Improving Patient Safety By Standardizing Radiology Pre-Procedural Time-Out

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Pratik Rachh, MD, MBA
Deborah G Walls, DNP, NP
Susan Reich, BS, LSSG
Edwin Herrod, RT (R) (VI)
Janice Newsome, MD
C. Matt Hawkins, MD

Department of Radiology and Imaging Sciences
Emory School of Medicine and Emory Healthcare

EMORY UNIVERSITY SCHOOL OF MEDICINE

Disclosures

The authors have no disclosures

Background

- **Wide variation in the Pre-Procedural Time-Out (PTO) and patient identification process for procedures performed at Emory Radiology**
- **Variations include:**
  - Patient identification methods
  - Site-marking processes
  - Personnel present during PTO
  - Defined roles of technologists, nurses, and physician or Advanced Practice Provider (APP) proceduralists during the PTO process

Purpose

- **Develop a standardized process for patient identification and pre-procedure time out**
- **Prevent wrong procedure, wrong site and wrong patient errors for radiology procedures across the system**
- **Ensure patient safety is a part of our culture**
- **Providers encounter the same time out process regardless of the facility they are working at**

Aim Statement

Develop and implement a standardized patient identification and pre-procedure time out process which is followed 100% of the time for procedures performed in radiology by January 2016

Baseline Observations

CTO Element	Performed	Not Performed
Staff introductions	2	11
Safety precautions specified	5	8
Agreement to proceed	9	4
Confirmation of order & consent	12	1
Images and name displayed on monitor	2	11

Direct observations of 13 Time-out events on 2 separate days in 3 modalities showed that none met the stipulated standards.

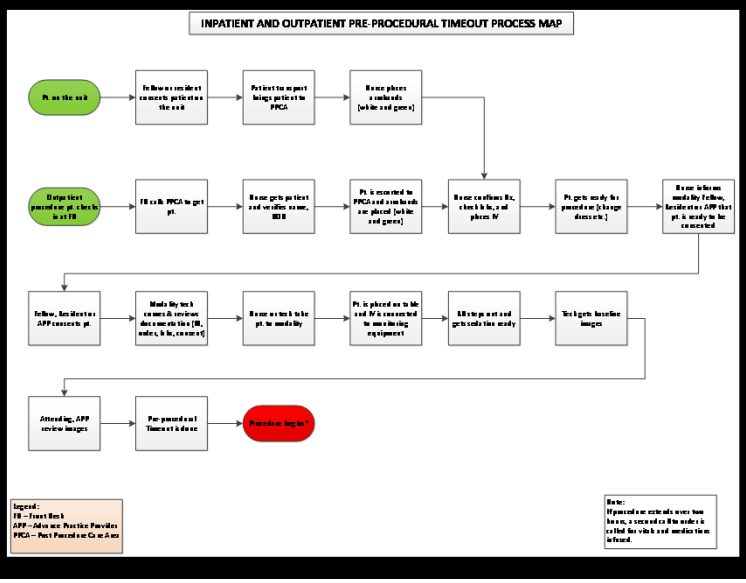
Culture of Safety Survey

- Prior to initiation of the project, faculty and staff perception of safety was assessed with a survey modeled after AHRQ Culture of Safety Survey

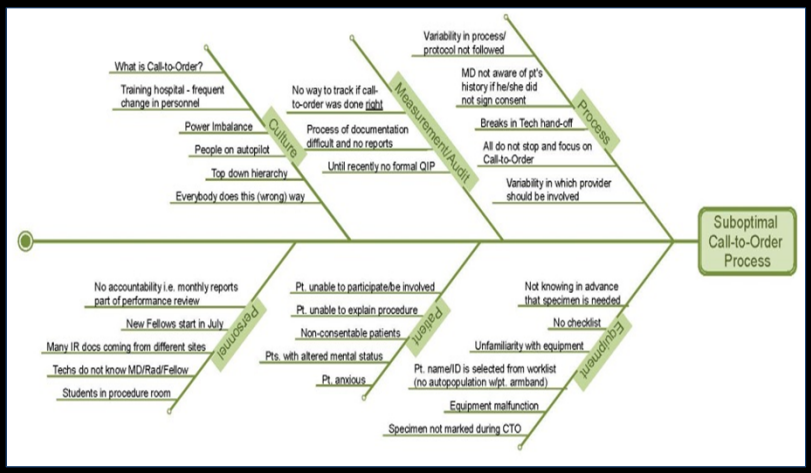
- Results showed a significant percentage of respondents (~40%) reported they often work in crisis mode and it's just by chance more serious mistakes don't happen

Surveys on Patient Safety Culture. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html

