Academic Medical Center | Patient Safety Organization
a component entity of Risk Management Foundation

Patient Safety Strategies and Tactics

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The AMC PSO is continuously working to identify successful strategies and tactics to reduce the risk of patient harm in the delivery of patient care. We are guided by malpractice claims data and informed by clinical experts to understand what happens when things go wrong, and what remedies may be available. To help those of you in practice avoid a known risk, a patient tragedy, and an allegation of malpractice, Patient Safety Strategies and Tactics, created by the AMC PSO, is intended to pass along ideas and interventions identified by your colleagues. The AMC PSO encourages you to assess your own risks and evaluate the potential of the solutions outlined below. Of course, if you have your own patient safety strategies or tactics, we'd like to hear about them.

Wrong-Site Surgery

Wrong-site (including wrong *side*) surgeries/procedures account for a relatively small portion of surgery-related malpractice cases, but they almost always represent events that are impossible to justify (or defend). The National Quality Forum defines wrong-site cases as "never events" and CMS will no longer reimburse for these cases. In 2010, The Joint Commission (TJC) reported that wrong-site surgeries were the third most commonly reported sentinel event; TJC estimates that wrong-site surgery occurs 40 times a week in US hospitals and clinics.

- CRICO's national CBS database counts 8,157 malpractice cases asserted from 2005-2009. For one-quarter (N=2,021) of those cases, a surgical service was responsible for the patient when the alleged harm occurred.
- 71 (3.5%) of the 2,021 surgery cases in the CBS database involved wrong-site procedures.
- Orthopedics is most commonly involved in wrong site surgeries.
- Neurosurgical wrong-site malpractice cases are the most expensive in terms of indemnity dollars.
- Neck and spine surgeries/procedures were most common, followed by skin biopsies.

WHAT TO FIX

General contributing factors in wrong-site surgery cases include:

- Not following policies/protocols
- Inadequate communication between providers
- Inadequate communication between providers and patients

Specific factors noted in recent wrong-site surgery cases include:

- Surgical team distracted by cell phone conversation during time-out procedure
- Pre-op verification form not readily available in OR
- Precise site not marked (two cases); "general area" mark later obscured by drape, surgeon's hand
- Patient not optimally placed relative to correct surgical site following intubation
- No standard for spinal surgery markers among surgeons working with common trainees
- Inexact positioning of staff around the operating table
- Surgeon thinking ahead into the procedure with resulting loss of situational awareness

- Provider fatigue (11th procedure of the day)

STRATEGIES AND TACTICS

The AMC PSO has identified the following practices employed to address the factors that can contribute to a wrong-site surgery:

1. Keep pre-op verification form with OR nursing staff instead of placing in the chart.
2. Focus on correct site procedures at earliest stages of preparation—before pre-operative sterilization and draping procedures begin—including how patients are positioned on the stretcher and table.
3. For spinal surgeries: require attending surgeon to mark surgical site at or immediately adjacent to the proposed surgical site.
4. Encourage attending to review the pre-op images with an attending radiologist when he/she believes there are abnormalities or questions about the films.
5. Surgeon marks surgical site (with non-washable, FDA-approved ink) so that incision is made through the mark.
6. Remark site if scrub prep removes the marking.
7. Ensure that the correct site mark is unmistakable and large enough not to be covered or obscured.
8. Anesthesia fully positions patient relative to correct surgical site following intubation.
9. Perform correct positioning of the primary surgeon for the procedure.
10. Execute an initial anesthesia time-out and surgery time-out with entire team.
11. Operating surgeon who will make the first incision is responsible to call time-out.
12. Place sign in OR: "No Music/Radio During Time-out."
13. Make time-out a reverent "full stop" of activity with dedicated attention and eye contact among team members.
14. Peri-operative Information Management System (PIMS) provides time-out script and means of documenting process with "hard stops" embedded.
15. Establish clear guidelines for use of cell phones in the operative setting.
16. Scrub person will not mount the blade on the scalpel until the time-out is completed; circulating nurse will document in real time.
17. At the *final* time-out (patient prepped and draped), the mark must be visualized by all team members.
18. Identify time-out steps and who is responsible with Surgical Safety Checklist poster.
19. Actively encourage speaking up.
20. Specifically detail instructions to residents and fellows doing spine level marking for multiple attending.
21. Employ "secret shopper" audits to ensure ongoing adherence to specific protocols.
22. Provide videotaped examples of poor, fair, and good time-outs.

We encourage you to contact us with additional strategies or tactics.

WRONG-SITE SURGERY CASE EXAMPLE

http://www.coa-aco.org/library/health-policy/wrong-sided-surgery-in-orthopaedics.html

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