

TreatSafely



Minimizing Error

Maximizing Quality

CHECKLISTS

An effective safety barrier

Session Objectives

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- To discuss the role of checklists in healthcare
- To discuss considerations for implementing effective checklists
- 5 W's (why, where, when, who, what)
- To describe the process for creating better/safer workflows with checklists

Checklists - Why

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- Memory aid for minimum necessary steps
 - Make the minimum set of steps explicit
- Enable process verification
- Enable higher level of performance
 - Couple checklists with performance standards
- Instructional checklists
 - Generally more detail and steps more explicit

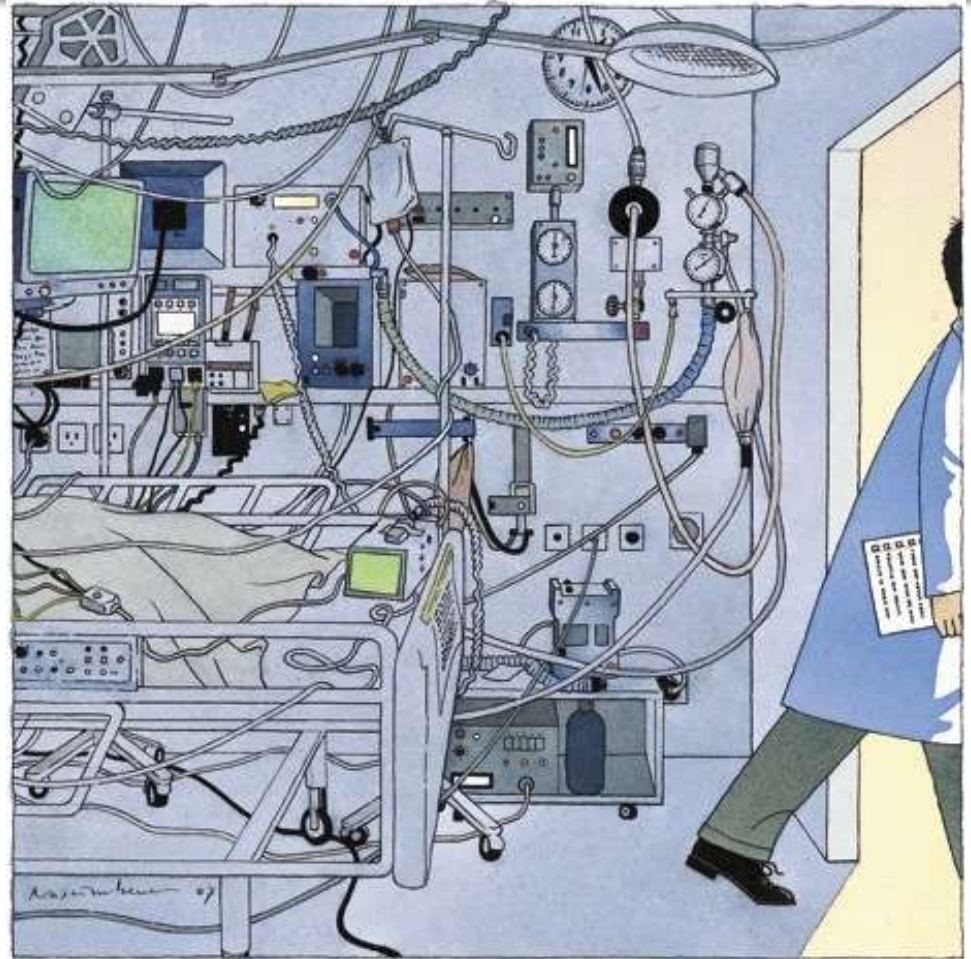
Checklists - Why

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- **Complexity.**
- **Multidisciplinary team.**

“To handle complexity, we’ve split up the tasks among various specialties”

“The biggest source of serious error in this business is a failure of communication”



Checklists - Why

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- Simple checklists at Johns-Hopkins reduced line infection rates from 11% to 0%
- The same model was deployed statewide in Michigan
- During the initial 15 months in Michigan, it was estimated that the checklist saved 1500 lives and \$175 million

