

# IMPROVING PATIENT SAFETY IN MRI THROUGH INCREASED WHO CHECKLIST COMPLIANCE

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## Context:

- Anaesthesia for non-theatre environments in the complex paediatric population has recognised risks<sup>1</sup>
- A 'good' checklist balances simplicity with precision<sup>2</sup>, creating a focal point for a team to pause, consider critical information and adapt as required
- 'Bad' checklists are 'burdensome'<sup>3</sup> and devalue existing safety processes



## Plan:

- Understand user perspective of checklist documentation in MRI
- Adjust to problems with the team as the basic unit of learning<sup>4</sup>
- Iterative cycle of improvement
- Aim for > 95% documentation of checklist completion

## Do:

- A phased approach (Figure 1)
- Longitudinal checklist documentation compliance monitoring
- A: Multidisciplinary (MDT) workshops
- B: Formal MDT survey
- C: Clarifying roles and workflow, refining checklist content and visual reminders



External influence: This project ran in parallel with 'Project Apollo', a Trust-wide initiative to improve safety processes and efficiency in the wake of the first wave of the pandemic

Fig 1: WHO Checklist Compliance in MRI over 8 months

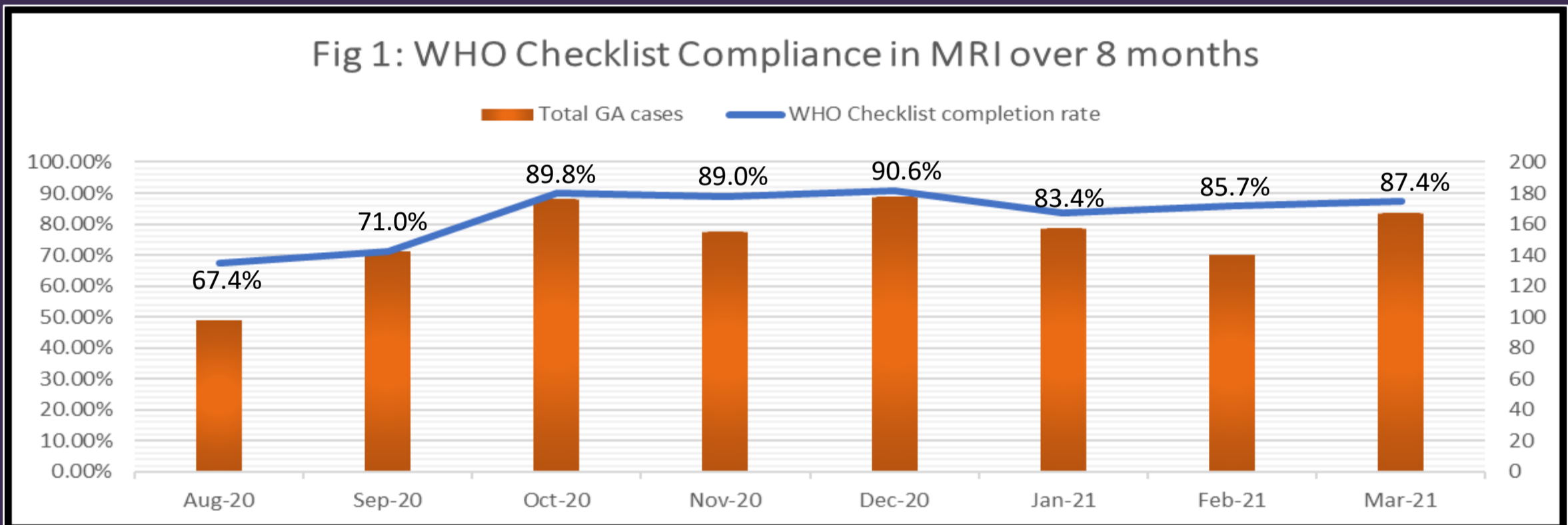


Fig 2: MDT survey findings

33 Anaesthetists	19 ODPs	15 Radiographers
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### Emergent themes across disciplines

- Unclear role allocation for task completion
- Unclear process for pausing
- Perceived time pressures to continue list
- Checklist content more relevant for surgical theatre
- Not enough relevant reminders in MRI suites

### Data Analysis:

- Starting at 67.4% - highest rate 90.6%, sustained >83% in 6 months

### Moving forward:

- Continuing refinement of checklist content and radiology specific aide-memoires
- Improving user interface on electronic patient record system
- Feedback to superintendent radiographers with area-specific data, disseminate across teams

### Reflection on generalizable points:

- Sustainable change is effected via small incremental refinements
- The multidisciplinary team approach reflects the nature of healthcare delivery and should be the basic unit to target change and education within an organisation.

### References:

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