the children's hospital at Westmead

The Sydney children's Hospitals Network

Determining Best Practice for the Application and Integration of the Clinical Procedure Safety Checklist

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Introduction

Aim: To improve the safety of patients that require procedural sedation or anaesthesia.

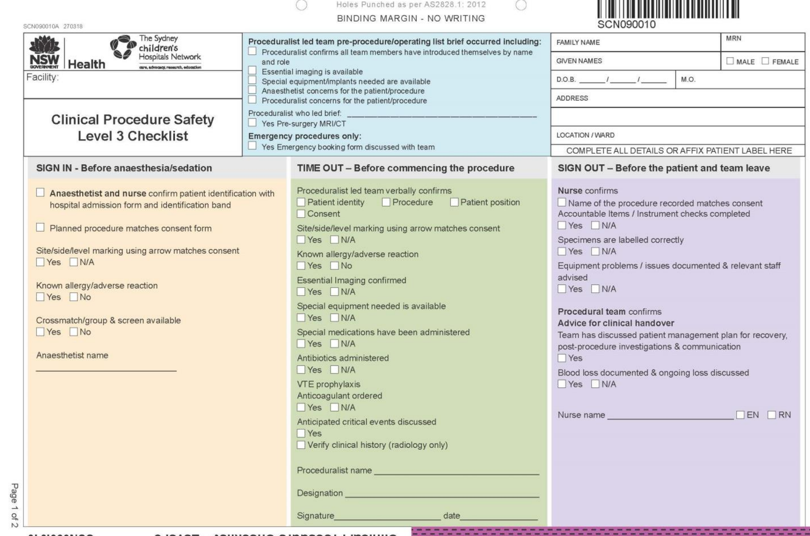
Wrong site procedures resulting in serious harm or death is one of the highest reportable sentinel event with communication listed as one of the most frequently identified root cause (Australian Commission on Safety and Quality in Health Care 2018; Joint Commission 2015).

The NSW MoH PD 2014_036 was implemented in 2014. The organisation reviewed best practice methods to introduce the Clinical Procedure Safety Checklist.

The Checklist with Team Brief at the start of each procedural list was implemented in 2016 to improve communication and mitigate any patient safety risk. The Team Brief method was a significant change in clinicians practice.

In 2018 the organisation introduced the electronic medical record eMR (SurgiNet) - this enabled the integration of the Checklist.

Contemporary and clinically focused education strategies were applied to improve teamwork, communication and support clinicians with the introduction of the Team Brief method and the integration of the Checklist to the eMR. Quality assessment was undertaken to understand the effectiveness of the Checklist, the process and education.



Clinical Procedure Safety Level 3 Checklist

SIGN IN – Before anaesthesia/sedation

TIME OUT – Before commencing the procedure

SIGN OUT – Before the patient and team leave

Method

Introduction of the Clinical Procedure Safety Checklist and Team Brief process pre eMR

- Established multidisciplinary support team.
- Reviewed best practice methods and benchmarking.
- Developed Checklist.
- Support team educated clinicians on the process using PowerPoint/face to face method.
- Checklist sample was displayed for staff viewing.
- Staff were informed of staggered implementation dates.
- Support team provided clinical support to 100% of clinicians in 144 procedural lists over a 3 month period.
- Support team provided visual audit feedback (63) – thematic analysis was undertaken.
- Implemented action plan following results of visual audits.
- Continued patient documentation & visual audits over a 2year period were conducted.

Integration of eMR Clinical Procedure Safety Checklist and Team Brief process

- Multidisciplinary support team worked with eMR team to integrate the Checklist ensuring mandatory field options.
- Engaged multidisciplinary eMR super user support team.
- Developed a Safe Work Practice
- Walk through/simulation sessions were conducted to determine best practice for eMR integration.
- Application of contemporary education methods – developed a self-directed learning PowerPoint including YouTube.
- Super users supported clinicians at point of care.
- Randomised electronic patient documentation in SurgiNet (60) and visual audits were conducted by an independent person over a 6 month period.

Results

Introduction of Clinical Procedure Safety Checklist and Team Brief process pre eMR

Pre Team Brief implementation

Pre brief implementation staff feedback highlighted the need for improved multidisciplinary communication and Clinical Procedure Safety Checklist compliance.

Pre implementation audit results demonstrated a 60% Clinical Procedure Safety Checklist compliance by the multidisciplinary team.

Team Brief introduction - support team visual audit

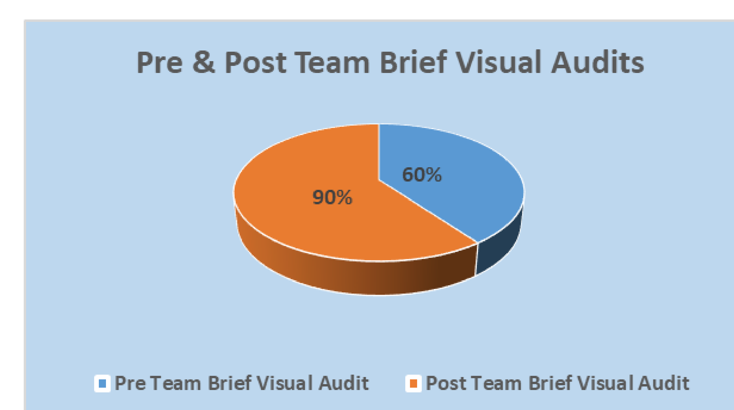
Thematic analysis of the feedback identified 3 themes:

- Start time delays
- Checklist compliance
- Understanding of the brief process

Based on the results of the thematic analysis an action plan including further education and clinical support was implemented.

Post Team Brief implementation – quarterly visual and patient documentation (paper form) audits – 2year Period

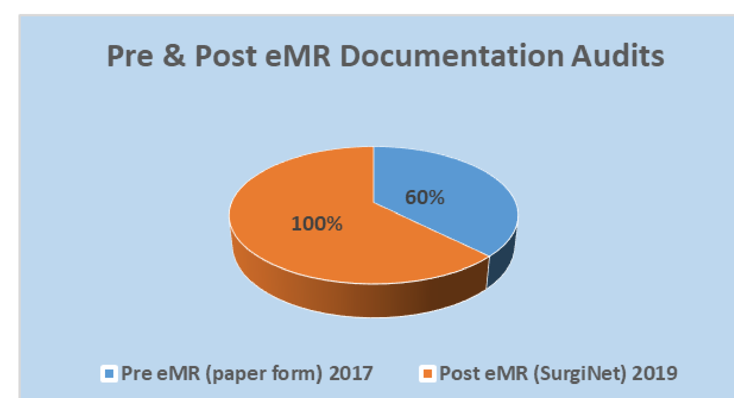
Audit results demonstrated a 90% Clinical Procedure Safety Checklist compliance by the multidisciplinary team and improved start time.



Integration of eMR Clinical Procedure Safety Checklist and Team Brief process

Audit results of randomised eMR (SurgiNet) elective patient documentation demonstrated a 100% Clinical Procedure Safety Checklist compliance.

Visual audits demonstrated – the multidisciplinary team understood the Team Brief method 90% of the time.



Conclusion

A focused approach with multidisciplinary clinician engagement, contemporary educational methods and continual clinical support was key to the success of the implementation of the Clinical Procedure Safety Checklist, Team Brief and the integration with eMR (SurgiNet).

The eMR (SurgiNet) functionality of mandatory field completion and the application of contemporary teaching methods contributed to a significant increase in compliance and understanding of the Team Brief method. The future focus is on strategies for sustainability.