Wrong-Site Surgery Occurs 40 Times a Week

Joint Commission Announces Preliminary Results of Project to Prevent "Never Happen" Events

Mark Crane | Jun 29, 2011

June 29, 2011 — Despite intense efforts to prevent wrong-site surgery in recent years, the adverse event "that should never happen" occurs about 40 times a week nationwide, the Joint Commission Center for Transforming Healthcare said today.

The center announced the preliminary results of a project with 8 hospitals and ambulatory surgery centers. The facilities found that problems with scheduling and preoperative/holding processes, as well as ineffective communication and distractions in the operating room, contributed to increasing the risk for wrong-site surgery. A "time out" without full participation by all key people in the operating room was identified as another contributing factor that increased risk.

"The 8 hospitals and [ambulatory surgery centers] identified where errors can creep into the process and took steps to correct them," Mark R. Chassin, MD, FACP, MPP, MPH, president of the commission, said during a news conference today. "We hope to use their experience as a roadmap to measure risks."

"All facilities and physicians who perform invasive procedures are at some degree of risk," he said. "The magnitude of this risk is often unknown or undefined. Providers who ignore this fact, or rely on the absence of such events in the past as a guarantee of future safety, do so at their peril. Unless an organization has taken a systematic approach to studying its own processes, it is flying blind."

Because wrong-site surgeries are relatively rare events, they are difficult to study. Research has shown that there is usually no single root cause of failure. Instead, such events are frequently the result of a cascade of small errors. "There's no silver bullet or easy answer," Dr. Chassin said.

Wrong-site surgery includes invasive procedures on the wrong patient in addition to wrong-procedure, wrong-site, and wrong-side surgeries. In 2010, it was the third most common sentinel event reported, Dr. Chassin added.

The 8 facilities found that addressing documentation and verification issues in the preoperative/holding areas decreased defective cases that increase the risk for wrong-site surgery from a baseline of 52% to 19%. In turn, the incidence of cases containing more than 1 defect decreased 72%.

"We found that in 39% of cases, errors were introduced that increased risk," he said. "The biggest was inadequate information about the patient. Often, the information is taken by a staffer in the surgeon's office, who may have to deal with several hospitals and different protocols. Confusion can result. The solution is a carefully standardized way of collecting information."

Marking the incision site varies greatly within facilities, increasing the risk for a preventable error. "In the past, the mark was made in the holding area," said Mary Reich Cooper, MD, JD, senior vice president and chief quality officer of Lifespan Corporation, which has 4 hospitals in Providence, Rhode Island.

"We found discrepancies between what was seen there before the surgeon arrived and what he thought he was doing in the operating room," Dr. Cooper said. "So now we have surgeons go out to the holding area to make the initial mark. Then in the operating room, before the procedure starts, we affirm that mark, asking if everyone sees the mark. We shut down our [operating room] for a day and put everyone through training. Every new staffer gets the
same training."

Dr. Chassin noted that unapproved pens had been used to do the marking. "Sometimes, the mark was washed away during the prep," he said. "So make certain that only approved indelible pens are used. This was a simple but important intervention."

Time-outs were handled inconsistently in several locations. "Was the time-out occurring before prep and drape, or after? Who leads the time out? The circulating nurse or the attending surgeon?" said Tom Feldman, chief executive officer, Center for Health Ambulatory Surgery Center in Peoria, Illinois. "We closed some gaps and decreased variation. That helps everyone in awareness."

"At the time-out, we stop all activities so we can all focus on this last opportunity to correct a mistake," said Dr. Cooper. "Everyone needs to stop what they're doing. We script the staff to ask if everyone can see the mark. Everyone must respond before the operation proceeds."

Dr. Chassin urged physicians and hospitals to view the joint commission's Targeted Solutions Tool, which provides a step-by-step process to measure performance. The first set of solutions focuses on improving hand hygiene. Additional solutions for wrong-site surgery will be added in the fall. Solutions for problems with hand-off communication will be added later in the year.

The 8 facilities that volunteered for the project are AnMed Health, Anderson, South Carolina; Center for Health Ambulatory Surgery Center, Peoria; Holy Spirit Hospital, Camp Hill, Pennsylvania; La Veta Surgical Center, Orange, California; Lifespan-Rhode Island Hospital, Providence; Mount Sinai Medical Center, New York City; Seven Hills Surgery Center, Henderson, Nevada; and Thomas Jefferson University Hospital, Philadelphia, Pennsylvania.

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