Surgical Errors

Importance of Story Telling

Culture of Safety Conference Review

SURGICAL ERRORS

Few medical errors are more devastating than those that involve patients who have had surgery on the wrong body part, had an incorrect procedure or had surgery intended for another patient. Although these types of ‘never events’ do not happen often, the ramifications when they do occur are significant. The following surgical cases were reported to the Sentinel Event Team (SET) in 2016 (and we are seeing comparable numbers for 2017):

• 16 surgical or invasive procedures performed on the wrong site;
• 9 retained foreign objects after surgery or invasive procedure;
• 2 surgical or invasive procedures performed on the wrong patient.

Wrong site surgery cases occur for a variety of reasons. Two of the most common causal factors identified through root cause analysis (RCA) and shared with the SET include: deviation from and/or lack of pre-surgical procedures and ineffective/inaccurate communication. Some contributing factors that have been identified in RCAs for surgical cases are:

• Incomplete/inaccurate consent form,
• Failure to use two patient identifiers,
• Failure to communicate accurate information, and
• Failure to do a complete surgical timeout.

Wrong site surgeries are not limited to the operating room. They may occur wherever invasive procedures are performed. In a recent SE, an invasive procedure performed at a patient’s bedside resulted in a wrong site surgical error. The facility did not have a procedure in place for a timeout and surgical safety checklist to be used during bedside procedures. As a result of the RCA, the facility implemented a timeout and checklist procedure for invasive procedures outside of the operating room.

In 2016, the American College of Surgeons and the American Academy of Orthopedic Surgeons sponsored the first National Surgical Patient Safety Summit (NSPSS). The two-day event included more than 100 representatives from medical professional associations, insurers, health care systems, payers and government agencies, with the goal of developing surgical care and surgical education curricula standards and prioritize safety efforts. Dr. William Robb, co-chair of NSPSS stated, “Surgical safety improves when non-technical strategies, tools and behaviors are combined with proficient surgical skills. Each member of the surgical team needs to know how to effectively communicate and appropriately adapt during an adverse event. An empowered, well-trained surgical team improves surgical performance and outcomes.” (2016 Press Release, American College of Surgeons)

Multi-disciplinary workgroups developed draft recommendations, which include the following:

• Surgical safety education programs with assessments of competence for all members of the surgical team on effective communication, resilience, leadership and teamwork.
• Safety training modules for the entire surgical team.
• Training on teamwork at all levels of medical education.
• Shared decision-making practices and procedures to ensure an informed and prepared surgical patient.
• Patient-centered, timely and accurate surgical consent processes.
• Communication tools/procedures to improve the transferring of patient information.
• Surgical site marking and ID policies – pre-surgical team “brief” and “time out”, and postsurgical “debrief”
• A common data collection system to measure and improve patient safety outcomes.

Additionally, The Joint Commission (TJC) has included a section in their 2018 National Patient Safety Goals (NPSG) to prevent mistakes in surgery. It is based on several principles with the primary being: wrong-person, wrong-site and wrong-procedure surgery can and must be prevented. The simplified version of NPSGs to prevent surgical errors includes the following:

- Ensure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.
- Mark the correct place on the patient’s body where the surgery is to be done.
- Pause before the surgery to make sure that a mistake is not being made.

The TJC 2018 NPSGs can be found at: [https://www.jointcommission.org/standards_information/npsgs.aspx](https://www.jointcommission.org/standards_information/npsgs.aspx).

The Agency for Healthcare Research and Quality (AHRQ) recently posted a new “Toolkit to Promote Safe Surgery.” This toolkit helps perioperative and surgical units in hospitals identify opportunities to improve care and safety practices and implement evidence-based interventions to prevent surgical site infections. The toolkit includes practical resources that reflect real-world experiences of the frontline clinicians and subject matter experts who participated in the AHRQ Safety Program for Surgery, a national implementation project. It builds on AHRQ’s Comprehensive Unit-based Safety Program (CUSP) and the core CUSP toolkit.

The toolkit has two complementary guides: “Applying CUSP to Promote Safe Surgery” and “Surgical Complication Prevention.” These guides address technical and adaptive work. Technical work addresses procedural aspects of care that can be explicitly defined. Adaptive work is designed to change attitudes, values, beliefs and behaviors of those delivering care and improve organizational safety culture. ([www.ahrq.gov/professionals/quality-patient-safety/hais/tools/surgery/index.html](https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/surgery/index.html)


The Institute of Safe Medication Practices (ISMP) uses storytelling as a fundamental strategy to create change, and they have embedded storytelling in every aspect of their work (“Telling true stories is an ISMP hallmark. Here’s why you should tell stories too…,” ISMP Medication Safety Alert, August 2017). Storytelling – conveying compelling stories about medication errors and impactful change strategies - draws attention to problems and encourages people to act.

