RI standardizes safe-site protocol

All of Rhode Island’s 13 acute care hospitals have agreed to a single safe-surgery protocol, in what is thought to be a first for a state. The protocol, announced in July 2009, outlines steps for 3 phases of surgery—briefing, time-out, and debriefing—and includes elements of the Joint Commission Universal Protocol and World Health Organization (WHO) Surgical Safety Checklist.

A multidisciplinary task force developed the policy over 2 years after consulting with colleagues as well as the Joint Commission and other agencies.

There were 2 major reasons for standardizing the protocol, according to William G. Cioffi, MD, chief of surgery at Rhode Island Hospital in Providence, one of the leaders of the effort.

First, because Rhode Island is a small state, physicians and nurses often work at more than one facility.

“It was apparent there was wide variability in practice patterns,” he says. “We thought the lack of consistency was creating a problem, not only at our own institution but throughout the state.”

The second reason was to determine best practices for preventing surgical errors, which have been a stubborn problem throughout the country.

Rhode Island Hospital, which has 719 beds and performs about 25,500 surgical procedures a year, has had 2 wrong-site surgeries in the ORs and 2 at the bedside in recent years. The hospital signed a consent agreement with the Rhode Island Department of Health in May 2009 to review its policies and procedures, to develop a near-miss reporting system, and to confirm all surgical staff are knowledgeable about the time-out and policies and procedures.

In October 2008, The Miriam Hospital, also in Providence, signed a consent agreement over a wrong-side arthroscopic surgery, saying it would revise its surgical-site policy, among other steps.

A Joint Commission official, Mike Crafton, who worked with the task force and the state hospital association to develop the policy, told the Providence Journal, “We don’t have any data that would show the rate of wrong-site surgeries is more frequent in Rhode Island versus other states.” He said it is clear from Joint Commission data “that wrong-site surgery is an issue around the country.”

Not just a checklist

The task force wanted to develop a communication process for the OR, not just a checklist.

“We wanted the time-out, briefing, and debriefing to be valued, not just tolerated,” says Diane Skorupski, RN, MS, CNOR, NE-BC, Rhode Island Hospital’s director of perioperative services, a task force leader.

“We felt it can become rote when the team just goes through items on a list and checks them off.”
Rhode Island Surgical Safety Checklist

All team members have an obligation to verbalize their concerns at any step in the process.

<table>
<thead>
<tr>
<th>Before induction of anesthesia</th>
<th>Before skin incision</th>
<th>Before patient leaves operating room</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Briefing process</strong></td>
<td><strong>Time-out process</strong></td>
<td><strong>Debriefing process</strong></td>
</tr>
<tr>
<td>☐ Completion of site marking by surgeon* and second licensed provider</td>
<td>☐ Initiated by attending surgeon</td>
<td>☐ Initiated by attending surgeon prior to leaving the operating room</td>
</tr>
</tbody>
</table>
| ☐ Identification of team members and roles  
  • Each introduces himself/herself* | ☐ Patient, procedure, site/side identification (confirmed with consent by RN/licensed provider) | ☐ Specimen labeling and designation |
| ☐ Surgeon identifies patient, procedure, site/side (confirmed with consent by RN), and discusses the plan for surgery* | ☐ Surgeon’s initials on procedure site/side visible after prepping and draping | ☐ Postop plan of care (ICU bed, ventilator, etc) |
| ☐ Antibiotic status/glycemic control/beta-blockers/medications needed on field/irrigation as applicable* | ☐ Can we see the marking? | ☐ Patient temperature |
| ☐ Patient position* | ☐ | ☐ Review of what worked well and what could have been done differently |
| ☐ Equipment/implants required for procedure | ☐ | ☐ Identify any instrument/equipment concerns |
| ☐ Patient safety considerations: blood, DVT prophylaxis, allergies, special considerations (hearing deficit, language barrier, friable skin, risk for pressure ulcer, pacemaker, etc) | ☐ | ☐ Identify edits for physician preference card |
| ☐ Relevant information available: X-rays, PACS up on screen, lab work, consent | ☐ | * Joint Commission element of performance |
| ☐ Are we ready to begin induction? | ☐ | |

The protocol follows the format of the WHO checklist and includes required elements from the Universal Protocol, such as the site marking and time-out (illustration).

“But the process has to be customized to the patient, which is what the briefing and debriefing are meant to do,” Dr Cioffi says. He added the protocol must be adaptable to many situations, from a 15-minute myringotomy to a multiorgan transplant.

**Marking the site**

The Rhode Island protocol is specific about who must mark the site and initiate the time-out:

• Completion of site marking is by the surgeon and a second licensed provider.

• The time-out process is initiated by the attending surgeon.

Involving the second person in site marking is an example of the protocol’s checks and balances, Dr Cioffi says. “The literature is clear that if only the surgeon is involved in marking the site, there are mistakes a certain percentage of the time. We thought it was important to have a second independent person verify the mark.”

In addition, he says, “Other people in the room have a responsibility to
help ensure the safety of the patient. They need to be engaged in the process from the beginning.”

**Surgeon initiates time-out**

Having the attending surgeon initiate the time-out generated a lot of discussion, he says. “Originally, we thought anybody could initiate the time-out. It is a way to engage all the team members.” But in the end, because the surgeon has the ultimate responsibility for performing the procedure, “we thought the best process was to have that person initiate the time-out. That doesn’t mean they are the only ones participating.”

Being specific about who should lead the time-out was also a way to decrease variability. Moreover, when the surgeon leads the time-out, everyone pays attention, Skorupski says.

The decision has been received well at Rhode Island Hospital. In team meetings with surgeons, anesthesiologists, nurses, and other OR personnel, opinions were not unanimous, but “it was common among those groups that the surgeon should do it,” Dr Cioffi says.

**Speaking up**

An essential element of a safety protocol is ensuring that team members feel safe speaking up if something seems amiss.

An important issue is “how you approach people who choose to be non-compliant,” Dr Cioffi says. “To feel empowered, you have to know that if someone impedes the process, we will have zero tolerance toward not participating in the process to make the OR environment safer. That is what we’re striving for.”

In the past, he acknowledges some surgeons did not buy into the process. Now he says there is awareness that a wrong-site surgery “is very destructive to a hospital. Everyone suffers, even if the patient has no untoward consequences.”

Even older surgeons who would not have bought into the process 5 years ago do now, he notes. “They understand what a mistake or wrong surgery does to the morale of the institution and to themselves, even if they have not been involved in one.”

He says OR leaders try to address noncompliance “as close to the time it happens as possible.”

The surgical leadership now takes a team approach, Skorupski adds. “We communicate openly, and we are visible in the OR. We do a lot of point-of-care coaching.

“If an employee is putting us at risk, that is a conversation we have to have with them. It’s not about blaming,” she adds. “It is about bringing about best practices. You have to be visible, supportive, and answer questions.

“You can’t just educate a group and walk away.”

—Pat Patterson