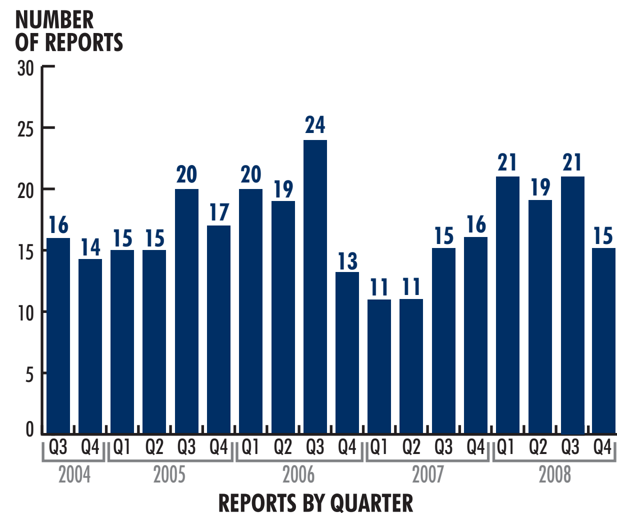
Quarterly Update on the Preventing Wrong-Site Surgery Project

The most recent update from the Pennsylvania Patient Safety Authority shows another 15 wrong-site surgeries reported during the fourth quarter of 2008 (see Figure). As before, minor adjustments have been made in prior quarters to reflect new information. Encouraging trends are appearing, however. The Health Care Improvement Foundation's Partnership for Patient Care Wrong-Site Surgery Prevention Program is a regional collaboration with the Authority to prevent wrong-site surgery. Begun in March 2008, it has not had a wrong-site operative procedure in any of its 30 participating facilities in three months and has not had a wrong-site anesthetic procedure in eight months. Authority analysts will continue to monitor the progress and are planning to replicate the initiative in another region. One characteristic of the collaborative is that facilities discussed with each other how they would prevent various scenarios (based on reports submitted to the Authority) from happening and how they would respond if the scenarios did occur.

Figure. Pennsylvania Patient Safety Authority Wrong-Site Surgery Reports by Quarter



Survey on Surgical Site Marking Pens and Techniques

Authority analysts will disseminate a survey, to be communicated through the Patient Safety Officers of Pennsylvania hospitals and ambulatory surgical facilities, in which operating room (OR) managers can share their good and bad experiences related to the use of various marking pens and techniques for marking surgical sites. (For more information about surgical marking pens, see the article "Surgical Site Markers: Putting Your Mark on Patient Safety" in the December 2008 issue of the *Pennsylvania Patient Safety Advisory*.) Others will be encouraged to contribute by downloading an online copy of the survey and submitting their experiences to the Authority.

The Time-Out Script Competition

The editors have received *five* script entries for the Time-Out in the OR Competition (depicted on next page). For the first round, the editors will accept open-ended review and comment from all who wish to do so. The editors may publish some of the critiques in the second round, but will not identify any reviewers. The reviewers may make a general comment on any script or comment on any parts of any scripts, positively or negatively, but should specifically consider at least three issues: (1) compliance with the time-out elements of the Joint Commission Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ intended to prevent wrong-site surgery; (2) active participation of all the important members of the operating team; and (3) efficiency. Efficiency will be defined as the length of time involved in performing the script.

During the regional collaborative to prevent wrong-site surgery, mentioned above, OR managers at 27 facilities noted the durations of the time-outs. The median for 227 observations was 1 minute and the mean was 90 seconds. Atul Gawande, MD, has stated that the aviation industry has a rule of thumb that, to maintain effectiveness, a routine checklist addressing a single task should take less than 90 seconds to perform (personal communication). Please note that the Time-Out in the OR Competition includes only the parts of a time-out script that identify the patient, procedure, and side or site of the procedure. Implant availability, antibiotic administration, allergies, and other additions to the Universal Protocol not related to preventing wrong-site surgery have been eliminated from the time-out scripts. Elements of the time-out that involve confirmation or documentation not based on conversation have also been eliminated. Please send your reviews and comments on any or all components of any or all scripts electronically to the editor at jclarke@ecri.org. An electronic copy of the scripts can be obtained online from the Pennsylvania Patient Safety Authority's Web page on preventing wrong-site surgery (see below). Please ensure that you link comments to specific scripts by their numbers. This is your chance to help shape robust scripts for time-outs.

The Pennsylvania Patient Safety Authority remains committed to preventing wrong-site surgery and welcomes any comments, suggestions, and specific inquiries from facilities with specific problems or questions concerning wrong-site surgery. Communications should be directed to John Clarke, MD, FACS, clinical director of the Pennsylvania Patient Safety Authority at ECRI Institute, by telephone at (610) 825-6000 or by e-mail at jclarke@ecri.org.

(continued on page 35)

Scripts for Mary Jones (DOB 01/01/1921, MR# 007) Left Total Hip Replacement (Supine Position)

Script #1

Circulating nurse, holding the informed consent and preoperative checklist (to the anesthesia provider): "What is the patient's name and date of birth?"

Anesthesia provider, reading from the patient label on the anesthesia record after it has been confirmed with the patient's identification bracelet: "Mary Jones, January 1, 1921."

Surgeon: "I concur that this is Mary Jones. I am doing a left total hip replacement in the supine position."

Circulating nurse (to the scrub technician): "Do you agree?"

Scrub technician: "Yes."

Circulating nurse (to the anesthesia provider): "Do you agree?"

Anesthesia provider: "Yes."

