

## Joint Commission Steps Up Efforts to Reduce Wrong-Site Surgery

By: [MARY ELLEN SCHNEIDER, Hospitalist News Digital Network](#)

07/07/11



Procedures performed on the wrong side of the body, the wrong site, and even the wrong patient continue to happen at a national rate as high as 40 times every week, according to Dr. Mark R. Chassin, president of [the Joint Commission](#).

"Awareness about the problem has increased, but we clearly have to do more to get a lot closer to zero," he said during a recent teleconference.

One indication that things are moving in the right direction is the improvements seen at Rhode Island Hospital in Providence. In November 2009, the hospital was facing a [\\$150,000 fine](#) from the state health department and an order to install video cameras in all of its operating rooms following reports of five wrong-site surgeries in 2 years.

Today, officials at the hospital say they have changed their ways and they have the safety record to prove it. There have been no wrong-site surgeries at the hospital in about 20 months, according to Dr. Mary Reich Cooper, senior vice president and chief quality officer for Lifespan Corp., which owns Rhode Island Hospital.

"We were able to show the front-line staff – as well as the surgeons and the patients coming into the hospital – that not only was safety our first priority, but we [also] were prepared to put a tremendous amount of resources into making safety our first priority," Dr. Cooper said.

Lifespan's Rhode Island Hospital is one of eight hospitals and ambulatory surgery centers that are working with the Joint Commission's [Center for Transforming Healthcare](#) on a project to reduce wrong-site surgery. As a result of that project, which started at Rhode Island Hospital in 2009, The Joint Commission has released a set of potential causes of wrong-site surgery and the targeted fixes that hospitals and surgery centers can use to eliminate them. The plan is to begin adding those interventions to a [Targeted Solutions Tool](#), an electronic application that allows all accredited or certified organizations to access the information and customize it.

The results of the project will give hospitals and surgery centers around the country a road map for pinpointing and measuring their risks of wrong-site surgery, said Dr. Chassin. He advised hospitals to start reviewing risks at the very beginning of the process, when an operation is scheduled. The Joint Commission's project revealed that in 39% of cases, errors that increased the risk of wrong-site surgery were introduced during the scheduling process.

The scheduling process is ripe for errors, Dr. Chassin said, because the person supplying the patient and procedure information typically works in the surgeon's office and often is not directly affiliated with the hospital or center where the surgery will take place. If that person is dealing with many different hospitals and surgery centers, all with different processes and requirements, it's easy to get confused and relay incomplete or inaccurate information, he said.

And the scheduling process is just one area identified by the Joint Commission as having potential for errors that could lead to wrong-site surgery. The eight pilot organizations, some of which have never had a wrong-site surgery in their

facility, found risks in all phases of their surgical processes ranging from inconsistent procedures for marking the surgical site to omissions in the "time-out" process just before surgery.

"It turns out that this is a much more complicated problem than it might seem to be at first," Dr. Chassin said.

But developing specific fixes for each of those risks has helped to sharply reduce the chances of wrong-site surgeries at the eight pilot sites, Dr. Chassin said. For example, addressing documentation and verification issues in the preoperative holding areas decreased the percentage of cases with risks from a baseline of 52% to 19%.

At Rhode Island Hospital, efforts were made to improve the "time-out" before surgery. All other activities were stopped to allow operating room personnel to focus, and they used a script to ensure that all last-minute safety checks – such as asking everyone in the operating room if they could see the surgical mark – were completed, Dr. Cooper said.

The Joint Commission has been working on wrong-site surgery for a number of years, issuing Sentinel Event alerts in 1998 and 2001 and developing the [Universal Protocol](#), a standardized approach to eliminating risks for wrong-site surgery.

Dr. Chassin urged hospitals and surgery centers to perform a systematic assessment of their surgical processes even if they haven't had a wrong-site surgery. "The magnitude of the risk is often unknown," he said. "Health care facilities and physicians who ignore this fact, or rely on the absence of such events in the past as a guarantee of future safety, do so at their own peril."

The following are commonly identified errors from the Joint Commission – and their solutions:

- **Error:** Schedulers accept verbal requests for surgery information.

**Solution:** Use a single fax number for scheduling.

- **Error:** Someone other than the surgeon marks the site.

**Solution:** The surgeon marks the site in the preop area.

- **Error:** Time-outs don't occur if there are multiple surgeons.

**Solution:** Complete separate time-outs for each new surgeon.

- **Error:** Staff isn't empowered to ask questions.

**Solution:** Share data and let the team ask questions.

- **Error:** Staff rushes during patient verification.

**Solution:** Explain why standardized processes are important.

- **Error:** The briefing process is ineffective.

**Solution:** Do a preop briefing in the OR with the patient.

- **Error:** Staff is distracted during the time-out.

**Solution:** Perform a standardized time-out and stop all other activities.

For a full list of the 29 main causes of wrong-site surgery, go to the [Joint Commission Center for Transforming Healthcare](#) website.

Copyright © 2011 International Medical News Group, LLC. All rights reserved.

This page was printed from [www.EHospitalistNews.com](http://www.EHospitalistNews.com) . For reprint inquires, call 877-652-5295, ext. 102.