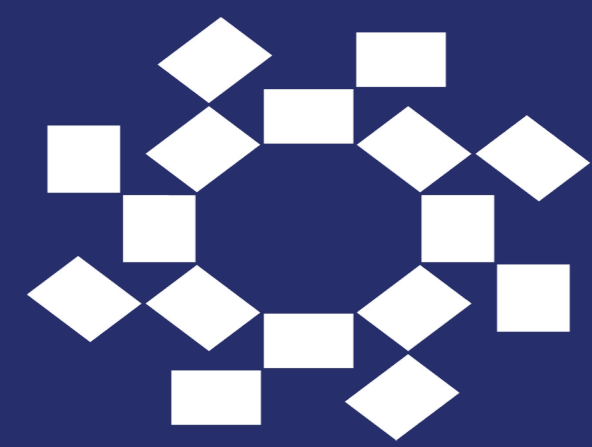




Pre-Flight Checklist: The Pre-Procedural Checklist and Huddle

Jake Rienzo, MD; Robert Nugent, MS4; Raymond Malapero, MD, MPH, FASA; Michael H. Entrup, MD, FASA
Department of Anesthesiology, Hackensack Meridian Health Jersey Shore University Medical Center, Neptune, NJ



INTRODUCTION

- In August 2023, three patients entered our operating rooms and procedural areas with incomplete or inaccurate information that could have resulted in patient harm.
- A critical assessment of these cases through our Root Cause Analysis process identified communication gaps and staff's interpretations of what was considered essential information as causative factors.
- An interdisciplinary task force developed a checklist/handoff tool in order to improve communication and team building between periprocedural healthcare providers and to standardize the process and the essential information communicated prior to entry into the operating room.

METHODS

- Our RCA process identified the following issues as contributing factors:
- different groups (i.e. Periop nurses, Anesthesia personnel, Operating Room/Procedural nurses, surgeon/procedure teams) were independently checking essential information and signing off on a sheet at the bedside prior to entering the operating room or procedure room
 - there was no formal active communication or process between each of the above groups in the holding area prior to O.R. or procedure room entry
 - each group only focused on information that was essential for their portion or responsibility
 - A task force consisting of holding area nurses, operating room nurses, anesthesiologists and CRNAs, surgeons and proceduralists, and perioperative/periprocedural leaders developed a checklist tool and established that a preprocedure “huddle” should convene prior leaving the holding area and entering the operating room or procedural area.
 - Phase I of this project was to take place in our Main Holding Area where patients undergoing procedures in our main O.R. and our Electrophysiology Suite were checked in prior to their procedure.
 - Audits were performed to measure compliance, incidents of patients getting into procedural rooms without complete essential information, and staff satisfaction.
 - Phase II implementation would expand the tool and process to all anesthetizing locations after review of data and modification of the process and/or checklist form.

INTERVENTION

- CHECKLIST/HANDOFF TOOL
 - Based on the presentation format of I-PASS (Illness Severity, Patient Summary, Action List, Situational Awareness, and Synthesis) for transitions of care.
- TEAM HUDDLE
 - The form is reviewed and completed as a team (Hold & Prep nurse, O.R. circulating nurse, Anesthesiologist and/or CRNA) and, when feasible, the patient.
 - Any team member may raise questions or concerns or Stop the Line if information is missing or incomplete. (All team members have undergone HRO training).
 - Team members present for the huddle are identified on the form.
 - The form stays with the patient into the operating room or procedure room and is collected in the PACU for review and audit. It is not part of the permanent medical record.
- IMPLEMENTATION DATE
 - October 2023
- INCIDENT REPORTING
 - All safety events (Near Miss, Precursor, Sentinel) or concerns are reported in One Link, our incident reporting system. Reports are reviewed daily by hospital and departmental leadership and appropriate action taken.

JSUMC Hand-Off Checklist to Enter Operating Room

To be reviewed & completed together by

Circulating RN
Anesthesia Personnel
Hold & Prep/ICU RN

Identify Correct Patient (check against chart and patient ID band)	Full Name	☐
	Date of Birth	☐
	MRN	☐
Confirmatory Info	Planned Procedure	☐
	Surgeon(s)	☐
	Interval H&P done	☐
	Surgical Site Marking	☐
Patient Information	Procedure Consent	☐
	Blood Consent	☐
	Anesthesia Consent	☐
	NPO Status	☐
	Pregnancy Test	☐
	DNAR/DNI Status	☐
Procedure	Allergies	☐
	Antibiotics ordered	☐
	Premeds administered	☐
	Surgeon available	☐
All agree? Any gaps or questions?	Implants available	☐
	Type & Screen sent	☐
Checklist Complete & Confirmed May proceed to Operating Room		☒

