Interventional Radiology Coordinator Checklist

A PROPOSAL TO: Interventional Radiology Attending Physicians and Staff R.N.’s and Medical Imaging Management

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Children’s Memorial Hospital
Where kids come first.
Better Service and Increase Safety in I.R. with Implementation of Coordinator Checklist

PURPOSE

We, the staff nurses of Interventional Radiology, propose a cost-effective solution to an increasing problem here at Children’s Memorial Hospital: incomplete patient prescreening and planning, and increasing delay of scheduled procedures. Safety questions are not a part of the prescreen questionnaire in current use. Coordinators for the department use an outdated format to prescreen patients and are inconsistent in obtaining pertinent information for each case as each coordinator practices individual methods instead of using a standardized form. This practice has resulted in delay of care the day of procedure and rescheduling of cases due to lack of information pertinent for proceeding with a procedure. Plans of care can change during a case such as the need to give contrast or administration of a certain medication.

All changes can be implemented seamlessly if the right questions are answered prior to the patient’s procedure appointment. We recommend that you implement a new checklist that is formatted to inquire on patient assessment head to toe, potential for contrast allergies, potential airway complications and status of pre-laboratory and medication/equipment orders. Implementation should be initiated in two weeks.

Checklists were recommended by World Health Organization (Haynes, Weiser, Berry, Liptsz, Breizat, et al., 2009) to ensure safety of patients worldwide. Concomitant reductions in the death rates and complications among patients were noted by WHO during their study using a 19-item surgical safety check list in 2007 to 2008 in eight hospitals and eight cities.

Using a standardized checklist would enhance communication between I.R. staff and be in keeping with JCAHO (Joint Commission Accreditation of Hospitals Organization) standards of safe practice.

PROBLEM WITH CURRENT PRESCREEN.

Currently, I.R. has two coordinators in charge of scheduling and prescreening appointments. Each coordinator uses a check-in document generated from the electronic schedule system that is printed out. As contact is made with the family to finalize the appointment, the coordinator then writes answers to questions on the check-in document. This practice comes from the procedure for screening used prior to electronic records. This process is not only hard to follow, but it is not centrally located. Communication of information is limited. Once all of the questions are completed, the check-in document is stored in a file folder in a cabinet. Only unit specific staff can retrieve this information. The question format is not standardized and is completed by rote. If a coordinator does not think to ask a certain question pertinent for the patient’s procedure, it is then up to the sedating nurses to recover that information during the appointment. This creates a delay in care, lowers accountability, and our ability to efficiently perform care is compromised.

At this time we schedule approximately 50 cases per week. At least 1/3 of these cases are sedations and contrasted procedures. Without proper screening for these two types of cases, we have the potential to have both delays and rescheduling for 1/3 of our cases on a given week. This translates into chargeable appointments without completion or partial completion of a procedure. In reality, three out of every 10 cases are delayed and or rescheduled. An I.R. procedure costs approximately $3,000.00. This translates into a potential $10,000.00 loss. Our current volumes are down 20%. Losing $10,000.00 each day would diminish the department’s budget, resulting in and restructuring of supply ordering and limited access to hire new staff during vacancies.

In terms of safety, the current checklist does not address specific contrast safety questions. Contrast has the potential to be life-threatening for patients with certain diseases and contrast allergies. These patient demographics require clearances and lab work to ensure the patient can receive contrast without it being detrimental to their health. The patient’s risk for death and complications rises when the screening isn’t completed.
# Prescreen Checklist

**Patient Name:**

## Sedation

<table>
<thead>
<tr>
<th>Systems check:</th>
<th>Current vs. Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart/Lung issues:</td>
<td></td>
</tr>
<tr>
<td>Gastro-intestinal:</td>
<td></td>
</tr>
<tr>
<td>Hem/Oncology:</td>
<td></td>
</tr>
<tr>
<td>Sleep apnea/airway</td>
<td></td>
</tr>
<tr>
<td>Metabolic:</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease:</td>
<td></td>
</tr>
</tbody>
</table>

## Contrast

<table>
<thead>
<tr>
<th>Diseases:</th>
<th>Allergies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid</td>
<td>Medication:</td>
</tr>
<tr>
<td>Kidney</td>
<td>Food:</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
</tr>
</tbody>
</table>

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## SOLUTION

Implementation of a prescreen checklist that is formatted to address:

1. Contrast questions
2. Sedation questions
3. Lab work ordered for procedure
4. Specimen orders
5. Clearance letters for contrast and sedation.
6. Clarification of procedure, side, size of device.
7. Translatable into electronic record format for rebuild June 2012
8. Easy to use.

Would improve patient safety, be cost efficient, prevent delays, enhance efficiency with I.R. case flow, and prevent budget loss for uncompleted cases. Not only does this improve working conditions for staff but it also improves patient relations with our families.
Concerns

COST AND CULTURE CHANGE.

Implementation of the new checklist would be cost contained. No extraneous spending would be needed as copy paper is already budgeted ($45.00/case/2,500 pages for 50 patients a week: 2,600 pts.) and training for staff would take 30 minutes with one week of piloting. Time for employees would be included in their work day hours. Transferring the checklist to Epic is also planned and included in the epic build budget and not considered extra operational man hours. No overtime would be needed.

I.R. Coordinators will be educated on the benefits of using the new checklist. As this checklist may increase the time they spend with a family during prescreening, the coordinators will be given extra time to complete each list and to give feedback about efficiency and truth in reporting during the one week pilot. They will be empowered to assist in any revisions needed before the “go live” date. The ease in use will encourage the coordinators not to revert to the old screening format and to keep using the new checklist. As it is our hospital’s goal to be completely off paper, we will make the Epic EMR build the goal for June 2012 in the new hospital. Once we are operating fully at the new hospital, paper checklists will not be supplied and the coordinators will be mandated to use the computerized version in Epic. This will ensure global reporting throughout the hospital for ordering services. The transition from paper to electronic will be gradual and gives the coordinators time to anticipate and comply with our hospital’s goal of paperless systems.

Quality insurance (QI) will be utilized by management in medical imaging to track compliance and trends. Reports on QI will be submitted during our quarterly unit meetings. Data for QI will be collected by the sedation nurses who will document any failed exams, reschedules, near misses with patient safety that resulted from improper/incomplete prescreening.

CONCLUSION

Authorizing implementation of prescreen checklist is cost efficient and ensures patient safety by minimizing death and complications. Endorsement of this new process will save thousands of dollars daily and prevent foreseeable delays in care which compromise a patient’s ability to be treated in a timely fashion.

The checklist addresses JCAHO expectations in regard to patient safety goals (right patient, right site, right implant, right medication) and enhances nursing’s opportunity to maintain Magnet Status by implementing process improvements, reporting data, and progression to EMR build.

We recommend implementation of the checklist in two week. Week 1 will focus on training and piloting the checklist. Week two will be implementation and feedback. Final revisions if required will be completed in 6 months. EMR build will be initiated at the 6 month mark and be completed by June 2012.

Thank you for considering implementation of a new prescreen checklist.