A lot of effort has gone into preventing wrong surgery through the Joint Commission’s Universal Protocol and other measures. Still, the data suggest the incidence hasn’t changed very much. The Joint Commission estimates about 40 wrong surgery cases happen every week in this country. The numbers are projected from Minnesota and Pennsylvania, 2 states that have mandatory reporting.

A new Joint Commission initiative is aiming for breakthroughs on this and other persistent problems like hand-washing failure and communication breakdowns during hand-offs, failures that harm thousands of patients and cost billions of dollars a year.

The Joint Commission’s new Center for Transforming Healthcare, rolled out September 10, 2009, teams with groups of hospitals to apply quality improvement methods long used by industry like Lean Six Sigma. The intent is to develop “targeted practical strategies,” Joint Commission President Mark Chassin, MD, MPP, MPH, said at a press conference.

The Joint Commission says it will share the strategies, such as assessment tools and packages of interventions, with accredited facilities at no extra cost.

The program is separate from accreditation today. But Dr Chassin said over time the commission will consider building elements that work into accreditation requirements.

**Beyond easy fixes**

The center will start by tackling 3 issues:

- hand hygiene
- preventing wrong surgery
- hand-off communication.

Eight hospitals volunteered for the hand hygiene initiative, among them Cedars-Sinai Health System in Los Angeles and Johns Hopkins Hospital in Baltimore.

As the group began digging into the issue, Dr Chassin said they found the problems were “beyond easy fixes.” Among barriers they discovered were not having soap and hand-rub dispensers in convenient places and faulty data that led the hospitals to think hand-cleaning rates are better than they are. On average, caregivers actually were cleaning their hands less than 50% of the time.

Targeted solutions are now being tested, such as holding everyone accountable and responsible—physicians, nurses, technicians, therapists, housekeepers, and others and using a reliable way to measure performance.

**Wrong-surgery initiative**

Two hospitals will work on preventing wrong surgery, Rhode Island
Hospital, a large teaching center, and Newport Hospital, a community facility, both part of the LifeSpan system based in Providence, Rhode Island. Hospitals in the state have had several widely reported wrong-surgery incidents.

Given the effort already spent on prevention, what can this initiative add? Rhode Island hospitals spent 2 years developing a statewide surgical safety protocol introduced in July 2009 (September 2008 OR Manager).

Mary Cooper, MD, JD, LifeSpan’s chief quality officer, told OR Manager she and other leaders see an opportunity to introduce tools like Lean Six Sigma, which the hospitals do not currently have experience with.

The heart of the matter

“We wanted to do something about preventing wrong surgery that gets to the heart of the matter,” she says. The Joint Commission center is providing LifeSpan with 2 Six Sigma Black Belts, one of whom is a surgeon, and a “master change agent” for the wrong-site surgery project. They are working with front-line staff as well as physicians. The project started in July 2009, with results expected by next spring or summer.

Focus on variation

The wrong-site project is focusing on 2 areas, Dr Cooper explains.

Newport Hospital will look at standardizing surgical site marking. Though site marking has been an expectation for a long time, she notes, there is variation. For example, even if everyone in a hospital signs, “yes,” there still are differences in the distance from the mark to the incision site and in the size of the mark.

At Rhode Island Hospital, the focus will be on situations where there are inherent variations, making it difficult to mark the site. Examples are procedures where there will be 2 incisions on the same side or where a laparoscope will be inserted in a different location than the intended procedure.

“As we talk to colleagues around the country, we have found that procedures that are done incorrectly and are near misses tend to be ones where people scratch their heads and say, ‘I’ve never come up against this before,’” Dr Cooper says. “It is not the routine procedures where people are making mistakes.”

The hospital will also look at surgical site verification in emergencies, when care is rushed.

Stepping forward

“It was very important to us to step forward and tackle this problem, in large part because we have had wrong-site procedures about which we and the state have been very vocal,” she says.

“It was important for us to say, not only are we going to be open, but we want to be out there looking for innovative approaches to make sure this doesn’t happen to the next patient.”

The Joint Commission said the center has received support from the American Hospital Association, the Federation of American Hospitals, and companies including BD, Ecolab, GE Healthcare, and Johnson & Johnson.

Learn more about the Joint Commission Center for Transforming Healthcare at www.centerfortransforminghealthcare.org/