Checklists - Why

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- THE ODDS:
 - ~200 steps per patient
 - ~400 patients per year
 - ~20 repetitive tasks (per fx)
 - ~30 fx/patient
 - ~0.1% failure rate – 1 in a 1000



Annual number of missed\failure steps =
 $(200*400+20*30*400)*0.001 = 320$ (minor or major)

Checklists - Why

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Table 2. Ranking of QM tools based on the effectiveness, in part following the suggestions of ISMP.¹³

<p>0. Environment problem correction (Not tool)</p> <ul style="list-style-type: none">• Sound Control• Visual Control• Cleaning• Neatening• Isolation• Environmental Design <p>1. Forcing functions and constraints</p> <ul style="list-style-type: none">• Interlock• Barriers• Computerized order entry with feedback <p>2. Automation and computerization</p> <ul style="list-style-type: none">• Bar codes• Automate monitoring• Computerized verification• Computerized order entry <p>3. Protocols, standards, and information</p> <ul style="list-style-type: none">• Check off forms• Establishing Protocol / Clarify Protocol• Alarms• Labels• Signs• Reduce similarity	<p>4. Independent double check systems and other redundancies</p> <ul style="list-style-type: none">• Redundant measurement• Independent review• Operational Checks• Comparison with standards• Increase monitoring• Add status check• Acceptance test <p>5. Rules and policies</p> <ul style="list-style-type: none">• External Audit• Internal Audit• Priority• Establishing / Clarify Communication Line• Staffing• Better Scheduling• Mandatory Pauses• Repair• PMI (Preventive Maintenance Inspection)• Establish and Perform QC and QA (Hardware and Software) <p>6. Education and Information</p> <ul style="list-style-type: none">• Training• Experience• Instruction
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Checklists – Where, When, Who, What

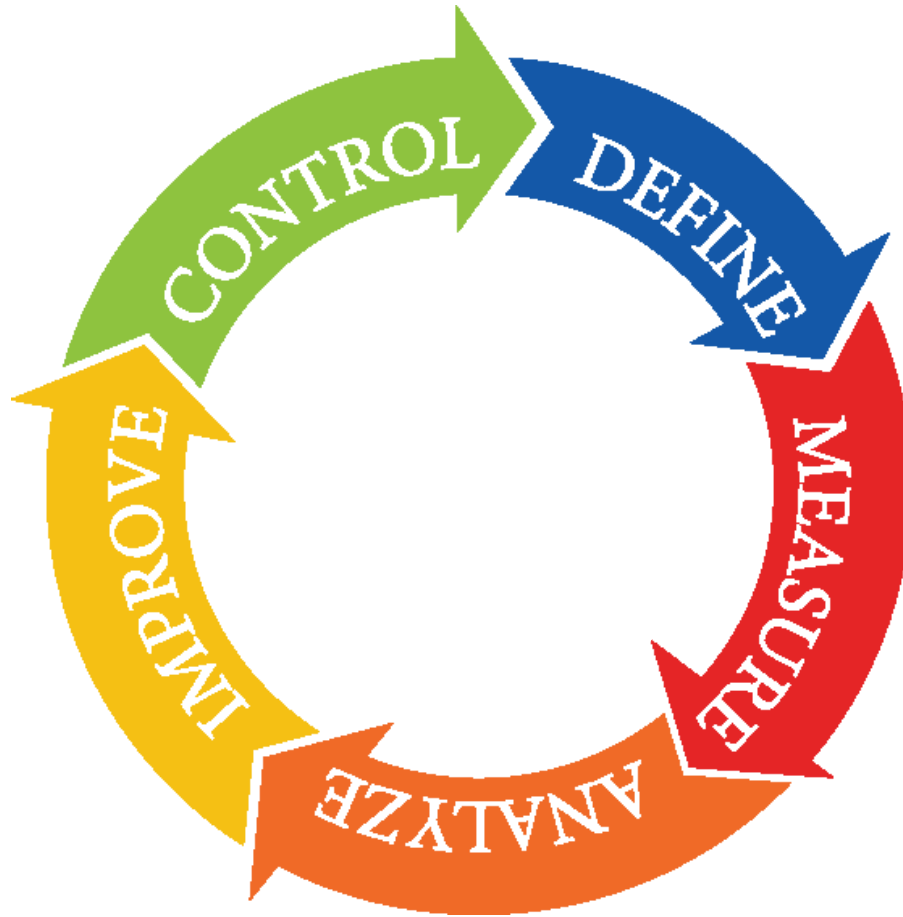
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- The tough part is determining Where, When, Who, and What
- Need to separate between
 - Ticklists (Tick fever) – BAD
 - Checklists – GOOD
- Need a process to make 4 W's effective

