

## Time Out: A Pause to Reflect and Prevent Errors


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### Correct Site Surgery

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## Objectives

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1. Discuss correct site surgery
2. Discuss the prevention of wrong site surgery
3. Describe initiatives directed at the **Prevention of wrong site surgery.**
4. Describe ways to promote correct site surgery



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## *Florence Nightingale* Notes on Hospitals, 1859

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“The very first requirement in a Hospital is that it should do no harm”



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## Safety and Nursing Shortage

- Changes in the US Work Force
  - 2002 2.7 million RNs
  - 80% in nursing
  - 60% work in hospitals (1.3 million RNs)
  - 11% vacancy rate (July 2001 AHA reported 126,000 unfilled FT RN positions)



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## Safety and Nursing Shortage (cont.)

- Nurses
  - Average age 46.2
  - Only 31% of working nursing population is younger than 30
  - Increasing number of men entering profession



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## Safety and Nursing Shortage Perioperative Setting

- Average age is 48!
- Less than 10% of AORN members are 30 or younger
- Hospital average for unfilled perioperative RN FTE 2.0



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## Future

- 2010 Total RN population will decrease
- 2020 20% fewer than needed  
(www.aha.org "Special Workforce Survey: Fact Sheet")
- 2020 400,000 RNs needed in all areas  
(New York Times, 4/13/01)
- Special skills needed: OR, ICU, Peds



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## Influencing Factors

- Increasing demand for healthcare providers
- Aging population and workforce
- Anticipated retirement of RNs
- Fewer students entering the nursing profession
- Restructuring
- Workplace dissatisfaction
- Regulatory & government interest
- Consumer demands



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## Findings

- Institute of Medicine
  - 44,000-98 000 deaths annually
    - ❖ Result from medical errors
      - Medication errors
      - Surgical mistakes
      - Surgical complications



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## And the Research Says

- Harvard Study (1984)
  - 3.7% of patients experience adverse events
    - ❖ 13.6% of these led to death
    - ❖ 58% deemed preventable
- Utah Study (1992)
  - 66% of adverse events were surgical
  - 12% of hospital deaths from adverse events
  - 54% deemed preventable



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## ...and the Research Says...

- Canadian Study (2000)
  - 33% of 192 surgical patients; 64 complications
    - ❖ 10 life-threatening complications; 2 deaths
- Outpatient Surgery (2000)
  - Mortality rate in liposuction is 19 per 100,000
    - ❖ 77.7% of embolus in outpatient setting



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## If 99.9% Were Good Enough

- The Internal Revenue Service, (US Tax collectors) would lose over 2 million documents this year.
- There would be a major plane crash every 3 days.
- 16,000 items would be lost in the postal mail every hour.



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## If 99.9% Were Good Enough (cont.)

- There would be 37,000 Automatic Teller Machine errors every hour.
- 12 babies would be given to the wrong parents each day.
- 291 pacemakers would be incorrectly installed this year.
- 107 erroneous medical procedures would be performed each day.  
(Institute for Healthcare Improvement, 2002)



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## Types of Medical Errors Seen in the OR

- Medication safety
- **Wrong site surgery**
- Specimen management
- Safe use of lasers
- Retained sponges or instruments



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## What is Wrong Site?

- AORN defines wrong site as:

“a broad term that encompasses all surgical procedures performed on the wrong patient, wrong part, wrong side of the body, or the wrong level of the correctly identified anatomical site.”



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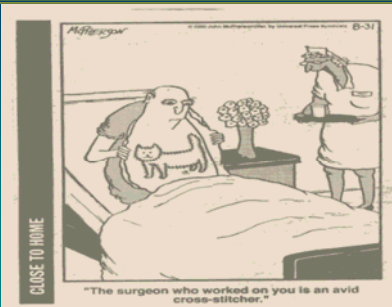
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CLOSE TO HOME

"The surgeon who worked on you is an avid cross-stitcher."

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### First and Foremost – Correct Patient

- Patient identification surfacing as a real issue
- Literature reports “wrong patient” surgery
- Back to Basics for nurses
- Risk increased in specific patient populations

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### Informed Consent vs. Site ID

- Two separate issues
- Informed consent is the surgeon’s responsibility
- Correct site, side identification and verification responsibility is jointly shared

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## Wrong Site Surgery

- In a study of 126 cases that have root cause analysis information in the Joint Commission Accreditation Hospitals Organization data base
  - 40% - Orthopedics
  - 20% - General Surgery
  - 14% Neurosurgery
  - Other – dental, maxillo-facial, cardiac/vascular, ENT and Eyes



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## What is the Scope?

- As of Feb 2002 JCAHO has 130 cases in its database and has issued a second Sentinel Event Alert.
- Effective July 2002 – Florida Board of Medicine institute new penalties
- July 2002 – Included in JCAHO 2003 National Patient Safety Goals



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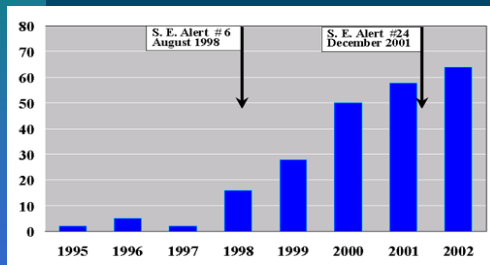
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## Sentinel Event Trends: Wrong-site Surgery (% of Total) 1995 - 2002



www.jcaho.org

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## 2005 National Patient Safety Goals from JCAHO

1. High-alert medications
2. Patient identification
3. **Wrong-site surgery**
4. Infusion pumps
5. Clinical Alarm Systems
6. Communication among caregivers
7. Health care associated infections



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## 2004 JCAHO Patient Safety Goal #4

- Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
  - Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
  - Implement a process to mark the surgical site and involve the patient in the marking process



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## What has Root Cause Analysis Told Us?

