



**EMBARGOED UNTIL FRIDAY, NOVEMBER 12, 9:00 AM**  
**For Immediate Release**

Leslie Ray  
Field Coordinator  
Oregon Patient Safety Commission  
503.224.9227  
[leslie.ray@oregonpatientsafety.org](mailto:leslie.ray@oregonpatientsafety.org)

Andy Van Pelt  
Director of Communications  
Oregon Association of Hospitals and Health Systems  
503.479.6018  
[avanpelt@oahhs.org](mailto:avanpelt@oahhs.org)

## **Oregon Hospitals Make Surgery Safer**

### ***Rapid statewide adoption of the safe surgery checklist proven successful***

Portland, Ore. (November 12, 2010). Risk of surgical complications in Oregon hospitals is being cut significantly—perhaps by as much as 30 percent overall—by the adoption and use of a safe surgery checklist. In the year and a half since the Oregon IHI Network committed to implement the checklist throughout the state, 54 of Oregon’s 56 acute-care hospitals that perform surgery have implemented the World Health Organization (WHO) Surgical Safety Checklist or a customized checklist that incorporates the WHO principles. The speed with which this innovation has spread in Oregon is a result of a collaborative effort by the local chapter of the Association of periOperative Registered Nurses (AORN) and the Oregon IHI Network, seven organizations committed to patient safety and working together to support hospitals’ adoption of the checklist.

The two Oregon hospitals that are not currently using the checklist are in the planning process for full implementation in 2011.

“The Surgical Safety Checklist is a simple concept that hospitals worldwide have used to reduce complications from surgery,” says Leslie Ray, PhD, RN, hospital field coordinator for the Oregon Patient Safety Commission. At certain points during a surgery, team members verify aloud that they are performing the right procedure on the right part of the right patient. Team members also confirm that the team is aware of difficult situations that may come up and that they agree on key issues after the surgery.

“It’s a process of adopting a more effective way of communicating,” Ray says.

The Checklist process is similar to a protocol from the airline industry known as Cockpit (or Crew) Resource Management (CRM). Both represent advances in team communication and collaboration. Studies of fatal airline accidents showed that, in many cases, flight crews had been aware of a risk but were unwilling to challenge the authority of the pilot. The 1978 crash of United Airlines Flight 173 in east Portland is often cited in these studies. The CRM protocol made it easier for every flight crew member to express safety concerns without fear.

Oregon hospitals were already using detailed checklists to guide discipline-specific processes in surgery. In contrast, the WHO Surgical Safety Checklist emphasizes a smaller number of highly critical items that the surgical team as a whole needs to consider and provides a way to share that information.

“Our hospitals are proud to have adopted a practice that is evidence based and a proven tool that makes surgery safer for patients,” said Diane Waldo, director of quality and clinical services for the Oregon Association of Hospitals and Health Systems. “Strong support for checklist adoption helps hospitals and surgical teams focus on critical communication elements during a surgical procedure. Every member of the surgical team has an important role in keeping the patient safe.”

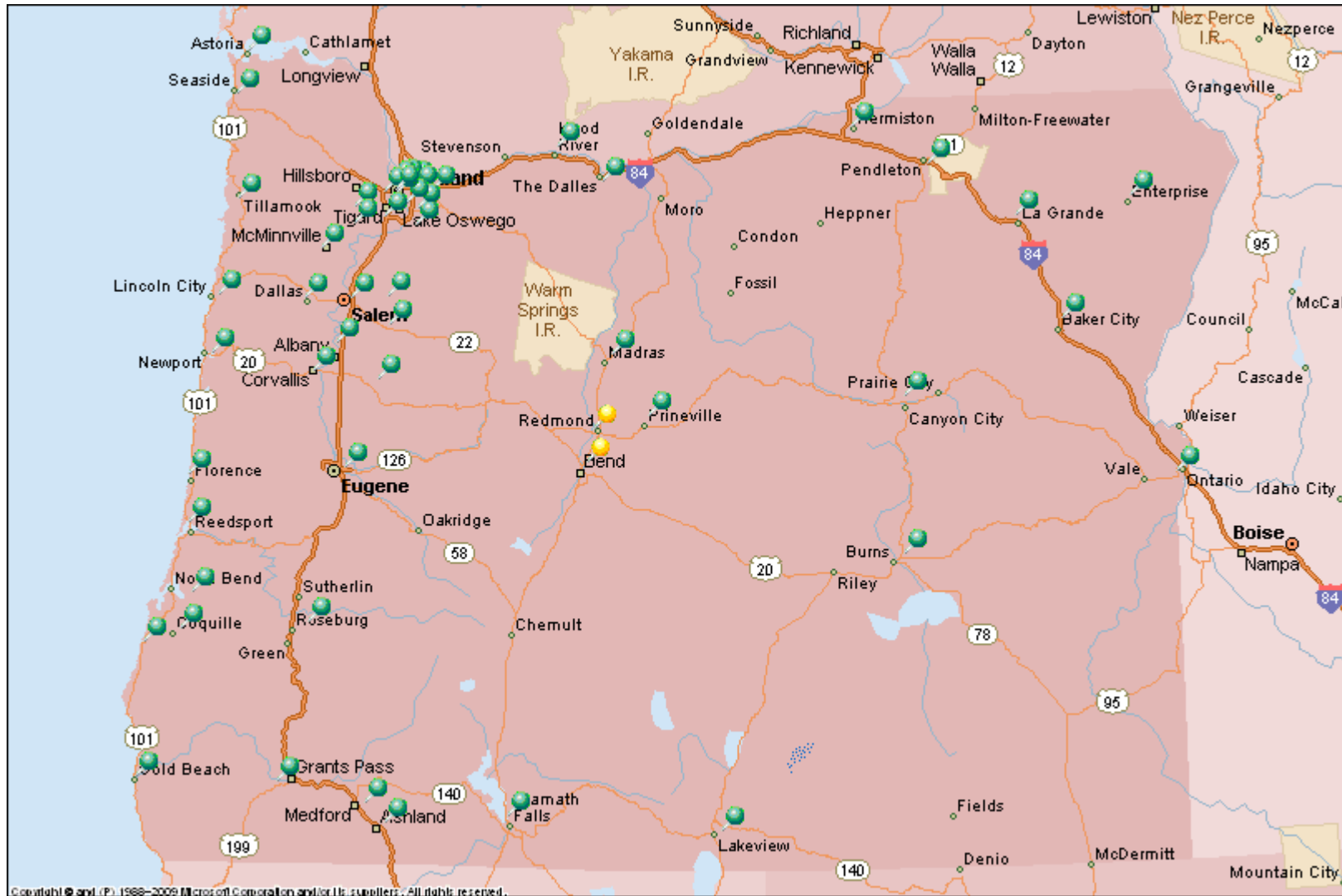
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### **About the Oregon IHI Network**

The Oregon IHI Network is a statewide hospital safety coalition, formed in 2005 in response to the Institute for Healthcare Improvement’s call to action, the 100,000 Lives Campaign. In 2009–2010, the Network’s focus is to spread use of the World Health Organization Surgical Safety Checklist. The Network consists of Acumentra Health, CareOregon, Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Medical Association (OMA), Oregon Nurses Association (ONA), Oregon Rural Healthcare Quality Network (ORHQN), and the Oregon Patient Safety Commission.

# WHO Surgical Safety Checklist Adoption in Oregon Hospitals

Status as of 10/28/10



● Adopted (54)    
 ● In planning (2)

Source: Oregon IHI Network. Includes all of the 56 Oregon hospitals with surgical programs, except the two VA hospitals.