This form must be completed prior to the patient being transported into the Operating Room.
It should be sent to the O.R. with the patient

This form is NOT part of the Medical Record

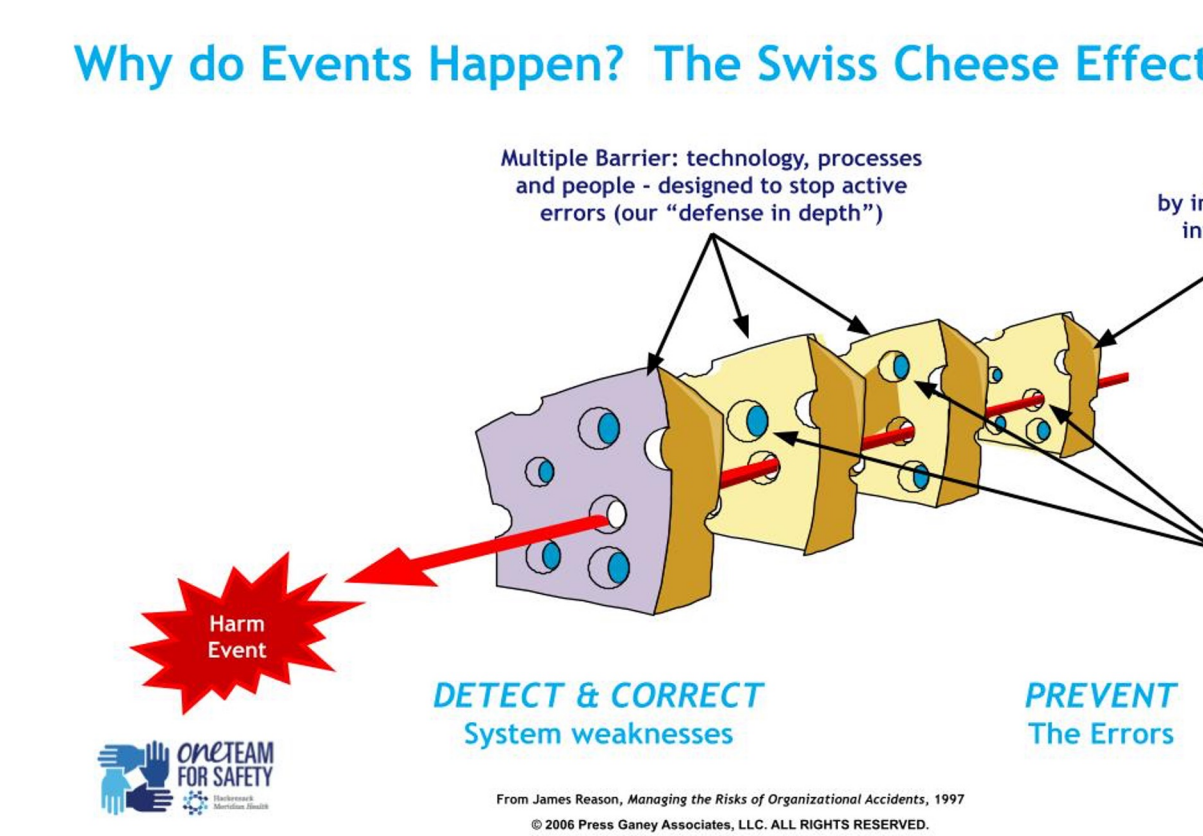
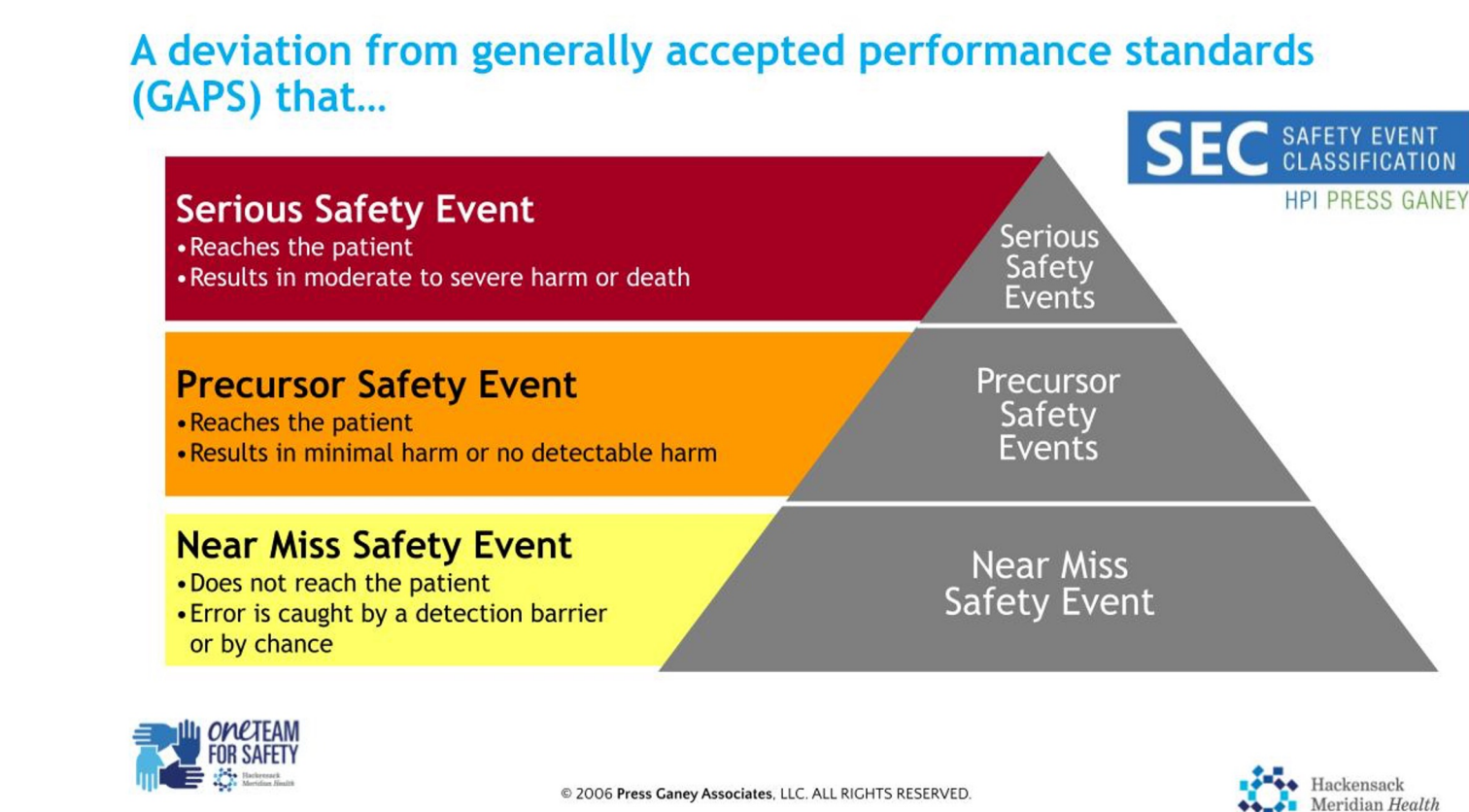
I-PASS
Illness Severity
Patient Summary
Action List
Situational Awareness & Contingency Planning
Synthesis by Receiver

