



Joint Commission Unveils Wrong Site Surgery Prevention Tool

Cheryl Clark, for HealthLeaders Media | July 5, 2011

With wrong-site surgeries occurring an estimated 40 times a week in the U.S., the Joint Commission teamed up with several hospitals to nail down precisely where and how these mistakes keep happening.

Now it has a tool that it says can help hospitals discover the flaws in their processes that can lead to irreversible or life-threatening mistakes.

"The Joint Commission has been at the forefront of the wrong site surgery problem for many years," said Mark Chassin, MD, Commission president said at a news briefing Wednesday. "Despite these efforts, the problem remains a significant one. In 2010, wrong site surgery was the third most common sentinel event reported" and it was the most common sentinel event reported between 2004 and 2010.

With the Joint Commission's Targeted Solutions Tool, which uses Robust Process Improvement methods, hospitals and surgical centers "will be able to follow some very simple sets of instructions with an electronic application available through every organization's secure electronic connection with the Joint Commission, Chassin explained. The tool measures each organization's risk "at the time of scheduling, in the pre-op area, and in the operating room."

Recommended checkpoints to eliminate these adverse events are being piloted tested by the eight participating hospitals and are expected to be added to the tool late this summer, the commission announced. Then they will be pilot tested to prove their effectiveness in different types and sizes of hospitals as well as ambulatory surgery centers and other care settings.

By Fall, the commission says it will have data to demonstrate whether the solutions can be sustained at a 90% or greater compliance rate.

"All facilities and physicians who perform invasive procedures are at some degree of risk," said Chassin. And though the risk is often unknown, "healthcare facilities and physicians who ignore this fact, or who rely on the absence of such events in the past as a guarantee of future safety, do so at their own peril. Unless an organization has taken a systematic approach to studying its own process and determining its own risk of wrong site surgery, it is literally flying blind."

In partnership with eight hospitals or surgery centers, the commission released a list of key areas and opportunities for errors or defects that even hospitals and surgeons that have never performed a wrong-site surgery should scrutinize, Chassin said. These strategies are the ones that will be pilot tested.

Integrity of Patient Data

Perhaps more than ever before, the list highlights points in the process that occur long before the patient enters the hospital, when an assistant or nurse in the physician or surgeon's clinical office is scheduling the procedure and entering information into the patient's record.



ACADEMIC MEDICAL PROFESSIONALS
INSURANCE EXCHANGE RISK RETENTION GROUP
1250 Broadway, Suite 3401
New York, NY 10001

www.academicins.com

AHPIA Solutions, Inc.
Attorney-in-Fact

Tel: 646 808 0600
Fax: 646 808 0601

"The person supplying crucial information is typically working in a surgeon's office, often not directly affiliated with the hospital or center where the surgery takes place" Chassin said. And, that person has many different hospitals and centers to work with. If those facilities have different requirements for producing information, "confusion can result and incomplete or inaccurate information may be conveyed."

Chassin said that the team realized that 39% of the wrong-site surgery cases involved errors that were introduced during the scheduling process, when inaccurate information about the patient or the surgical procedure was put in the record.

But errors occur at every point in the process prior to surgery, "from incomplete or inaccurate information during scheduling, to missing documents at the time of preoperative preparation, to inconsistent or ineffective procedures for marking the surgical site, to key omissions in the crucial time out process before surgery," he said.

Accuracy in Surgical Site Marking

Another problem area they discovered was that often, the surgical site was not marked close enough to where the incision was to be made, or the mark was covered up and not visible to the surgical team, or in washing the patient, the mark was removed because the patient or team member used an unapproved marking pen.

Site Verification During Pre-Op

The team also analyzed problems with documentation and verification in the pre-op holding areas. Addressing those decreased the error rate from a baseline of 52% to 19%, Chassin said.

Mary Reich Cooper, MD, senior vice president and chief quality officer for Lifespan Corp. of Providence, RI, said that at Rhode Island Hospital, the team discovered flaws in the process of marking the surgical site. "We had it separated in two parts, in the holding area and in the operating room itself. But one of the things we found was that at times, there were discrepancies between what was seen in the holding area, when the surgeon was not there," to what was seen in the operating room.

The solution: Now the surgeons all go out to the holding area to make the initial mark with the patient and the staff. "And then they subsequently affirm that mark by placing a finger on the mark and asking if everyone can see the mark."

Changing surgeon behavior is challenging, acknowledges Rudy R. Manthei, DO, chief operating officer at Seven Hills Surgery Center in Henderson, NV.

"One of the biggest problems we have is that physicians tend to think the way they do procedures is the way they need to be done. But we find that if you educate the physician and spend time explaining the significance of the problem, and the impact it will have on patient outcomes, that they will embrace that, especially if you do it on a one to one (basis) and don't put them in a position to challenge their authority. They respond very openly to that."

Adopting these sequential steps to their surgical practice "does tend to slow them down. But it does create the leadership that's necessary for the staff," Manthei said.



ACADEMIC MEDICAL PROFESSIONALS
INSURANCE EXCHANGE RISK RETENTION GROUP
1250 Broadway, Suite 3401
New York, NY 10001

www.academicins.com

AHPIA Solutions, Inc.
Attorney-in-Fact

Tel: 646 808 0600
Fax: 646 808 0601

The eight hospitals and ambulatory surgical centers that volunteered to address the issue include:

- AnMed Health, Anderson, SC
- Center for Health Ambulatory Surgery Center, Peoria, IL
- Holy Spirit Hospital, Camp Hill, PA
- La Veta Surgical Center, Orange, CA
- Lifespan-Rhode Island Hospital, Providence, RI
- The Mount Sinai Medical Center, NY
- Seven Hills Surgery Center, Henderson, NV
- Thomas Jefferson University Hospitals, Philadelphia, PA

"Surgery or any procedure on the wrong site of the body, or at the wrong location, or even on the wrong patient, should never occur," Chassin said.

Targeted solutions for the Wrong Site Surgery Project will be available in the Center's Targeted Solutions Tool in the fall of 2011.