

SAFE SURGERY SAVES LIVES COLLECTIVE

✓ Checklist Action Series

Checklist Action Series

September 2, 2010

Tanis Rollefstad and Marlies van Dijk


cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

safer healthcare
now!

Checklist Action Series Hosts



Marlies van Dijk

Western Node Leader *Safer Healthcare Now!* and Moderator



Tanis Rollefstad

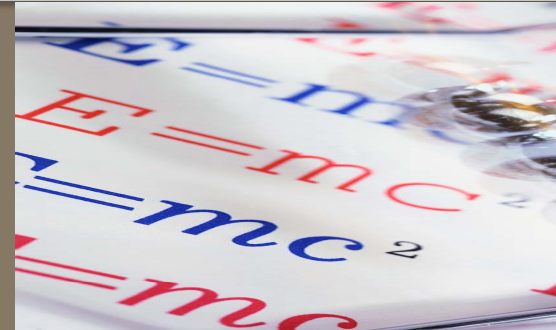
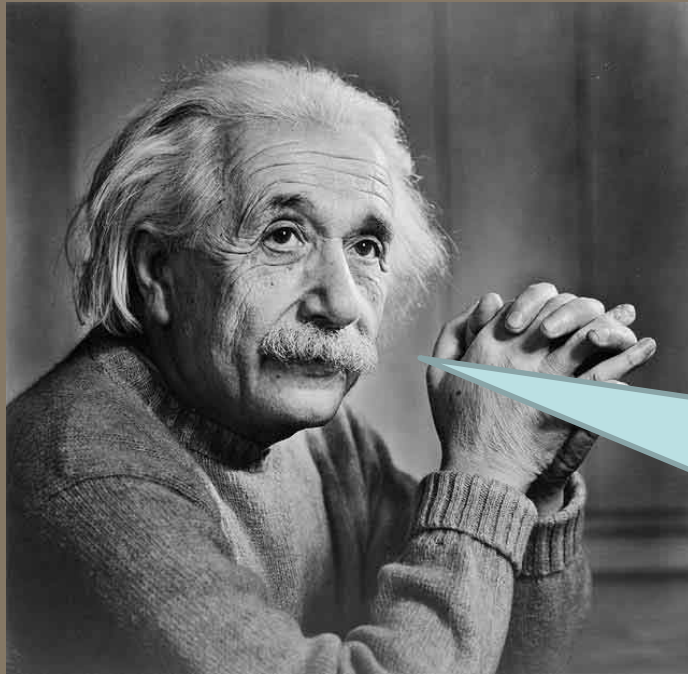
Western Node SIA *Safer Healthcare Now!* & Technical Host for Checklist Action Series

Objectives for Today's Call

- Hear highlights of Checklist Action Series
- Share “a-ha” moments and advice
- Learn key elements for implementation



Energy



It's not as simple as it looks!

Write in your biggest challenge!

Some Guiding Principles

- You can adapt what is listed – and how you do the checklist – but don't remove the “dialogue pieces”
- Checklist is solution to a goal - what is yours? Name it!
 - Reduce harm? Reduce errors? Improve teamwork? Improve communication? Something else?
- Checklist shouldn't take longer than the procedure itself
- Make it easy to do right thing, hard to do wrong thing

General Change Concepts

- Improve workflow
- Change work environment
- Enhance patient relationship
- Manage variation
- Design systems to avoid mistakes

Improve Workflow

- Synchronize steps
 - Identify trigger “start time” and coordinate all activities around it
 - Ensure everyone in the room to do checklist
 - Map the steps in the process
- Do tasks in parallel
 - Complete time out while skin prep dries
- **Consider people as part of same system**
 - Introduce OR team to the patient and to each other, including role
 - Involve patients, senior leadership, pre-admission clinics, surgeon’s offices, recovery rooms and wards

Improve Workflow - Surgeons

- Workflow will change
- Surgeons or residents will have to be there at briefing
- Sustainability of the checklist
- Policy examples

