**Bringing Emergency Manuals to Your Institution: A Step-by-Step Guide for Successful Implementation**

2018 ASA Annual Meeting Seminar

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**All Material Based Upon:**



[**https://www.implementingemergencychecklists.org**](https://www.implementingemergencychecklists.org)

Participant Workbook

# [Getting Started](https://www.implementingemergencychecklists.org/implementing-the-checklist/getting-started/)

**Identifying a local champion**

*Every successful implementation starts with a local champion who can lead this effort and partner with others to share duties. The champion should feel a personal commitment to the project and be willing to invest the time and effort that will lead to success. He or she will ideally be a respected clinician who collaborates well with colleagues across disciplines. Excellent communication skills and the capacity to anticipate and understand barriers are important to building broad consensus around the use of emergency checklists in practice. The champion should feel a personal commitment to the project and be willing to invest the time and effort that will lead to success.*

**Who will be the local champion?**

# [Getting Buy-in](https://www.implementingemergencychecklists.org/implementing-the-checklist/getting-buy-in/)

**Understanding the Value of Checklists for Your Institution**

**How will we make the case to leaders? What tools can we access to help us build the case?**

**Engaging Leadership**

**Who are the critical clinical and administrative leaders in our department and institution?**

Examples: Chiefs of Anesthesiology and Surgery, Chief Medical and Quality Officers, Nursing Director, OR/Perioperative Medical Director, Division Chiefs, Pharmacists, Board of Trustees, Risk Managers

**Presenting at Meetings and Conferences**

**Which meetings might it be helpful to attend to “sell” the idea?**

Examples: Leadership/Executive Meetings, Surgical Coordinating Committees, Department Staff Meetings, Nursing Department Meetings, Surgical Department Meetings

**Meet individually with potentially resistant thought leaders**

**Who are the clinical thought leaders most likely to resist the implementation? What strategies might we use to help each of them support (or at least not obstruct) the implementation?**

**Think of getting buy-in as a marketing campaign**

**Which of the following ideas might be useful to include in our marketing campaign?**

* *Announcements and invitations for further discussion at faculty meetings or at departmental conferences*
* *Email updates on emergency checklist implementation*
* *Bulletin board posters with photos of trainings or simulations, or lists of FAQs*
* *Making or showing video demonstrations of emergency checklist use*
* *Promotional materials such as buttons or stickers*
* *Sharing individual staff testimonials*
* *Placing flyers inside doors of toilet stalls*
* *Computer screen-saver messages*
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# [**Creating a Multidisciplinary Team**](https://www.implementingemergencychecklists.org/implementing-the-checklist/creating-a-multidisciplinary-team/)

***Active involvement from all perioperative disciplines is critical to success***

*No single discipline can produce a successful implementation in isolation. Everyone involved in making checklists part of emergency event management must embrace the change and have a shared vision of how the team works.*

*The checklist champion should first identify the individuals in each of the perioperative disciplines who are thoughtful, respected, reliable, collaborative, and able to participate. These individuals may or may not hold official leadership titles in the facility. Nurses, residents, and/or technical staff all have valuable perspectives and often welcome opportunities to participate in safety initiatives for their own professional development.*

*General expectations for team members include:*

* *Participation in regular implementation team meetings (with the understanding that the implementation work could take 6-12 months)*
* *Participation in selecting, customizing, and testing the emergency checklists*
* *Encouragement of checklist adoption with peers*
* *Developing, leading, and participating in presentations, trainings, and simulations*

**Who will we ask to join our team?**

# [Select, Customize, and Test the Checklists](https://www.implementingemergencychecklists.org/implementing-the-checklist/customizing-the-checklists/)

