The Continuity of Care Checklist: A Critical Frontier in Patient Safety

Patient safety is a widely recognized priority in health care, and new innovations in technology are contributing greatly to that effort. In the clinics and hospitals where I work, it is possible to track patients with electronic sensors as they make their way through the hallways, verify their chemotherapy administration using bar codes, confirm delivery of each drug dose with computerized prompts when treatments are due, and collect all the information in an elaborate electronic medical record. Such procedural safeguards are essential for ensuring that the right person gets the right treatment at the right time.

To assure safety in medical tasks, Gawande\(^1\) and others have developed checklists as a safety maneuver. The idea for checklists comes from areas such as manufacturing quality assurance and the commercial aviation industry, where eliminating variation and adhering to well-defined procedural steps can markedly diminish the chance for mistakes. In a landmark study, Haynes et al.\(^2\) showed that adhering to basic steps—personal introduction, review of tasks, verification of equipment function, and the opportunity to discuss concerns regarding the case—can reduce complications of surgery. Such checklists are now being widely adopted in medical care and likely to radically enhance patient safety.

Implicit in the concept of a safety checklist is the idea that who is involved in the procedure makes no difference. Indeed, safety checklists are designed to allow anyone to step into a role and “get it right” because the checklist prompts each actor to review the right tasks. An airline pilot steps into the cockpit and reviews the checklist for the next flight; who the previous pilot was, where the plane was, and which plane it is make no difference.

This presumption of anonymity is so profound that the first steps in the surgical checklist are to confirm that the patient is actually the patient and to introduce the team (surgeon, anesthesiologist, nurses, others) to one another. Much of the success of a checklist approach is undoubtedly to address the deficiencies that arise from the lack of continuity of personal care. No one expects the surgical team to “know” the case, any more than we expect the pilot of a Boeing 737 to know this aircraft as opposed to every other 737 available.

The virtue of the checklist, like computer prompts to record vital signs or deliver medicines exactly on time, is that they diminish the need for anyone to have been familiar with that case. However, and notwithstanding the remarkable gains that these safety measures are likely to yield, my recent experiences on the inpatient service suggest that—in substituting reliance on automated systems for reliance on continuity of care—we are losing an integral piece of medical service and safety.

Consider a typical admission to our women’s cancers service. A patient is seen in the emergency room by residents and attendings and admitted (invariably after 6 p.m.) to a cross-covering inpatient medical team. In the morning, the patient is transitioned to the “regular” medical team, led by an attending physician and physician assistants (PAs). The schedule is such that the attending usually rounds for a 2-week bloc, while the PAs work 3 days in a row on a staggered schedule. Within 72 hours in the hospital, the patient has been under the care of a half-dozen different primary coverage groups. Each transition includes a “pass off” or “sign out,” and, like the game Telephone, the story changes a bit each time such that it becomes unrecognizable after a few iterations. Furthermore, this describes only the primary medical service. The ancillary medical teams (nutrition, physical therapy, pharmacy, care coordination), nursing services, outside or referring oncologists, and/or consulting medical teams are all also afflicted by the same cross-coverage and swirling mix of schedules.
An integrated electronic medical record (EMR) does not solve the problems inherent in the complicated interweaving levels of care created by the current staffing system. To extend the transportation analogy, the system makes sure that the airplane has a full tank of fuel, that the bolts are all in place, and that the aircraft leaves the gate on time, but no one knows where the plane is going or where it has been. And that is the problem: a patient’s experience is far larger than the sum of their procedures or documentation of vital signs.

My recent inpatient experience has convinced me that lack of continuity of care by the same primary covering team is the most serious challenge to improving outcomes in our current hospital setting. Furthermore, it is a challenge that cannot be wholly addressed using technical solutions. Building on the work of the checklist approach, I propose a study that compares outcomes for patients who had the same physician and nursing team each day for the duration of the hospitalization—or at least where the absolute number of transitions was minimized—with outcomes for those with our current standard schedules. Such practices would demand an overhaul of how medical staffing is organized and flies in the face of regulations that seek to minimize the patient-contact hours of medical trainees, among other concerns. But I would readily wager that patient and family satisfaction, duration of hospital stay, cost of hospital stay, and medical outcomes would all improve if the same people cared for the patient day after day.

References