Change Work Environment

- **Give people access to information**
 - Use a glitch book
 - Use a whiteboard to capture “near misses” and “good catches”
- Use proper measurements
 - Connect measures to aim “Why are you doing the checklist?”
 - Solicit prompt, frequent and ongoing feedback from OR team
 - Measuring culture at an OR level could give you a building block
- Develop relationships
 - Find, engage and support respected clinical champions “Who are the key influencers?”
 - Initiate other changes to improve culture and teamwork (have a multidisciplinary lunch room)
 - Don’t remove parts of the checklist that encourage people to speak up

Enhance Patient Relationship

- Listen to patients
 - Use surveys to assess awareness and impact of checklist
 - Use follow-up processes to get patient perspectives
 - Have patient awake and sitting up during the checklist
- Coach patient on use of checklist
 - Develop and use patient brochures/posters
 - Inform patient of process at pre admission clinic and Dr's offices
- **Focus on outcome to patients**
 - Get and use outcome data and patient stories
 - Put in context: Would you want a surgical checklist used in your Mom's surgery?
 - Frame the motivation: This is the right thing to do for the patient

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Your Burning Questions




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Manage Variation

- Standardize / Create formal process
 - Use same debrief questions every time:
 - What worked well?
 - What did we learn?
 - What could be improved for next time?
 - Use a script in question format
 - Can surgeons be part of debrief on regular basis?
- Develop contingency plans
 - What happens when senior leaders change?
 - What happens when clinical champions leave or burnout (checklist fatigue)?
- **Desensitize**
 - Re-phrase language during briefing
 - Will Mr. X require blood products today?
 - Will Ms. X need assistance with her airway?

Design Systems to Avoid Mistakes

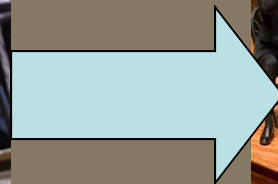
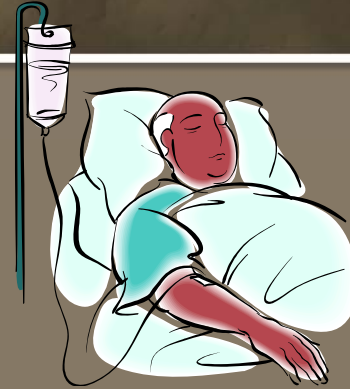
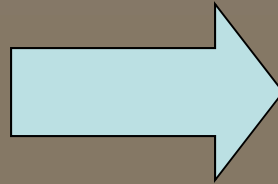
- **Use reminders**
 - Laminate posters and put in OR
 - Use posters and pocket cards
 - Use cues to use actual checklist to prevent reliance on memory
- **Use constraints**
 - Agree that XX won't start until checklist is completed
 - Make it easy to do right thing, hard to do wrong thing
- **Mass customize**
 - Use one checklist and “grey out” sections not applicable

Key Ah Ha's

- Three Phases of the Checklist - Workflow
- Adaptation is Key
- Caution: Over-customization
- Checklist is solution to a goal - what is yours?
 - Reduce harm? Reduce errors? Improve teamwork? Improve communication? Something else?

Some ideas that might work?

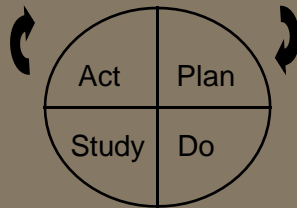
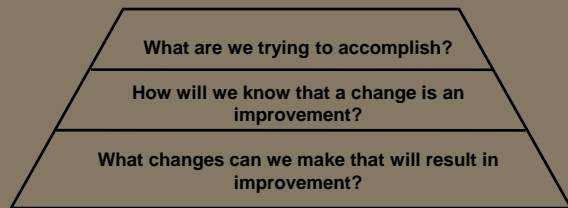
Goal