**How will we decide which of the available checklists to implement?**

**What kinds of customization will be required? Who will be responsible for working on these customizations?**

*Examples of potential customizations needed:*

* *Personalize with your facility’s name and logo.*
* *Add relevant telephone numbers on checklists for specific events (e.g., blood bank, rapid response team, etc.)*
* *If your facility has installed alarm buttons, consider referencing them where appropriate.*
* *Review medications to ensure they reflect the names and dosage forms available.*
* *Check equipment instructions to make them compatible with your facility’s devices.*
* *Consider availability and location of resources (e.g., TEE, cardiopulmonary bypass, specialized clinical teams) and update regularly.*
* *Consider whether the checklists should reference existing internal procedures (e.g., OR fire or massive transfusion) and include key elements of those procedures*
* *Caveats:*
	+ *When adding content or changing format, triple check for any introduced errors (e.g. medication dosing may be incorrectly adjusted by autocorrect)*
	+ *Consider additions carefully for wording and format. Adding more information is not necessarily better for prioritizing key actions.*

**Would printed copies or electronic versions provide better ease of access for review, and real-time crisis management, and ease/economy of updating and revising?**

**Where will we begin using the checklists? (e.g., operating rooms, maternity, recovery areas, ICU, ambulatory surgery centers)**

**How many copies will we need for each clinical location?**

* *Both nursing and anesthesia workstations?*
* *What’s the best standard, consistent location in these locations? Try to locate checklists between chest and eye level, easily visible but not interfering with normal work flow*

**What is the best physical format: lamination vs synthetic paper vs protective sleeve, loose-leaf vs spiral bound. Consider:**

* *Durability*
* *Ease of updating/replacement*
* *Ability to maintain cleanliness*
* *MRI compatibility*
* *Large font, colorful label on the spine of binders to increase visibility*
* *Distinctive and easily recognizable color for the covers or binder*
* *Labeling: Listing “Return to OR # \_\_\_\_” for each copy in bright sticky label on front helps return of accidentally misplaced copies*
* *Adding to Anesthesia Tech start of day checklists to make sure each OR has tool in proper location(*

### Anticipating printed checklist production cost

*Depending on the number of clinical events included, the format and quantity of the checklists, and whether they’re produced in-house or through a professional printing shop, the cost can range from $15-50 per copy. Cost savings on the printing can be achieved by producing black-and-white versions but the usability will be compromised (*[*more details on print costs*](https://cdn2.sph.harvard.edu/wp-content/uploads/sites/119/2017/07/Shopping-checklist.pdf)*)*

**How much will this cost us?**

\_\_\_\_\_ Anesthetizing locations \* \_\_\_\_\_ copies per location = \_\_\_\_\_ manuals + 10% (*for backup stock)*

= \_\_\_\_\_ total copies \* $ \_\_\_\_\_ estimated unit cost = $\_\_\_\_\_\_\_\_ Total Cost

*($15-20 for self printed - >$50 for Stanford manual professionally printed)*

**Testing your checklists**

*Once you have selected and customized your checklists, it is important to test them in team simulations before using them on a real patient. Testing reveals any need for further revision by highlighting steps that may not flow correctly and/or instructions that may be confusing. The testing step is also when team members become more comfortable with the checklists and more confident in using them.*

**How will we test the checklists in our institution? Who will we need to be involved in the process? What resources will we need to be able to conduct testing?**

# [Training Staff](https://www.implementingemergencychecklists.org/implementing-the-checklist/training-staff-to-use-the-checklist/)

### Checklist introduction and orientation

*Your emergency checklists training should include the following steps:*

1. *Introduce yourself and the team guiding the implementation of the checklists.*
2. *Introduce the rationale and benefits of using the checklists.*
3. *Discuss how they are used and by whom.*
4. *Encourage participants to discuss potential challenges to using the checklists.*
5. *Give participants the opportunity to practice using the checklists.*
6. *Invite participants to share their thoughts and feelings about the checklists and answer any questions they may have.*
7. *Let the participants know they have your support and the team’s ongoing support throughout implementation of the checklists.*

