ALLIANCE INNOVATION AWARD

The Alliance of Independent Academic Medical Centers will present the Alliance Innovation Award on an annual basis to its institutional member who best exemplifies creative and innovative approaches to medical education and research which result in better patient outcomes. The institution selected for this prestigious honor must demonstrate an institution-wide change in one of the following categories:

- The development and/or implementation of innovative medical education programs for residents, physicians and other staff or
- The development and/or application of scientific discoveries

ALLIANCE OF INDEPENDENT ACADEMIC MEDICAL CENTERS

Innovation Application Form

Institution Name:	Virginia Mason Medical Center
City, State:	Seattle, WA
Web Site:	vmmc.org
Institution Contact:	Lynne Chafetz
Title:	Vice President and General Counsel
Phone: 206-515-5822	E-Mail: Lynne.Chafetz@vmmc.org

1. Please describe how the nominee has developed and/or implemented *innovative medical education programs* for residents, physicians and other staff which have resulted in better patient outcomes: (OR answer question 2)

2. Please describe how the nominee has developed and/or applied scientific discoveries which have resulted in better patient outcomes: (OR you may leave blank if question 1 has been completed)

The Virginia Mason Medical Center's Attestation Timeout Project Team developed and implemented an improved surgical timeout process engaging all team members in a robust exchange with the aim of improving teamwork and communication, and ensuring that the right patient has the right procedure done on the right site, at the right time, by a team who knows the patient's unique history, has prepared for the surgery, the potential complications, and has assembled the right equipment. In January 2009, Virginia Mason's Perioperative services team implemented a modified World Health Organization's (WHO) Pre-Procedural Checklist. By January 2010, observational audits showed that the checklist was being used consistently, but that the process of having the surgeon perform the check- list was not generating team participation. In 31 rooms surveyed, 50% of the time non- physician personnel did not even stop their activity during the pause, nor did they speak their names and offer comments, as was intended. The perioperative timeout was identified as a **special project to integrate Graduate Medical Education with institutional patient safety and quality improvement initiatives**. Resident physicians in two programs, Anesthesia and Surgery, worked as active Leads and Champions on this team. The group hypothesized that aligning role specific work and creating a shared stake in accomplishing the checklist would make a more effective timeout and ensure team engagement. The checklist was divided into role specific activities, assigning team members to attest to "what they knew for sure" about the procedure and patient. Specific training in teamwork and communication reinforced the change – 1) the need to share a common perspective, 2) situational awareness of the environment, 3) using a standard method to convey information, and 4) critical language. This training helped all team members stop and focus on the timeout, participate fully, express their concerns and perspectives, and add important information.

Post implementation data (summer/fall 2010) reveals:

1) increased frequency for team members to speak both their first and last names 90-100% across all groups
2) all Operating Room team members are stopped during the pause, and
3) new information was being contributed 20% of the time.

By November 2010, a six month comparison of the Agency for Healthcare Research and Quality's (AHRQ) Culture of Safety survey questions showed the following changes among the perioperative staff members:

People support one another in this unit **5% improvement**

In this unit, people treat each other with respect **11% improvement**

We are actively doing things to improve patient safety **7% improvement**

Our procedures and systems are good at preventing errors from happening **7.5% improvement**

Nurses & physicians in this unit work well together **7% improvement**

Staff will feely speak up if they see something that may negatively affect patient care **4% improvement**

Staff feel free to question the decisions or actions of those with more authority **9% improvement**

Staff are afraid to ask questions when something does not seem right **17% improvement**

Overall, the culture at this facility encourages patient safety **5% improvement**

Feedback by perioperative staff in November 2010 about the new process showed:

- The new checklist is an improvement **83.4% agreement**
- I am more comfortable speaking up in the new pause format **78.1% agreement**
- The new format promotes more discussion **82.2% agreement**
- The new format takes too long **51.6% agreement(average 2 minutes & 19 seconds)**

Attached below is new checklist.

3. Has the nominee received national recognition for innovative medical education and/or research contributions?

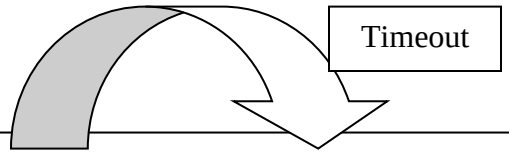
X Yes □ No

If yes, please describe: VM participated in National Initiative 1 in 2007-2009 with efforts focused on resident-to-resident handoff communication. That work was honored with the AIAMC Innovation Award in 2008, and 2010, as well as a Qualis (Quality Improvement Organization for Washington State) Transition of Care Patient Safety Award in 2009.