- Risk increase by:
- Failure to engage the patient in the process
  - Inaccurate or incomplete communication
  - Absence of formal verification procedures
  - Inadequate staffing levels
  - Too much, too fast, too little time



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## Veterans Health Association

- Nationwide healthcare network
- > 7.7 million surgical procedures annually
- March 2000 - VHA Perioperative Leadership Learning Network adopted the Surgical Site Identification Project
- Engaged over 240 healthcare professionals at 6 medical centers



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## VHA Program: What they did

- Found that surgeons agreed that marking site was important but were inconsistent in how to mark
- Found that factors of success were dependant on defined steps
- Created the "7" Absolutes



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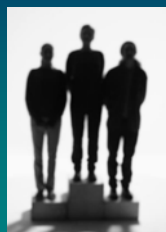
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## Factors for success

- Verbal communication between team members
- Clearly defined responsibilities
- Explicit procedure strategies and expectations
- Safety checklist and written documentation



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## Correct Site Surgery

Endorsed by:

- American College of Surgeons
- American Society of Anesthesiologists
- American Society for Healthcare Risk Management
- American Hospital Association
- American Association of Ambulatory Surgery Centers

**Correct Site Surgery Tool Kit**  
...building a Safer Tomorrow



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## “7” Absolutes: #1

- Preoperatively each procedure involving laterality will be scheduled with right or left designation.



The Palm

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## “7” Absolutes: #2

- Preoperatively, each correct surgical site will be verified by an RN with the OR schedule and the patient’s medical record number.



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### “7” Absolutes: #3

- Preoperatively, the patient, designee or hospital care provider will verify each surgical site in the presence of an RN and will mark.



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### “7” Absolutes: #4

- Preoperatively, the circulation RN and the anesthesia provider will interview the patient and review the patient’s current medical record to re-verify each surgical procedure and site.



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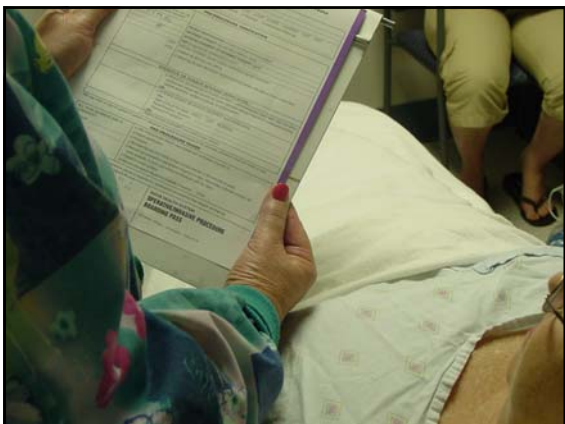
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## “7” Absolutes: #5

- Intra-operatively, the circulating RN anesthesia provider and surgeon will review the patient's medical record, results of diagnostic studies and verbally confirm the site.



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## “7” Absolutes: #6

- Intra-operatively, once the patient is draped, the surgical team will pause and verbally confirm each site prior to incision.



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## "7" Absolutes: #7

- Intra-operatively, the circulating nurse will document the verification process in the patient's medical record.



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## Intention of the "7" Absolutes

- To be a clinical practice model which serves as a foundation for the development of a facility specific surgical site verification policy .

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## Role of Professional Organizations

- AORN / AAOS / ACS
- Set direction - create position statements and guidelines
- Disseminate information
- Engage in professional education
- Engage in public awareness initiatives

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## Before the Day of Surgery

- Incorporate the scheduling process
- Include site and side identification in preadmission process
- Attempt to reconcile discrepancies in advance



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## Holding Area



- Identify problems:
- Before the patient enters the OR
  - Before the patient is medicated
  - Went the surgeon can document resolution of discrepancy



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## What to Check

- The printed OR schedule
- The surgical consent
- What the patient or his/her advocate states



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**IFPN** **Intraoperative**

- OR Schedule says...
- Patient states & points to...
- Consent form says...
- Site/side marked is ...
- Final stop, pause and confirm done at ...



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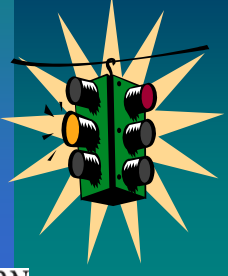
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**IFPN** **What Does JCAHO Recommend?**



- Creation and use of preoperative verification process
- Implementation of a process to mark the surgical site that involves the patient in the process.

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**IFPN** **JCAHO Universal Protocol**

- Developed by experts
- Endorsed by 400 professional associations/organizations
- Consensus statement on 8 principles
- Defines clear steps to prevention
- Implemented in the US, May, 2004

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## Time Out Day

- June 22, 2004
- 1st National Time Out Day

Promote Universal Protocol in JCAHO standard to eliminate wrong site surgery



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## Performance Improvement

- Process needs to be active
- Documentation review alone may offer a false sense of security
- Monitor orientation activities especially for temporary employees



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## Role of Professional Organizations

- Set direction - create position statements and guidelines
- Provide professional education opportunities
- Engage in public awareness initiatives
- Work with our colleagues in Medicine and Industry



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Engagement of the entire surgical team across the perioperative process is the number ONE way to prevent errors.



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### What We All Strive For: Patient Safety and Optimal Outcomes




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