Examples Posted on CoP

- Checklist adaptations
- Patient handouts
- Patient surveys
- Audit worksheets
- Feedback forms
- Scripts
- Stories

Principles for Testing & Implementation

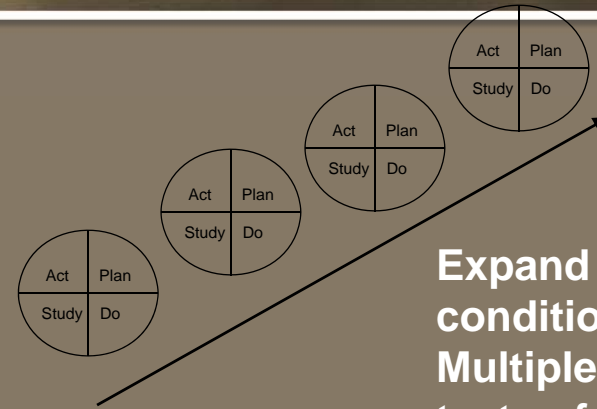


Aim?

Measures?

Ideas?

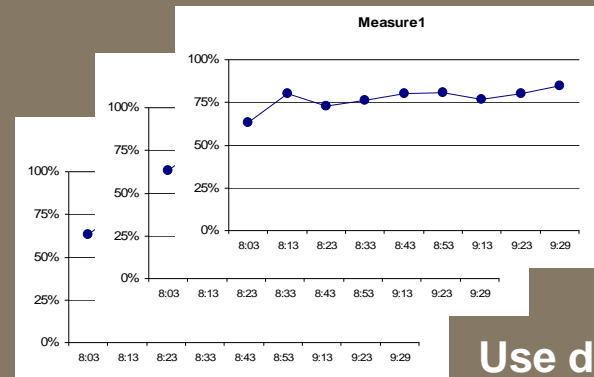
Test and implement using small tests of change



Expand conditions – Multiple small tests of change



Engage the champions



Use data & feedback for learning

Next Steps

- Invitation to Wave 3, likely the orientation in December and start in January 2011

Checklist Action Series Planning Group



Anna Pevreal, Clinical Nurse Specialist, Surgical Suites, Jewish General Hospital, Quebec



Dr. Craig Bosenberg, Anaesthesiologist, Vancouver Island Health Authority, British Columbia



Dr. Daniel Wong, Cardiac Surgeon, Royal Jubilee Hospital. Clinical Instructor, University of British Columbia



Susan Macknak, RN, QI Consultant, ASQ Certified Six Sigma Green Belt, Regina Qu'Appelle Health Region, SK

Thank you to Our Checklist Action Series Planning Group



Rob Barrett, Pilot with Air Canada



Dr. Corrine Jabs, Surgeon, Section Head, Gynecology at Regina
Qu'Appelle Health Region



Virginia Flintoft, Project Manager, Central Measurement Team, SHN;
Health Policy, Management and Evaluation University of Toronto



Ioana Popescu, Project Manager, Safe Surgery Saves Lives,
Canadian Patient Safety Institute

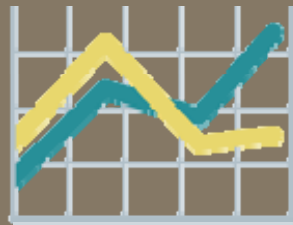
Continuing Medical Education (CME) Credits



- 1.5 CME credits from Royal College of Physicians & Surgeons of Canada for each webinar
- For Certificate of Attendance contact Angela Thiessen angela.thiessen@hqca.ca or call 403-521-7106

Poll

1. How useful was this webinar?
2. Did you learn something new today?
3. What else would you like to hear about the checklist?



Questions?

Tanis Rollefstad, Safety & Improvement Advisor

Phone: 306.693.0780

Email: tanis.rollefstad@hqca.ca



Checklist Action Series

Funded By



BC Patient Safety & Quality Council



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