Confirmation	
Team Member	Print Name
Holding/ICU RN	
Anesthesia	
Circulating RN	
Date & Time	
Patient Label	

POST-INTERVENTION RESULTS

- Use of the checklist tool and Team Huddle prevented patients from entering procedural areas when essential information was incomplete, inaccurate, or conflicting.
- ZERO patients entered the operating room or procedural area with incomplete or inaccurate essential information when the checklist was utilized and the Team Huddle occurred.
- Increased compliance when staff understand the reason for the checklist tool and Team Huddle process. This underscores the importance of education and data sharing.
- Enhanced team building.
- Enhanced patient satisfaction and patient reassurance that the team is taking patient safety seriously.

PREVENTING & MITIGATING HARM TO PATIENTS



DISCUSSION

- Effective communication and the utilization of checklists serve to prevent events that may result in patient harm by preventing errors or mitigating the impact of errors/events to the patient.
- Our implementation of a preoperative/preprocedure checklist and active communication during the Team Huddle process before the patient is transported into the operating room has resulted in preventing patients from entering the O.R. with incomplete or inaccurate essential information.
- Members of the perioperative team all have the same essential information.
- Team building is enhanced with this “huddle” prior to the patient leaving the holding area.
- Patients have come forward to express their gratitude for this process and are comforted knowing that their safety is our highest priority.
- Compliance has been an issue during nighttime and weekend hours. Additional education of staff regarding the importance of this checklist tool and huddle is necessary.
- Checklist tool has been modified as needed.
- Phase II will expand the utilization of the checklist handoff tool and Team Huddle to all anesthetizing locations in the hospital.
- Plan to expand the Team Huddle to include members of the surgical/procedure team (i.e. surgeon, proceduralists, residents & fellows, PAs, NPs, etc.).

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