Preventing Wrong Site Surgery

Karin Bierstein, J.D., M.P.H.
Associate Director of Professional Affairs

The surgical time-out is an important patient safety protocol that many hospitals and operating teams are not yet implementing correctly. Beverly K. Philip, M.D., Professor of Anaesthesia at Harvard and the Brigham & Women's Hospital in Boston, is also an ASA liaison to the Joint Commission and a member of ASA's Committee on Quality Management and Departmental Administration (QMDA), has been participating in a special Joint Commission workgroup seeking consensus on enhancing the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.™ This column describes the three areas of particular concern to anesthesiology targeted by Dr. Philip:

1) The time-out is currently performed immediately prior to incision, instead of before the induction of anesthesia. Prior to induction, the patient can assist in identifying the correct site and all surgical preparatory processes can still be modified;

2) There has been a sharp increase in the reported frequency of wrong-site nerve blocks; and

3) The concern that placing additional items in the "time out" (e.g., antibiotic administration, patient positioning or availability of specific instrumentation or prostheses) as part of an "extended time out," might deflect attention from the primary purpose of the "time out' and decrease its effectiveness.

ASA's responses and the QMDA Committee's recommendations also appear below.

The need to examine the practical implementation of the surgical time-out or "pause" is borne out by communications such as the following note from a QMDA team completing a site visit under our Anesthesia Consultation program earlier this year:

> *"Last week we performed a consultation visit at a hospital threatened with immediate revocation of accreditation after a Joint Commission surveyor witnessed surgery with inadequate time-outs and other improprieties, such as operative reports completed before the surgery.*
>
> *"The hospital gave patients pens preoperatively to mark themselves where they thought the surgeons should operate. The anesthesiologists, surgeons, and nurses stayed remote, confused about the whole process."*

While rare, wrong-side amputations and other procedures are devastating to the patient – and to the clinicians who feel responsible for the accident. A steady rate of six or seven Sentinel Event reports each month to the Joint Commission is more than enough to have warranted an examination of the barriers to implementation of the Universal Protocol.

2007 Joint Commission Wrong-Site Surgery Summit

In February, the Joint Commission, the American College of Surgeons, the American Medical Association and several other organizations convened a special "summit" on wrong site surgery to discuss "Why the Universal Protocol Isn't Working and What Should Be Done." Dr. Philip attended on behalf of ASA and heard, among other presentations, a review of Sentinel Event statistics that showed worrisome time-out problems involving both general anesthesia and nerve blocks. Dr. Philip reported to QMDA that the Joint Commission had identified "Anesthesiology" as a discipline with a new spike in wrong site reports, specifically, wrong–sided peripheral nerve blocks, which increased from 2 percent of reports by specialty from 1995-2005 to 16 percent in 2006.

As a result of this information, ASA President Mark J. Lema, M.D., Ph.D., wrote a letter to the Joint Commission stating that "Wrong-side nerve blocks should never happen" and that "The American Society of Anesthesiologists wants to take the leadership role in addressing this issue, to develop processes that will enhance the Universal Protocol and eliminate the occurrence of these sentinel events."

The disturbing growth of wrong-sided nerve blocks was not the only matter of concern to anesthesiology at the February summit. Dr. Philip, along with many of her experienced physician colleagues, vigorously opposed the concept

Karin Bierstein, J.D., M.P.H., advises ASA committees and members on health policy and practice management strategies.

A Note from James S. Hicks, M.D., M.M.M., Chair of Committee on QMDA

The accompanying article represents a status report on the ongoing effort of the Committee on Quality Management and Departmental Administration to address the "wrong site surgery/wrong site block" prevention initiative. Several months ago, ASA was invited to attend the first Wrong Site Surgery Summit since 2003, and Beverly K. Philip, M.D., was appointed to represent the committee and ASA. There have been numerous exchanges of opinion since the summit, and recently Dr. Philip attended a follow-up summit via conference call. This article articulates the position the committee has taken with regard to anesthesiology's involvement in the prevention of both wrong site surgery as well as wrong site blocks, a topic much more immediate for many anesthesiologists.

ASA is indebted to Dr. Philip for her efforts in representing ASA on this issue (and many similar issues in the past), and also to Karin Bierstein, J.D., M.P.H., Associate Director of Professional Affairs, for her contributions to this article and the "Practice Management" column as a whole for the past 12 years. This is Ms. Bierstein's final "Practice Management" column in the *ASA NEWSLETTER* as she enters private industry this month. ASA is most fortunate to have had her considered opinions and dedicated service and, on behalf of the members of ASA, the members of QMDA with whom she has worked on many projects, wish her the greatest success in her new endeavors.

of the "Extended Time Out," a highly prescriptive protocol for verification of the availability of antibiotics, special instrumentation and/or prostheses and other checklists. The Extended Time Out has the potential to detract from the primary purpose of preventing wrong patient, wrong procedure and wrong site events.