“In complex processes, after all, certain steps do not always matter”

DMAIC Cycle

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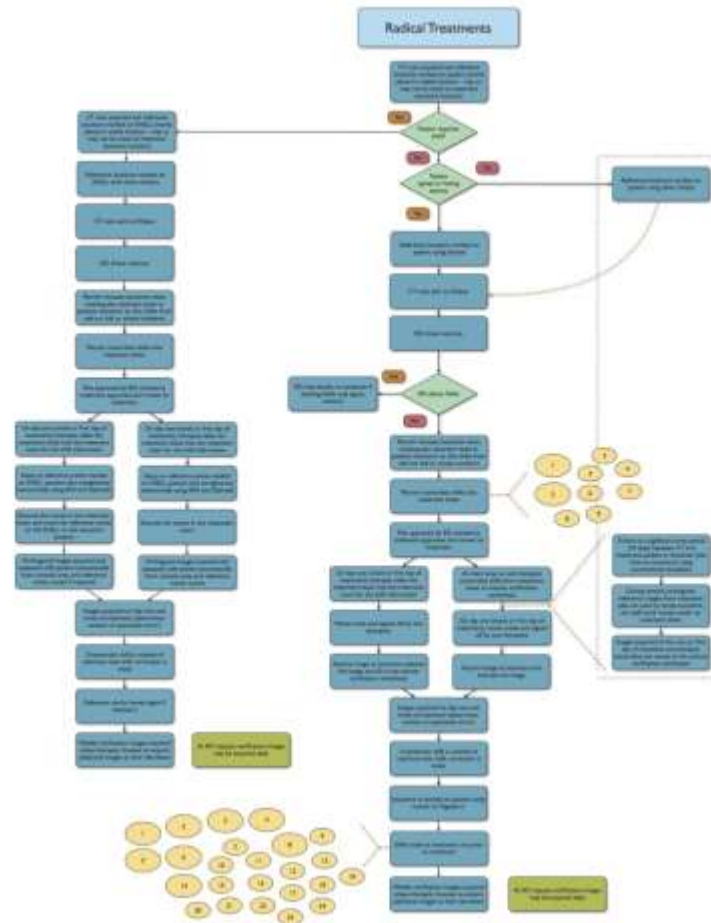


Checklists – Where, When, Who, What

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1. Map your workflows
2. Overlay incidents (errors/near misses) and critical steps/items – *Where, When*
3. Study and design a checklist – *Who, What*
4. Implement
5. Monitor and study
6. Go back to 2