ISMP lists the following benefits of storytelling:

- **Stories are powerful.** Lessons without stories rarely lead to learning and change.
- **Stories grab our attention.** They grab and hold our interest in a way that research data and quantitative numbers alone cannot.
- **Stories are mentally rich.** They help make analysis not just an intellectual experience but a more personal experience.
- **Stories provide new perspectives.** They can challenge preexisting assumptions and open up new ways of thinking of an issue.
- **Stories are more likely to be remembered and retold.** Data, while important, by itself cannot paint a rich picture of an incident. Stories help humanize events.
- **Stories inspire and incite change.** Studies have shown that the persuasive effects of stories can impact behavior better than abstract presentations of data. ISMP cites the example of a 2-year-old child who died after chewing on an improperly disposed fentanyl patch that he had picked up on the wheels of his toy truck while playing in his grandmother’s nursing home room. The hearing and retelling of this story by nursing home staff did more to change staff behaviors around patch disposal than any policy or data regarding accidental access.

ISMP also acknowledges that there are challenges to storytelling related to healthcare providers’ concern about litigation risks and negative public perception. This secrecy makes it impossible for an entire organization to learn from its mistakes.

ISMP offers the following recommendations related to storytelling:

- **Setting the stage.** A ‘Just Culture’ is important to promoting openness in staff members without fear of punishment.
2017 MHA/HIIN SEPTEMBER CULTURE OF SAFETY CONFERENCE REVIEW

Dr. Spurlock offered the following suggestions to attendees:

• Be willing to speak up and do what others won't;
• Use time with leaders wisely.
• When you are making a request to a leader, be prepared and succinct.
• Build on organizational goals.
• Use storytelling.
• Let the best idea win.
• Know when to push and when to back off.
• Model the behavior you desire.

Presentations were given by risk and quality specialist peers from three facilities:

• Janet Maguire, from Maine Medical Center (MMC), reviewed the National Patient Safety Foundation “Free from Harm” recommendations from 2015. She also shared some of the challenges and successes of the MMC Risk Management department including: looking at systems and not individuals; adding “successes” to RCAs, risk managers making unit rounds and following up with staff when events are reported, sharing stories, and peer to peer support referrals.

• Erin Hayes, from St. Mary’s Regional Medical Center, shared administrative changes at St. Mary’s as well as challenges and successes. She reviewed the Reporting Culture (benefits and barriers), the Learning Culture (to evaluate processes), and Just Culture (determine root cause of error with consequences based on type of behavior). She shared their focus on teamwork and communication using TeamSTEPPS and improved patient safety by applying Crisis Prevention Institution training. Also, transparency is practiced by publicly sharing data, which shows dedication to responsibility and accountability.

• Angela Gibbs, from Inland Hospital, presented information on high reliability organizations, developing a culture that supports high reliability and implementing the AHRQ Culture of Patient Safety survey. Some of the results of the survey included identifying themes of strengths and opportunities, increased collaboration with process improvement tactics, sharing lessons learned (successes and harms) and strengthening leadership’s commitment to a culture of safety.

2017 MHA/HIIN SEPTEMBER CULTURE OF SAFETY CONFERENCE REVIEW (CONTINUED)

The Maine Hospital Association, with the Hospital Improvement Innovation Network and the SET, held a conference on September 21, 2017. The keynote speaker was Dr. Bruce Spurlock, President and CEO of Cynosure Health. Dr. Spurlock’s presentation, “Building Safe Systems from the Middle: The Culture, the People and the Process” focused on ways middle managers can be effective in leading organizational change. Some of the challenges facing managers include the lengthy time it takes for new evidence to be incorporated into clinical practice (on average, seventeen years) and the multiple demands facing facilities and hospital leadership. He also discussed the concept of ‘ex-novation’, removing ideas, practices or other items that allows an organization to adopt fresh thinking and new improvements (J. Kimberly, 1981).

IMPORTANCE OF STORYTELLING (CONTINUED)

• Crafting stories. Stories should have just enough detail to: describe key events leading up to the incident, describe the underlying causes of the risk/error, link causes and outcomes, describe lessons learned and make the story memorable. To the extent possible, the patient and individuals who were involved with the event should be de-identified.

• Sharing stories. Establish a simple yet formal process for sharing internal and external stories that focus on risk, errors, adverse events and improvements. Determine whether organizational stories can be shared verbally and/or in writing. Organizational leaders need to be visible and active in storytelling. Stories that are told appear to have more of an impact than written stories.

http://www.ismp.org/newsletters/acuteCare/showArticle.aspx?id=1175
UPDATES FROM THE SENTINEL EVENT TEAM

- The SET is observing an increase in the number of RCAs that include an audit to determine the effectiveness of action items identified through the RCA process. This demonstrates facilities’ understanding of the importance to evaluate the effectiveness of action items in addressing causal factors of adverse events, and if implemented actions were not effective, further modification. This Plan, Do, Study, Act approach is a standard tool used in process improvement.

- On-site reviews – the SET continues to conduct on-site reviews to determine if covered facilities are in compliance with the SE statute and rules. While doing these reviews, the SET also identifies best practices and would like to share what Calais Regional Hospital has done to help staff in reporting possible sentinel events. Each unit has posted laminated sheets with information so staff have a visual and readily accessible reference of what SEs must be reported.

- The Joint Commission released an updated “Framework for Root Cause Analysis and Corrective Actions.” Two columns were added to the analysis section: Root Cause Types (Table A-1) and Causal Factors/Root Cause Details (Table A-1). Additionally, in Table A-2 a section for Action Strengths has been added and provides examples of stronger, intermediate and weaker actions. This will be helpful as a reference for all team members when creating action items. The new template can be found at: https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/