for strategies to leverage changes in the process of care that can translate into improved outcomes for surgical patients.

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