Joint Commission tools to prevent wrong surgery

Surgical teams received more ammunition in their quest to avoid wrong-site surgery when the Joint Commission’s Center for Transforming Healthcare issued its latest set of guidelines, called the Targeted Solutions Tool (TST).

Released February 14, 2012, the TST is available free to Joint Commission-accredited hospitals and ambulatory surgery centers (ASCs). Users log onto a secure page on the center’s web page, where they are invited to enter data from their own experience and to generate analysis reports, procedure guidelines, and training programs tailored to their specific needs.

Zeroing in on wrong-site surgery

The tool emerged from a 2009 study by the center. At that time, the Joint Commission decided to expand on its Universal Protocol for avoiding wrong-site surgery. The agency still found troubling the persistent, if rare, occurrence of such serious errors. It estimated that in an average week there were 40 incidents of wrong person, wrong procedure, or wrong site in US operating rooms.

Because few states require reporting of these incidents, verification was difficult. The Joint Commission, according to an internal account, used data from Minnesota and Pennsylvania, which are among the states that mandate reporting, from October 2009 to October 2010. Statistical analysis of the results indicated a national wrong-site surgery rate of 35.37 per week—better than 40, but not much. Even that figure, the report notes, is only an estimate, because different states define wrong-site surgery differently, and even where mandated, reporting may not be consistent.

Finding a fix

Participants in the TST project included 3 surgery centers and 5 hospitals. Each facility reviewed its own procedures, looking for weaknesses that could potentially lead to errors in treatment related to surgery, and sought ways to counteract them.

The 8 study participants examined their procedures for surgical scheduling, the preoperative holding area, and the operating room. They identified 29 risk factors that could have led to errors. They developed fixes and put them into practice. As a result, according to a Joint Commission release, they were able to reduce risk factors by 46% in scheduling, by 63% in preop, and by 51% in the OR.

They documented the changes, and 6 additional facilities conducted a pilot test with similar results.

The potential for wrong-site surgery, they discovered, begins with scheduling, which often takes place in the physician’s office. Telephone calls not confirmed in writing, and last-minute changes could lead to mix-ups along the way. In preop, missing or incomplete documents could result in having the wrong records associated with a patient. In the OR, a hasty time-out or incomplete site marking were primary risks.
One of the 6 pilot-test facilities has a new time-out policy as a result of the study. As Director of Clinical Services Tracy Helmer, RN, explains, what used to be casual is now formal.

“We built a time-out process that revolved around key participation in the group,” Helmer says. “Prior to the TST project, the circulating nurse would call a time-out, but the procedure was less formal. Now, we turn the radio off, and everybody stops what they’re doing to focus on the patient and works as a team.”

**Roles are specified**

Roles are specified, he adds: The surgeon names the patient and the procedure the patient has consented to, the nurse confirms the identification, and the anesthesiologist identifies allergies or other concerns.

“It’s a hard stop,” Helmer says. He notes that the new procedure “takes only seconds longer than before.”

Some improvements are more general.

According to Andrew Ward, MD, medical director of Algonquin Road Surgery Center, Lake in the Hills, Illinois, another TST test site, the tool also helps clinicians work together as a team.

“After having implemented the tool,” Dr Ward says, “we’ve gained buy-in from the surgeons, the staff, and the anesthesiologists.” The result, he adds, is nearly 100% compliance in the operating room.

Helmer adds, “We gained a tremendous amount of insight from all kinds of perspectives. One of the most profound things that I saw, working with the Joint Commission and some of the most influential people in medicine, is that they have the same kinds of problems that our little surgery center has.”

**A wealth of resources**

Among the resources provided in the TST are training modules, which include videos showing examples of both good and bad practices. Interactive training programs help staff assess their progress.

The user can identify weak points in the current procedures, as the original study participants did, and enter them in the TST’s secure site. A data analysis function will produce charts to clarify where priorities should lie. For example, the charts show the rate of defective cases per day, as well as the percent of those cases that contain multiple defects, showing where the primary focus should be. Because it targets the weak points, TST can also show what a facility is doing right and what it does not need to spend time reworking. Charts break down results by specialty and surgeon.

TST also contains training programs and implementation guides. The Joint Commission estimates that a TST-based project will take most organizations 14 to 16 weeks, but they will begin to see improvement in about 8 weeks.

ASCs that are not among the 850 accredited by the Joint Commission can still access the program’s multimedia news release and Universal Protocol for patient safety at http://www.jointcommission.org. They can also use the World Health Organization (WHO) surgical safety checklist. Another resource is the detailed British checklist (code named “POSH SPICE”) located at http://www.wikisurgery.com/index.php?title=Patient_checks.

**No margin for error**

Like airplane crashes, wrong-site surgeries are catastrophic but rare. Thus, many clinicians have never witnessed one and see that as a sign of success.
Like pilots, however, they may have experienced—perhaps without realizing it—some near misses.

As Helmer notes, “The near-miss type of event is seen more frequently than we would want to admit.” Improper scheduling, incorrect laterality, mistaking left and right in site marking, an incorrectly placed incision or selecting the wrong implant, even if corrected during the procedure, can be terrifying in retrospect.

“An event doesn’t have to actually take place for you to have that feeling of insecurity, that something could have gone wrong,” he says. ❖

—Paula DeJohn

The TST tools and other resources are at www.centerfortransforminghealthcare.org

Read more about the CTC project in the article, “Devil in details: Identifying defects that could lead to a wrong surgery,” in the August 2011 OR Manager.