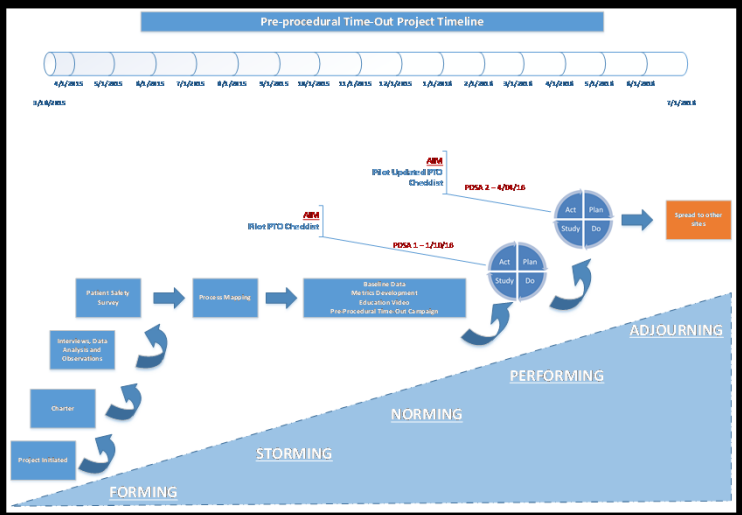
Current State Process Map



Cause and Effect Analysis



Project Timeline



Test of Change

- Develop PTO checklist and a standardized process for its use
- Interdisciplinary PTO team training and empowerment to speak up for patient safety
- Emphasis on organization's "Pledge" to ensure Safe and Just Culture
- Pre-procedural time-out awareness campaign
- Development of metrics and sharing of performance at monthly team meetings

Safety Checklist

IN PROCEDURE ROOM

- ☐ Rally involved personnel
- ☐ Confirm all members have introduced themselves

Time Out/Call-to-Order: Led by the Proceduralist

- ☐ Announce Call- to-Order
- ☐ Is everyone focused on event?
- ☐ Involve patient if they are able
- ☐ Confirm 2 patient identifiers on WHITE armband (MRN, Full Name, DOB)
- ☐ Review consent and order
- ☐ Any allergies?
- ☐ Correct name on monitor/labels?
- ☐ Is correct side and site marked?
- ☐ Is patient secured to the table?
- ☐ All equipment and medications available?
- ☐ Any special safety precautions (i.e. labs…)?
- ☐ Is everyone in agreement?
- ☐ Is electronic documentation complete?

TIME OUT
CALL TO ORDER

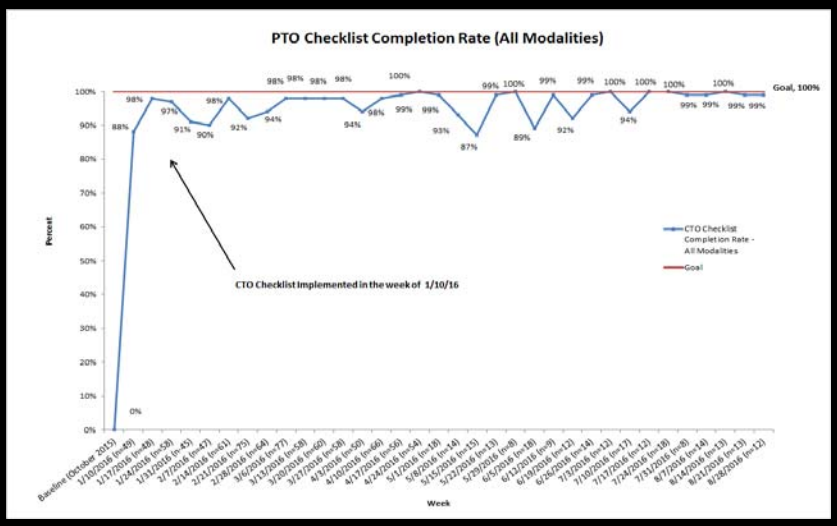
Awareness Campaign

Campaign Poster

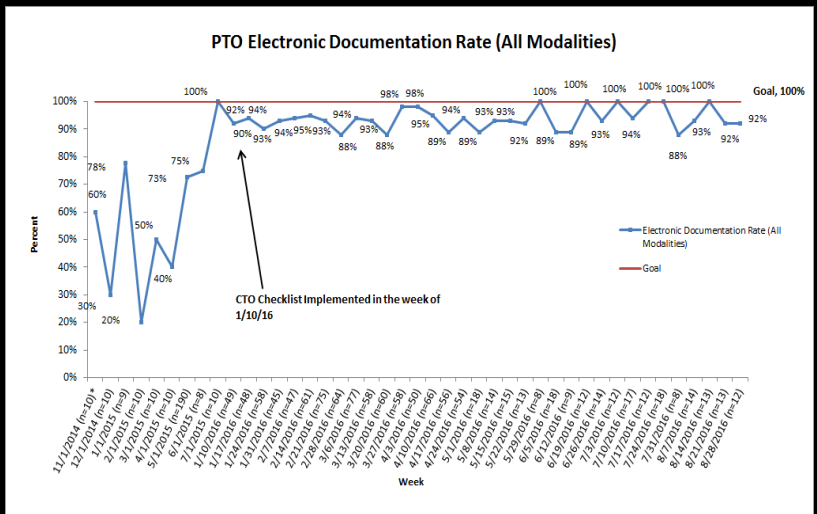
Buttons

Staff Training Videos

Metrics



Metrics



Post-Implementation Results

- Average rate of completion of all elements of the checklist (n=1168) across three modalities (Interventional Radiology, Computer Tomography and Ultrasound) is 96%
- Silent observer observations indicate that 80% to 100% of procedures met the new standards
- Average rate of documentation in electronic medical record (n=1168) has been 94% since implementation

Conclusions

- Emphasis on creating a safe environment for our patients led to the identification of wide variations in PTO practice
- Workflow process and culture change require focused, multidisciplinary teamwork actively supported by executive leadership

Conclusions

- Currently, the new standardized PTO process is completed >90% of the time
- Next steps include sustaining gains, integrating PTO training into new staff onboarding process, and spreading the new process at the remaining four institutions