**How will we introduce and orient our anesthesia providers to these checklists?**

**Simulation**

*Simulation is a valuable way to familiarize your team with use of the checklists, gain buy-in, and improve team performance. During simulation, your teams can gain clarity on the roles of the reader and crisis manager, and see how quickly the checklists can be reviewed. Many* [*apps*](http://kidocs.org/2014/06/apps-simulation-review/) *exist to help with in-situ simulation.*

### Simulation training options

### *There are several options for training on emergency checklists through simulation:*

### *Low-cost, low-tech simulation options*

### *Ingredients for In-situ drills (\*zip file) – everything you need to run your own in-situ drills*

### *Trigger videos or “Simulated simulation” option*

### *Demonstrations on video* [*with*](https://youtu.be/iaHiSYR11u0) *and* [*without*](https://www.youtube.com/watch?v=Ko99M5ZHg3Y&feature=youtu.be) *use of cognitive aids, with* [*instructor debriefing guide*](https://www.dropbox.com/s/13yz7dqr5z1nqpw/Checklist%20Video%20Discussion%20Guide.doc?dl=0)

### *Live simulation with audience participation option*

### *Formal high-tech simulation at a* [*Professional Sim Center*](http://www.ssih.org/Home/SIM-Center-Directory)

### Which of the simulation options will work best for our anesthesia providers? Which techniques will be best for which providers (faculty, CRNA/AAs, trainees) ?

### Facilitation and debriefing

### Who will facilitate the training? How will we incorporate debriefing into the training? Who will do the debriefing?

**Finding the time for checklist training**

*It can be difficult to find time to train your team on using the emergency checklists, even if your hospital leadership is supportive of this effort. Here are some ideas to creatively carve out training time, generated from interviews with clinical champions.*

* *Block off 1-2 hours at the end of a slow day and allow OR nurses and surgical techs to train alongside surgeons, anesthesiologists and nurse anesthetists.*
* *If you are having a hard time finding surgeons to participate in the training, recruit retired surgeons with more flexibility to stand in during drills.*
* *Use existing protected educational time, case conferences, or other blocked time for in-services to have trainings or run simulations.*
* *Coordinate with your continuing education department to see if CEUs can be made available for training participants.*
* *Use case cancellations and/or schedule gaps to run emergency drills. Have scenarios ready and available for spontaneous moments of downtime.
Tip: Verbally present a surprise event and supplement the verbal case with a mobile-device simulated monitor. Include audible pulse-oximetry for tone and rhythm to engage participants without having to use OR equipment.*
* *Anticipate which personnel may not be able to attend training sessions (e.g., evening and night shift workers) and plan for ways to involve them in training opportunities, such as videotaping presentations, utilizing the facility’s on-line learning platform, live-streaming training exercises or emailing program handouts.*

**How will we make time for training at our institution? Are there existing education times that we can use for this training?**

**Can we offer CME/CEUs?**

**Can we take advantage of late starts, gaps, and early days for training?**

**How will we get surgeons, OR nurses and scrub techs involved in the training?**

**How can we account for training off-shift employees?**

**What other techniques can we use to train?**

# [Starting to Use the Checklists](https://www.implementingemergencychecklists.org/implementing-the-checklist/deploying-the-checklists/)

**Taking a phased approach**

**Where can we begin to use the checklist as a pilot?**

**Consistently encourage checklist use**

**How will we encourage use? What existing methods of reminding providers about new initiatives exist? Are there pause points at which reminders can be included?**

# [Monitoring Use](https://www.implementingemergencychecklists.org/implementing-the-checklist/monitoring-use/)

*To give clinical leadership and OR teams ongoing encouragement and support, you need to know when, how, and why they are using the checklists. Assessing checklist usage identifies both challenges to resolve and improvements to celebrate*.

**How will we measure and monitor usage of the checklists? Can we observe simulation exercises for use of the checklists? Can we use of the EMs be investigated as part of retrospective root-cause analyses after adverse events? What other methods might we be able to use to monitor usage?**

**Providing data feedback and reporting are critical to success**

**How might we share success stories with our faculty and staff?**