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

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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**

<table>
<thead>
<tr>
<th>CTO Element</th>
<th>Performed</th>
<th>Not Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Introductions</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Safety precautions specified</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Agreement to proceed</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Confirmation of order &amp; consent</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Images and name displayed on monitor</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

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.


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
Awareness Campaign

We STOP for Patient Safety

Campaign Poster

Buttons

Staff Training Videos

![Staff Training Video Screenshot]
Metrics

PTO Checklist Completion Rate (All Modalities)

Week

Metrics

PTO Electronic Documentation Rate (All Modalities)

Week
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