IMPROVEMENT IN WRONG SITE SURGERY – STILL HAZY AFTER ALL THESE YEARS

The World Health Organization (WHO) initiated the surgical site checklist (SSC) as part of their “Safe Surgery Saves Lives” campaign in 2009. Dr. Atul Gawande’s team developed the SSC, with the idea that a surgical safety tool, similar to the checklists used in aviation, would enhance communications and teamwork, and provide more consistent performance of surgical teams in patient safety/care measures. In a WHO multihospital pilot study accessing 7,800 patients across hospitals in 8 countries, use of the SSC demonstrated a decrease in mortality of 48% and a decrease in complications of 37%.

Since the release of the landmark study, the SSC has been introduced into 6000 hospitals worldwide. WHO estimated that at least 500,000 deaths per year could be prevented through worldwide implementation of the checklist (Wangoo, et al, “Compliance with Surgical Team Perceptions of WHO Surgical Safety Checklist; Systematic Review”, Int Surg 2016). Unfortunately, this level of improvement has not been seen over the subsequent 9 years. A 2014 multicenter Canadian study by Urbach, et al, that assessed 215,000 procedures across 101 hospitals found that morbidity and mortality only decreased by 0.05% post-implementation. Wrong site surgery is #4 out of the top 10 sentinel events reported to The Joint Commission from January – June 2018, and is #7 for sentinel events reported to the SE Unit through 2018, to date.

So why haven’t we seen the improvements predicted by WHO? In 2016, Wangoo, et al conducted a systematic review to assess the SSC compliance and evaluate surgical team perceptions and attitudes, post-checklist implementation. Twenty-six studies, thirteen assessing SSC compliance and thirteen investigating surgical team perceptions of SSC, were evaluated. The conclusions of the review were that SSC compliance varies significantly across studies, being highly dependent on staff perceptions, training, implementation strategies and effective leadership. Surgical team members had a generally positive view of the SSC with improvements in teamwork, communication, patient safety and staff awareness of adverse events.

IMPROVEMENT IN WRONG SITE SURGERY, CONT.

Key barriers to SSC implementation included confusion about whose responsibility it is to initiate the checklist and at what stage; nurses’ unfamiliarity with their role in the SSC due to high staff turnover rates; cultural stigma; and inadequate staff training designed to address the obstacles to SSC implementation. Other aspects of compliance that need to be considered are barriers such as start times (progressively worsening as the day goes on) and operation length, as well as staff initiative and attitudes.

According to Bates and Singh (“Two Decades Since to Err is Human: An Assessment of Progress and Emerging Priorities”, Health Affairs, November 2018), the lack of predicted success rates is likely to be influenced by leadership support and local safety culture. They also point out that errors related to human cognition or behavior in or out of the operating room would not be impacted by the checklist, suggesting the need for more study to understand and address surgical safety.

The Agency for Healthcare Research and Quality (AHRQ) points out that wrong site surgeries are relatively rare, occurring in approximately 1 out of 112,000 surgical procedures. An individual hospital might only experience such an error once every five or ten years. However, these estimates only included procedures performed in the operating room. One study using Veterans Affairs data found that half of wrong site, wrong procedure, wrong patient errors occurred during procedures outside of the operating room.

The Joint Commission has developed a new, free educational tool that details ways to identify risk factors and possibly improve processes related to wrong-site surgery. It lays out a situation in which a patient was scheduled for a trans-bronchial biopsy of the right upper lung to obtain specimens for determining if a lung mass was malignant.
IMPROVEMENT IN WRONG SITE SURGERY, CONT.

This scenario illustrates a number of possible contributors to the wrong lung biopsy, including:

• Consent (laterality was not included);
• Hierarchy (case bumped by a more senior physician);
• Equipment (only two C-arms that were functional);
• Staffing (there was only one diagnostic radiology tech, so the circulating nurse set up the C-arm);
• Time out (laterality was correctly noted on a whiteboard in the procedure room, but the whiteboard was not used to guide the time-out); and
• Communication (when the pulmonologist communicated the completion of the left lung specimen collection, the diagnostic radiology tech noted the discrepancy on the whiteboard, but assumed that the site was correct, and no one else appeared concerned).

Strategies are identified for each of the contributing factors, including:

• Education of staff that leadership will not tolerate intimidating or disrespectful behavior;
• Standardization of processes (clear identification of site and side, pre-operative verification workflow, assign roles to ensure that every team member participates);
• Hiring additional staff;
• Creating a structure and process for providing feedback to reported concerns;
• Team training to build effective teamwork; and
• System-based strategies to mitigate the risk of cognitive bias.

