A multi-disciplinary approach to improving situational awareness in satellite paediatric oncology theatre lists

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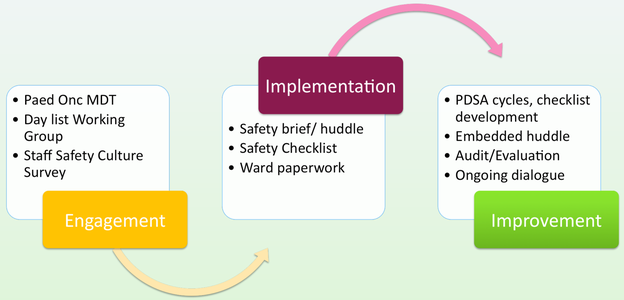
Aims

Participating in the SAFE project is part of our overarching aim to constantly strive for the highest quality care we can achieve and to reduce avoidable error and harm to children through the development of a proactive safety culture.

One component of our work has been embedding the concept of situational awareness into the running of the tertiary Paediatric Oncology unit, with the specific aims of: standardizing processes, reducing variability in performance and optimising safety.

Key participants in the huddle



Methods

•**Consultation** with the multi-disciplinary oncology team identified a key area of perceived vulnerability to be the twice-weekly elective lumbar puncture, intra-thecal and bone marrow lists.

•Retirement of the Associate Specialist and one of the nursing day ward coordinators previously pivotal in these lists had created **unwarranted variability in practice**.

•A baseline staff survey identified areas for improvement in terms of consistency of delivery of the service.

•**Standardising the process** was suggested as a way to minimise adverse incidents associated with these procedures.

•The **key challenges centered on engagement** and perceived barriers to the concept of "huddles" and the language of quality improvement.

Results: Initiatives embraced

1) Introduction of a "huddle" prior to each list. Key members of the theatre team and wider team now meet for 3-5 minutes prior to commencing the list and used a structured aide memoire to discuss safety concerns and identify potential issues. A huddle occurred prior to 99% lists in the last 5 months with a median duration of 3 minutes.

2) Introduction of a multi-disciplinary safety checklist, specifically to address issues with the oncology procedures and to offer consistency of documentation between medical and nursing staff.

3) Consistent procedure medical clerk-in paperwork. Patients are now clerked on the same paperwork as that used for day-cases thus reducing variability in documentation.

4) Improved two-way communication flow between day-ward and the ward.
Subjective reporting indicates that the overall level of satisfaction with the processes has markedly improved. The formal safety survey will be repeated in 6 months to assess this.

Conclusion

Participation in the RCPCH SAFE project has enabled proactive change management and the introduction of a number of safety initiatives within our tertiary oncology day-ward setting.

The main aim of our work to date has been to **tighten the processes and procedures to reduce variation** and therefore improve patient safety.

The **new checklist and huddle process are now embedded** in our clinical practice and have been met with increased staff satisfaction.

Ongoing improvement cycles will measure and modify the checklist as required.

The next steps in the project aim to **heighten situational awareness across the in-patient ward** setting and to build on the day-ward successes.