# CRISIS CHECK LISTS FOR SURGICAL AND IN-HOSPITAL EMERGENCIES

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Hospitals are faced with the challenge of improving reliability of their care and patient outcomes especially when treating unstable patients. 'Failure to rescue' of hospitalized patients with deteriorating physiology is caused by a complex array of organizational, team, technical and cultural failures including a lack of standardized team and individual expected responses, norms and actions. The aim of this study using a learning collaborative method was to develop consensus recommendations on the utility and effectiveness of checklists as training and operational tools to assist in improving the skills of hospital staff on the effective rescue of patients with abnormal physiology.

A scoping study of the literature was followed by a multi-institutional and multi-disciplinary international learning collaborative. We sought to achieve a consensus on procedures and clinical simulation technology to determine the requirements, develop and test a safe using a checklist template that is rapidly accessible to assistin emergency management of common events for general ward use.

Safety considerations about deteriorating patients were agreed upon and summarized. A consensus was achieved among an international group of experts on currently available checklist formats performing poorly in simulation testing as first responders in general ward clinical crises. The Crisis Checklist Collaborative ratified a consensus template for surgical and medical checklists that provides a list of issues for first responders to address (i.e. 'Check In'), a list of prompts regarding common omissions (i.e. 'Stop & Think'), and, a list of items required for the safe "handover" of patients that remain on the general ward (i.e. 'Check Out'). Simulation usability assessment of the template demonstrated feasibility for clinical management of deteriorating patients.

The talk will review the results of a successful implementation of crisis emergency checklists in improving patient care and outcomes. The concept of emergency crisis checklists is an attractive new addition to the expanding toolkit for continuous quality improvement by clinical teams but there are key caveats in how they must be implemented for success. Checklists are excellent 'aides memoire' and directives to correct procedures, but they are not a panacea. It is appealing to embrace a single tool to improve safety, and checklists have been found to be effective in some settings. Introduction of a new tool without full consideration of its purpose, benefits, team engagement and limitations may actually increase risk to patients, providers and the system as a whole. An organizational culture that values improving outcomes is essential for sustained uptake and sustained implementation of checklists.

The success of checklists will depend on engagement of the clinical team members, uptake and acceptance by providers, supported by a strongly motivated and committed team ethos.