Pinpointing risks of wrong surgery

Do you know where your OR’s process is at most risk for an error that could lead to wrong-site surgery?

A South Carolina health system identified its improvement opportunities and came up with solutions as part of a national project with the Joint Commission Center for Transforming Healthcare (CTH). Five hospitals and three ambulatory surgery centers participated in the project, with findings announced in June 2011 (related article).

Working with CTH, AnMed Health of Anderson, South Carolina, focused on four areas:

• surgical scheduling
• Surgery Assessment Center (SAC)
• preoperative/holding area
• operating room.

AnMed Health performs about 10,000 surgical procedures a year at its 460-bed medical center and 72-bed women’s and children’s hospital.

**Project phases**
The project was conducted in three phases:

• data collection
• data analysis to identify opportunities for improvement
• identification and implementation of solutions.

Aided by CTH consultants, AnMed Health collected about five weeks’ worth of data on all of its surgical patients using data collection tools it helped to design. The analysis turned up vulnerabilities in each area. In response, teams identified solutions and have been piloting them over the past few months.

“When we looked at our data, we decided to start where the patient actually starts, in the physician’s office where the case is posted. We made major changes in our scheduling process,” says Martha Rush, BSN, RN, CNOR, nurse manager for women’s and children’s surgery, postanesthesia care, and endoscopy.

**Physicians’ office**
The phone- and paper-based scheduling process was one issue the project team identified. Data showed nearly half of paperwork errors were due to cross-throughs or mark-outs on faxed scheduling forms, and 27% were due to more than one form being received. Plus, with phone calls, there’s no tracking mechanism to review what was said, Rush observes.

The solution—go electronic.

In a pilot, three surgeons’ offices have been brought online so they can post cases directly into the hospital’s surgical scheduling system, where they are able to view and post only to their portion of the schedule.
The rest of the surgeons’ practices will be brought on line, starting with those that AnMed Health owns and moving out to the rest. AnMed Health provides the software and training.

So far, Rush says it’s been a success.

“We made a lot of the fields for patient data required,” she notes, solving the problem of missing information. In many ways, she says, electronic scheduling is easier for the offices because they can schedule on their own time rather than having to call while the patient is in the office.

Another improvement is a new scheduling manual that helps offices to better prepare patients for surgery and their preop assessment appointments.

“We found a lot of offices didn’t know what we needed to schedule surgery,” Rush says. For example, if offices know the hospital needs the consent, history and physical, and other paperwork, fewer phone calls will be needed to retrieve missing information. The manual includes:

• the scheduling policy
• key phone and fax numbers
• information needed to schedule a patient for surgery
• what patients need to bring to the assessment appointment.

Surgery assessment center
Among areas identified for improvement were incorrect or missing documents or the scheduled procedure not matching the physician’s orders. To ease communication and reduce phone calls, the scheduling office was moved to the surgery assessment center (SAC). Previously, the two staffs spent a lot of time on the phone requesting information from each other.

“It has integrated both of the staffs and helped the flow of communication,” Rush says. “We felt that once we had this in place, some of the issues we faced downstream would take care of themselves.”

Preoperative/holding areas
Opportunities for improvement for the preoperative and holding areas were the consent not matching the schedule or not matching the orders as well as abbreviations and incorrect laterality.

To fix the consent issue, the process was changed so that at the time of the patient’s assessment visit, the consent is checked against the procedure scheduled and with the physician’s orders and documented as part of the assessment.

Two solutions identified were to:

• standardize site marking
• consider marking all sites regardless of whether they involve laterality.

As it was, surgeons were using a variety of types of marks without standardization. The vice president and director of medical affairs are working with the surgeons to standardize the site marking.

AnMed Health is also considering marking all sites, regardless of laterality, which the CTH consultants suggested.

Operating room
Data collection showed several vulnerabilities in the time-out process in the OR. Leading factors were:

• The person leading the time-out wasn’t reading all of the patient’s identifying information, particularly the medical record number.
• Team members weren’t ceasing conversations during the time-out.

AnMed Health is evaluating its choice of the two unique patient identifiers and

Safe Surgery 2015
It’s estimated that 20% of US hospitals are using the World Health Organization (WHO) Surgical Safety Checklist, according to surgeon Atul Gawande, MD, MPH, of Harvard. The checklist’s originator, Dr. Gawande is director of the Safe Surgery 2015 initiative and WHO’s global campaign to reduce surgical deaths.

Safety Surgery 2015 is partnering with the South Carolina Hospital Association to introduce the checklist in every OR in the state. The project then plans to roll out nationwide.

Some 80% of South Carolina hospitals have already tested the checklist, the association says, and many more have adopted it as a routine.

A pilot study published in 2009 in the New England Journal of Medicine demonstrated that with use of the WHO checklist in eight hospitals worldwide, major complications and inpatient deaths following major surgery declined.

Tools for introducing and using the checklist are at www.safesurgery2015.org
considering other options. The patient’s name and date of birth are cited by the Joint Commission as the most common identifiers used.

**Surgical checklist**

Surgeons and nurses have participated in strengthening use of the OR’s surgical safety checklist, a modified version of the World Health Organization (WHO) Surgical Safety Checklist.

A physician champion, Paul Frassinelli, MD, “has been instrumental in helping us know what the surgeons are interested in when they do a time-out,” Rush says. Nurses have been involved through the OR’s unit council, part of its shared governance structure. “This is probably the first time surgeons and nurses have come to the table together on this,” she says.

The updated checklist is under review by medical staff committees. Once approved, it will be rolled out with education for the staff. The final checklist will be enlarged, laminated, and posted in each OR so all team members can see the prompts.

The effort has received a boost from the state’s Safe Surgery 2015 initiative, which aims to introduce the WHO Checklist in all South Carolina hospitals (sidebar). The initiative has raised the checklist’s visibility among physicians.

**Success factors**

Rush says one of the biggest successes so far “is getting a physician champion to take the checklist and be passionate about why we need it and the exact meaning of it.”

Electronic scheduling is another win. Capturing demographic information electronically makes scheduling more accurate. Once schedulers get the information, they can link it through the hospital’s ADT (admission, discharge, and transfer) system directly into the patient documentation. “We have needed few phone calls back to the surgeons’ offices to confirm information.”

The project has been about “making it a safer journey for the patient and helping us to realize the points that are error-prone.”

—Pat Patterson