The import of this process is to point out the value of identifying risk points, ways in which an error could have been mitigated or prevented, and what improvements can be made within the organization.

(https://www.jointcommission.org/issues/article.aspx?Article=zmB4RP5LqzzXAiehMXgsLLLdGkATuE3MH5sBa6STRyk%3d&j=3963160&e=sarah.taylor@maine.gov&i=94_HTM&u=136273514&mid=1064717&jb=67)

PATIENTS’ EXPERIENCES AND PATIENT SAFETY

In the many efforts that are being undertaken to improve patient safety across the country, and around the world, is the experience of patients given appropriate weight? In a recent article in Health Affairs (“Learning from Patients’ Experiences Related to Diagnostic Errors is Essential for Progress in Patient Safety”), Giardina, et al discuss the importance of collecting patient feedback in gaining a comprehensive understanding of diagnostic errors and developing mitigation strategies.

Diagnostic errors are known to be underreported or poorly reported, in part because it is often difficult to identify when a diagnostic error has occurred. This article discussed the value of patients’ reports of their experiences of diagnostic errors. Unfortunately, most patient surveys do not address diagnosis-specific experiences, so the only avenue to identify these has been through patient complaints. Patient complaints are more often identified as indicators of satisfaction as opposed to safety triggers.

The Empowered Patient Coalition, a nonprofit organization that promotes patient advocacy and patient safety, began collecting patient experience data to learn about safety events from a patient’s perspective and to promote patients’ roles in improving the quality and safety of their healthcare. The Health Affairs article evaluated data from 465 patients or family members who reported a diagnostic error to the database between January 2010 and February 2016. Participants selected one or more of the following categories of safety issues: delay in diagnosis or treatment; misdiagnosis; proper tests not ordered; test results lost, misplaced or disregarded; and lab/pathology errors. 79.9% of reported diagnostic errors occurred in a hospital. About three quarters of the narratives reflected problematic clinician behavior related to the diagnostic process and not consistent with patient-centered care. 224 of the incidents reflected four themes of problematic behavior:

• Ignoring patients’ knowledge – 92 narratives mentioned instances where patients or their families felt clinicians had ignored or dismissed their reports of clinical clues such as worrisome symptoms, changes in patient status or failure to improve, resulting in diagnostic errors;
• Disrespectful clinician behaviors included belittling, mocking, behaving rudely and stereotyping patients;
• Failing to communicate included descriptions of ineffective communication styles as well as outright refusal to speak to patients/families; and
A number of hospitals have implemented communication-and-resolution programs (CRPs) as a means of enhancing transparency with patients after adverse events. CRPs involve communicating with patients about adverse events, investigations and explanations of what happened, and, when appropriate, proactively offering compensation. In addition to regulatory mandates to disclose errors and the push for more transparency in healthcare, there is also some evidence that implementation of CRPs has resulted in substantial improvements in liability outcomes and costs. In an effort to evaluate the effects on liability of CRP implementation, Kachalia, et al published an article entitled “Effects of A Communication-And-Resolution Program on Hospitals’ Malpractice Claims and Costs” (*Health Affairs*, November 2018).

Starting in late 2012, a CRP known as CARe (Communication, Apology, and Resolution) was implemented at four Massachusetts hospitals. Baystate Medical Center and Beth Israel Deaconess Medical Center are two large, urban academic medical centers (AMCs) involved in CARe, and two of each centers’ community hospitals were also included. Kachalia, et al evaluated the liability outcomes at both AMCs, and for two of the community medical centers.

CARe was designed by a coalition of participating Massachusetts hospitals and stakeholders from the state medical society, patient safety organizations, liability insurers, the state bar association and academic researchers that came together to form the Massachusetts Alliance for Communication and Resolution following Medical Injury.

A review of 989 CARe events concluded that adherence to the CARe protocols was high with regard to the program’s key elements: disclosing adverse events, relaying investigation findings to patients and offering compensation when prespecified criteria were met. 74% of events did not involve violations of standards of care, indicating that the hospitals did not selectively apply the process to events for which they expected to be held liable.

The study included 2,300 claims that included participating AMCs and community hospitals and comparison hospitals. All hospitals studied had similar patient mixes in terms of sex and age of patients. The case mix index was higher at AMCs than at the community hospitals.

The study found that implementation of CRPs at these 4 hospitals was associated with improved trends in rates of new
claims at most sites and in defense costs at the two AMCs. The implementing hospitals did not experience the reduction in claims costs or trends that earlier CRP adopters did. These hospitals were able to change their approaches to medical injury response to foster patient safety improvement without adversely affecting liability costs.

SENTINEL EVENT TEAM UPDATES

Happy Holidays to all!