Most important of all is the concern regarding when the time-out should occur: prior to induction (or placement of the nerve block), prior to incision, or both. What is the best time to ensure patient safety? Following a June 22 conference call between the Joint Commission Summit participants, and much discussion with the other members of the QMDA Committee, Dr. Philip sent a letter to the Commission's Peter Angood, M.D., reaffirming ASA's intent to help lead the effort to address the spectrum of wrong-site events as well as QMDA's unanimous opinion that the time-out must precede the administration of the anesthetic. See Figure 1.

Figure 1. ASA's Message to the Joint Commission

"We strongly concur that the Time Out should occur before the related anesthetic — before the patient undergoes risk from an anesthetic that may not be optimal for the true procedure needing to be done. The Time Out should occur before all preparatory processes such as positioning, prepping and draping are already completed, and while changes can still be easily made."

— Letter dated June 26, 2007, from Beverly K. Philip, M.D., to Peter Angood, M.D., Vice-President and Chief Patient Safety Officer at the Joint Commission

RAND to Launch Survey of Anesthesia Workforce Issues

The RAND Organization is about to undertake a survey of anesthesiologists and other providers to study workforce patterns and drivers. ASA has provided significant assistance with the development of the survey instrument and has given the RAND researchers the right to send out the questionnaire to all members for whom we have e-mail addresses. Dr. Lema and the other members of the ASA Executive Committee have examined this project closely and believe that future publication of the data sought will be valuable to the society and the membership.

Please give the RAND survey all due consideration. We are pleased to note that RAND has offered to make a $50 contribution to selected anesthesia foundations for each questionnaire completed and returned by an ASA member.

Solutions for Anesthesiology Practices and Patient Safety Policy Makers

ASA is seeking a seat on the Joint Commission's Sentinel Event Advisory Group and fully intends to continue to lead medicine in patient safety initiatives that will reduce the incidence of wrong-site surgery. As the Joint Commission begins to draft a new version of the Universal Protocol, Dr. Philip and other QMDA members will be watching that all changes serve to promote quality patient care.

By placing on the record ASA's firm conviction that patients should be awake so that they can identify themselves and help the surgical team determine the correct procedure and operative site, we hope that anesthesiologists in operating rooms across the country will be able to refer to the work of Dr. Philip and other QMDA experts in quality management in persuading surgeons that the time-out must be conducted by the entire team in the presence of the awake patient.

While patients have made mistakes too, there are several sound arguments to be made for an increased margin of safety if the time-out occurs prior to induction: First, the confirmation directly FROM THE PATIENT of identity, procedure and, when appropriate, laterality cannot help but add an additional element of safety. Next, should there be discrepancies in any element, these may be corrected without the risk of prolonged anesthesia or worse, the necessity for awakening an anesthetized patient. Finally, there is the enhancement of comfort, confidence and satisfaction for the patients who are made aware of the additional precautions taken for their safety.

It is also the view of QMDA that a two-step time-out protocol tends to be counterproductive. If the anesthesiologist and other members of the O.R. team perform the first time-out prior to induction and then are expected to participate in a second pre-incision time-out once the attending surgeon has arrived, it will be difficult for them to treat both pauses with the seriousness each deserves. The one exception may be for a two-surgeon procedure, when the first surgeon hands off to a second surgeon who was not involved in the single original time-out. A QMDA Committee member noted, though, that there had been a near-miss in his O.R. when a patient was shifted to a prone position in between surgeons.

Conclusion

The rate of occurrence of wrong site surgery and the spike in wrong site nerve blocks is of much concern. We are fortunate that Dr. Philip and her colleagues are taking an active part in seeking to improve the text and the implementation of the Universal Protocol. All anesthesiologists are urged to be vigilant — to do your part to prevent the tragedies resulting from surgery performed on the wrong patient, without due attention to the specific procedure intended, or on the wrong site.

Source Material:

- Letter from Beverly K. Philip, M.D., to Peter Angood, M.D., Vice President and Chief Patient Safety Office, Joint Commission, June 26, 2007. www.ASAhq.org/Washington/pmhomepage.htm
- Joint Commission: Universal Protocol text, Implementation Expectations, FAQs and other materials at www.jointcommission.org/PatientSafety/UniversalProtocol/