Checklists – Where, When, Who, What



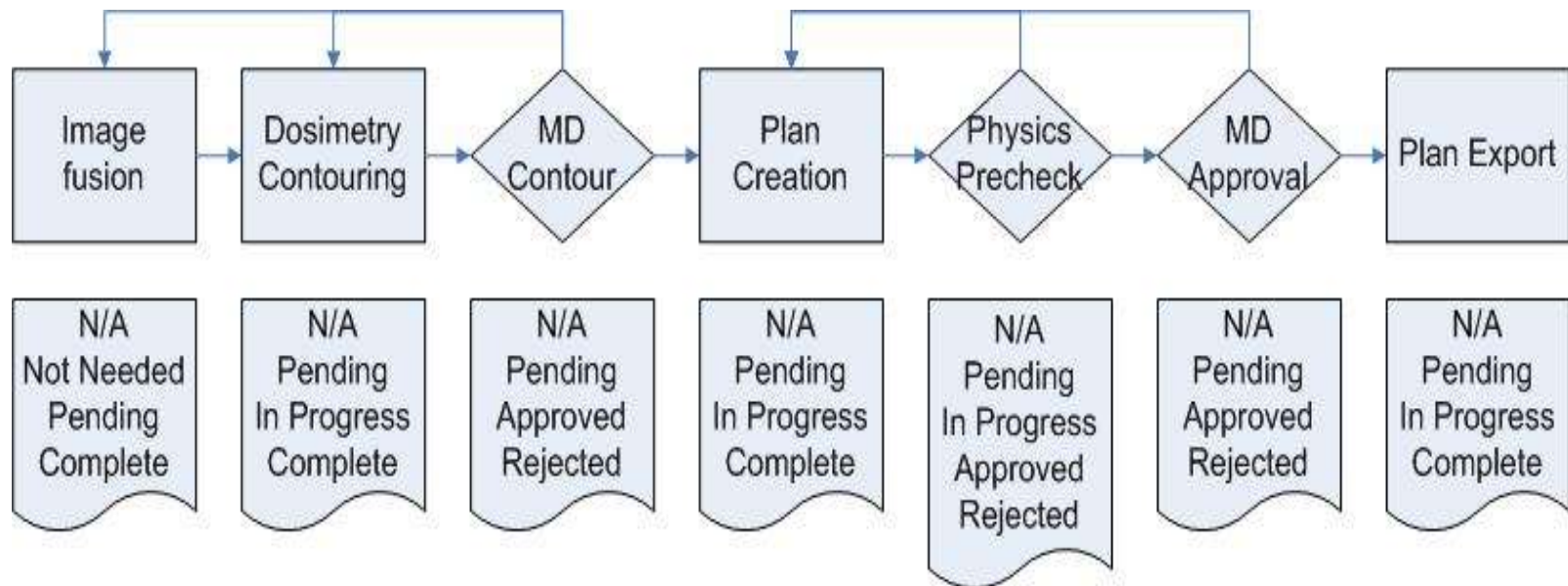
Possible checklist locations

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- Initiation of work (simulation, planning, treatment, etc.)
- Completion of work
- Approval tasks (treatment plans, OR procedures, etc.)
- Instruction checklists

Analyzed Workflow

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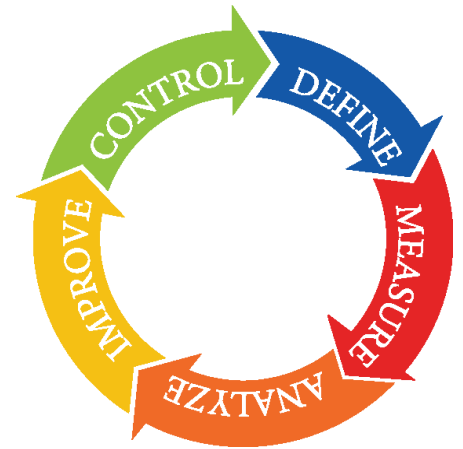
Failed items

- Items that are identified as failing/not done with checklist
 - Should be captured through ILS (all are near misses)
 - Unique opportunity to identify problem areas
 - Quantitative data on checklist effectiveness

Rejections

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- Plans, MUs, port films, QAs, etc.
- Should be captured – they indicate failures
- Rejections should not be considered a part of the normal process
- All rejections are near-misses



Cost of rework

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Sigma Level	DPMO	Error as %	Quality Yield	Cost of Quality/Cost of Poor Quality as % of Total Operating Cost
2	308,537	30.8%	69.0%	Uncompetitive
3	66,807	6.7%	93.3%	24-40%
4	6,219	0.6%	99.4%	15-20%
5	233	0.0233%	99.98%	5-15%
6	3.4	0.00034%	99.9997%	World Class

Implementation

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- Introduce checklists to reduce variability and ensure compliance
- Track items identified by checklists
- Analyze the data
- Determine to maintain, alter, or discontinue existing checklists

Summary

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- Checklists have demonstrable efficacy in many fields
 - Should be created with care
- Effective use requires maintenance “Must pause to sharpen the ax”
- Checklists greatly enhance compliance but not necessarily performance – need a safety culture to ensure performance

Acknowledgements:

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