4. If chosen for this award, will the nominee be present to receive it at the AIAMC 2011 Annual Meeting, to be held March 24th – 26th in St. Pete Beach, Florida?
(Please note the institution should ideally be represented by its CEO & CAO)

X Yes □ No □ Not Sure

Please send this completed form to
Kimberly Pierce-Boggs, Executive Director,
by e-mailing Kimberly@aiamc.org or faxing 888-AIAMC11 (888-242-6211)
NO LATER THAN DECEMBER 15, 2010



VM SURGICAL SAFETY CHECKLIST DRAFT

BEFORE LEAVING SURGERY PREP>>

Name of the person confirming

Prep Nurse _____
- ☐ Identify Patient, Procedure and Site/Side
- ☐ Consent is accurate and signed
- ☐ Blood products available, if ordered
- ☐ Allergies Noted ☐ Allergy bracelet on
- ☐ Day of surgery labs drawn and results available
- ☐ Relevant documentation reviewed and matched to the patient

Circulating Nurse _____
- ☐ Required implants/instruments/ equipment available

Surgeon _____
- ☐ Consent matches plan
- ☐ Relevant images and/or diagnostic tests available and matched to patient to confirm site/sidedness
- ☐ Site/Side marked with "YES" with patient involved to the degree possible ☐ N/A

Anesthesia Provider _____
- ☐ Time Out performed before block
- ☐ Block site(s) marked with initials ☐ NA
- ☐ Anesthesia assessment and plan completed

Comments _____
_____
_____
_____

BEFORE THE INCISION>>

Attending Surgeon or Primary Surgery Resident
- ☐ Call for Time out
- ☐ Solicit Report from Circ RN

Circulating RN
- ☐ **Identify self** / guest (PRN) – full name & role
- ☐ Identify patient 1. State Full Name
- ☐ Identify patient 2. State Date of Birth
- ☐ Consent signed for (state site & procedure)
- ☐ Foley - inserted / NA
- ☐ SCDs - in place / turned On / NA
- ☐ Heating Blanket - in place / turned ON / NA
- ☐ Rainbow sheet documentation accountability
- ☐ White board updated
- ☐ Solicit Report from Scrub Tech

Surgical Scrub Tech
- ☐ **Identify self** / guest (PRN) – full name & role
- ☐ Specific instrumentation available and ready to start case
  - ☐Specialty Implants / Equipment present for consented surgery
  - ☐Need for Vendor/Trainer with new equipment
- ☐ Confirms "YES" is visible in prepped field
- ☐ Drugs AND Solutions are all Labeled
- ☐ Preliminary Counts were performed / Done
- ☐ Solicit Report from Anesthesia

Anesthesiology
- ☐ **Identify self** / guest (PRN) – full name & role
- ☐ State significant Drug Allergies
- ☐ Antibiotics - ordered / administered / re-dosing plan
- ☐ State Blood &/or Blood Products Ordered / NA
  - ☐Amount Blood &/or Blood Products Availability / NA
  - ☐Cell saver plan / NA
- ☐ Concerns, Co-morbidities and Hemodynamics
  - ☐BetaBlocker plan / NA
  - ☐Diabetes or Glucose plan / NA
- ☐ Plan for Post-op Pain Management
- ☐ Solicit Report from Surgeon

Surgeon
- ☐ **Identify self** / guest (PRN) – full name & role
- ☐ State Name of Procedure, Site, Fields, Time Needed
- ☐ State Relevant Patient Clinical History
- ☐ Verify Imaging Matches - Patient /Site/Sidedness
- ☐ State Anticipated Difficulties / significant Co-morbidities
- ☐ State Anticipated Blood loss
- ☐ Post-op Plan – – disposition/ special bed?
- ☐ Solicit any others in room to identify self & role
- ☐ State Additional Information
- ☐ Encourage - any Additional Input or Safety Concerns

WRAP UP>>

SURGEON AND TEAM CONFIRM:
- ☐ Procedure
- ☐ If there is a specimen, the specimen is labeled correctly –
- ☐ Special instructions communicated to the pathologist, if applicable. ☐ N/A
- ☐ The surgeon swept the surgical site for retained items.
- ☐ Counts are correct
- ☐ Post op image reviewed, if applicable

What are the key concerns for recovery and management of the patient?

What could have been done better
- ☐ Nothing
- ☐ Something, and a response plan formulated (who, what, when)

Equipment issues to be addressed
- ☐ No
- ☐ Yes, response plan formulated (who, what, when)

Form is NOT part of the permanent medical record. Deposit completed forms in PACU receptacle.

Date _____

Patient Label Here