Script #2

Circulating nurse (to all members of the operating team): "It's time for the time-out."

Circulating nurse (to the anesthesia provider): "What is the patient's name and date of birth?"

Anesthesia provider, reading from the armband: "Mary Jones and her date of birth is January 1, 1921."

Circulating nurse (to the surgeon): "What is the intended procedure?"

Surgeon: "A total hip replacement."

Circulating nurse: "That information matches the consent."

Circulating nurse (to the surgeon): "What side is to be done?"

Surgeon: "The left side."

Circulating nurse: "That information matches the consent."

Circulating nurse (to the surgeon): "Is the site mark visible?"

Surgeon: "Yes."

Circulating nurse (to the surgeon): "Do we have the correct position?"

Surgeon: "Yes."

Circulating nurse (to the surgeon): "Are relevant x-rays available, labeled, and displayed?"

Surgeon: "Yes."

Script #3

Circulating nurse (to all members of the operating team): "Let's do our time-out."

Circulating nurse, after checking around the room to see that all members of the operating team involved in the patient's care have stopped what they are doing and are paying attention: "This is Mary Jones (looking at the name bracelet); her date of birth is January 1, 1921."

Circulating nurse, reading directly from the surgical consent: "Left total hip replacement."

Circulating nurse (to all members of the operating team): "Do you agree?"

Other individual members of the operating team: "I agree."

Circulating nurse: "The left hip is in the supine position and has been marked."

Script #4

Surgeon (to all members of the operating team): "Let's do the time-out."

Circulating nurse—after all members of the operating team have stopped what they are doing, have turned off any music, and are paying attention—reads from the informed consent: "This is Mary Jones; date of birth January 1, 1921; total hip replacement; left side; supine position."

Anesthesia provider, referring to the visible site marking and available documents: "I verify that we are doing a left total hip replacement on Mary Jones, medical record number 007."

Scrub technician, referring to the visible site marking: "I see the mark on the left hip. I have set up for a left total hip replacement."

Surgeon, referring to the visible site marking: "I agree that I am doing a total hip replacement on the left side. Available x-rays confirm the left side. I can see and verify the mark. Knife please."

(continued on page 35)

Script #5

Circulating nurse (to all members of the operating team): "It's time for the time-out."

Circulating nurse, looking at consent (to the surgeon): "Please give me the patient's name."

Surgeon, from memory: "The patient is Mary Jones."

Circulating nurse, looking at consent (to the anesthesia provider): "What is the name and date of birth on the wristband?"

Anesthesia provider, reading from wristband: "The wristband says 'Mary Jones, January 1, 1921.'"

The circulating nurse checks that the surgeon's and anesthesia provider's responses match the consent before proceeding to the next question.

Circulating nurse, looking at consent (to the scrub technician): "What procedure are you set up to do?"

Scrub technician: "I'm set up for a total hip replacement."

Circulating nurse, looking at consent (to the surgeon): "What procedure do you intend to do?"

Surgeon, from memory: "Total hip replacement."

Circulating nurse, looking at consent (to the anesthesia provider): "What procedure is listed on the schedule?"

Anesthesia provider, reading from OR schedule: "Total hip replacement."

The nurse checks that the scrub technician's, surgeon's, and anesthesia provider's responses match the consent before proceeding to the next question.

Circulating nurse (to the surgeon): "Please indicate on the x-ray the side the pathology is on."

Surgeon, pointing to the fracture on the x-ray image: "The pathology is on the left."

Circulating nurse (to the anesthesia provider): "What position is the patient in?"

Anesthesia provider: "The patient is in the supine position."

Circulating nurse (to the surgeon): "Please indicate the side the mark is on."

Surgeon, pointing to mark: "The mark is on the left."

Circulating nurse, looking at consent (to the anesthesia provider): "Which side is listed on the schedule?"

Anesthesia provider, reading from schedule: "The schedule says 'the left.'"

The nurse checks that the surgeon's and anesthesia provider's responses match the consent.

Surgeon (to all members of the operating team): "If anyone has a concern, please speak up."

(continued from page 33)

The Pennsylvania Patient Safety Authority devotes a Web page to educational tools for preventing wrong-site surgery. Its resources include all the Authority's publications on the subject, including *Advisory* articles, self-assessment tools, sample forms and checklists, educational posters and videos, illustrative figures and tables, patient-education brochures, and links to companion online information from other organizations. The Authority's Web page is http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/PWSS/Pages/home.aspx.

Also highly recommended is the Minnesota Hospital Association SAFE SITE Web site at http://www.mnhospitals.org/index/tools-app/tool.370?view=detail.

PENNSYLVANIA PATIENT SAFETY ADVISORY

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The Pennsylvania Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act. Consistent with Act 13, ECRI Institute, as contractor for the Authority, is issuing this publication to advise medical facilities of immediate changes that can be instituted to reduce Serious Events and Incidents. For more information about the Pennsylvania Patient Safety Authority, see the Authority's Web site at http://www.patientsafetyauthority.org.

ECRI Institute, a nonprofit organization, dedicates itself to bringing the discipline of applied scientific research in healthcare to uncover the best approaches to improving patient care. As pioneers in this science for nearly 40 years, ECRI Institute marries experience and independence with the objectivity of evidence-based research. More than 5,000 healthcare organizations worldwide rely on ECRI Institute's expertise in patient safety improvement, risk and quality management, and healthcare processes, devices, procedures and drug technology.

The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP's efforts are built on a nonpunitive approach and systems-based solutions.