



Same-Day Surgery®

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IN THIS ISSUE

- Authority finds problems with crash carts. cover
- Steps to take with geriatric patients 101
- **SDS Manager:** "New" procedures you might want to add. 102
- **Benchmarking report:** Major causes of surgical malpractice 103
- Best strategy to prevent retained items 106
- **Enclosed in this issue:** 2010 Salary Survey

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Are you ready for an emergency? Don't get caught unprepared

Equipment, supplies often unavailable in life-threatening emergency—Supplies that were the incorrect size. Missing items. Empty oxygen tanks. Drained batteries on equipment. Unstocked or unlocked crash carts.

These actual incidents were reported to the Pennsylvania Patient Safety Authority, which recently released a data review of 2008 reported safety events.¹

"Emergency equipment and supplies often are not readily available when a patient experiences a life-threatening emergency," the authority said.

The authority identified 56 reports related to emergency equipment. Thirty-five dealt with emergency carts, and 21 dealt with missing supplies or malfunctioning equipment during an emergency. The issue of having rapid access to these items is common, says **Franchesca J. Charney, RN, MSHA, CPHRM, CPHQ, CPSO, FASHRM**, director of educational programs at the Pennsylvania Patient Safety Authority in Harrisburg. The reports come from hospitals, ambulatory surgery facilities, birthing centers, and certain abortion facilities. PA nursing homes report health care-associated infections only.

EXECUTIVE SUMMARY

The Pennsylvania Patient Safety Authority identified 56 reports of events over 12 months related to emergency equipment. Thirty-five dealt with emergency carts, and 21 dealt with missing supplies or malfunctioning equipment during an emergency.

- Have a team evaluate the needs of the unit/facility.
- Select appropriate equipment and supplies. Many facilities use a standardized checklist for the crash cart. (A checklist is included with the online issue of *Same-Day Surgery*.)
- Have a written plan.
- Train your staff, including the location and use of emergency supplies. Hold at least one or two mock drills annually.



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“The practice that I have seen used most successfully is daily assignment of this duty to staff personnel,” Charney says. “This assignment will become part of the daily duties of the assigned individual and therefore help to ensure functioning equipment and up-to-date supplies.”

Chris Lavanchy, engineering director of the Health Devices Group at ECRI Institute, which helped conduct the data review, says, “When there’s an emergency, afterward you have to replace supplies. You also have to make sure

they’re within the expiration date.”

Clinical staff might find this is a lower priority and somewhat of a monotonous task, Lavanchy warns. “If you did it every day, and you don’t find something specifically with an expired expiration date, you may become complacent,” he says. To avoid that situation, have oversight, Lavanchy advises. For example, an administrator periodically can check inventory to make sure it’s being kept up to date, he says. Also, periodically rotating this staff responsibility offers others the opportunity to learn, and fresh eyes might see more, experts say.

Consider these additional preparedness strategies:

- **Convene a team to evaluate the needs of the unit/facility.**

Who is on this team depends on your population and facility type, according to Charney. “However, you most certainly need the care providers who would respond to the emergency situation,” she adds.

- **Select appropriate equipment and supplies (e.g., automated external defibrillators).**

“You want to again focus on the population you serve, but most importantly you need to re-establish the airway and circulation,” Charney says. “You would then want to choose the appropriate equipment for your population and clinical staff skill level — intubation equipment/ventilator versus oral airways/ambu bag.”

For the crash cart, many facilities use a standardized checklist, the authority said. (A sample checklist is available with the online issue of Same-Day Surgery. For assistance, contact customer service at customerservice@ahcmedia.com.) Miami Children’s Hospital used Microsoft’s SharePoint software to develop a Web-based crash cart tracking system. The system sends nurse managers three notifications daily, beginning at noon, of which carts have not been checked, according to the authority. Monthly cart checks alert staff to any item near expiration, it said.

To avoid shortages of supplies and equipment, The Joint Commission recommends facilities use a continual process to manage its inventory, the authority said. The Accreditation Association for Ambulatory Health Care (AAAHC) requires adequate equipment, supplies, and medications be available as part of providing a safe environment for delivering care in ambulatory surgery centers (ASCs).

Jack Egnatinsky, MD, a surveyor, new surveyor faculty, and a medical director of AAAHC from Christiansted, U.S. Virgin Islands, says, “With

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Editorial Questions

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the current shortages of many drugs and medications used in ASCs, our surveyors generally do ask about how the organization is handling this in their organization.”

- **Train and educate staff.**

Document your training, and periodically retrain your staff, the patient safety authority advised.

Consider your population, Charney advises. For example, if you serve pediatrics, your staff should be certified in pediatric advanced life support (PALS). If you serve an adult population, you may have advanced cardiac life support (ACLS) certification. Be sure to include your anesthesia providers in such certification, as well as training, since they often “lead” the response to the code, experts advise.

Also consider training on emergency supplies, Charney says. “This training within the environment where the emergency situation may occur is very helpful to staff in terms of education of where supplies are, what equipment needs to be moved in or out of the room, etc.,” she says.

Standardizing drug and crash carts, so the same items are in the same drawers in the same order where possible, cuts down on confusion and saves time, experts advise.

Also consider training on how to activate an automated external defibrillator (AED), Charney says. “This may be a suggestion for facilities/ locations where defibrillators are infrequently used or in an area where staff do not have rhythm recognition skills and would not be able to use a manual defibrillator,” Charney says. “Some of my peers have noted acute care facilities’ transformation to AEDs [automated external defibrillators] in public areas and areas where clinical staff is not familiar with manual defibrillators.”

The patient authority strongly encouraged staff education any time new equipment is brought into the clinical area, she says. “This education may be done by the manufacture or an educator and may include troubleshooting of the equipment as well,” Charney says.

Make sure equipment is maintained so it can be used when needed, Lavanchy emphasizes. For example, follow manufacturer instructions for checking defibrillators, he says.

- **Maintain a state of readiness (e.g., through mock drills).**

“I really like mock drills,” Charney says. “You learn so much. The team learns, and issues are addressed immediately so when it is not a mock drill the team reacts in a more predictable response.

Mock drills can help identify problems with protocols or equipment, the authority said. All staff on all shifts should participate in at least one annual mock drill, the authority says, but consider holding such drills at least twice a year.

Holding a mock drill for malignant hyperthermia allows staff to experience how to mix drugs correctly, experts point out.

For drills and code responses, have a “recorder” who writes down times actions are taken and which drugs were administered, experts advise. Such recordings help with reviews, they say.

Charney says, “Hold unannounced mock drills, tape the drill, and then have the team review the drill and answer the questions: one, what did we do well, and two, what do we have the opportunity to improve.” (For information on developing a written plan, see story, p. 99. For list of items to consider when evaluating your ability to manage a clinical emergency, see p. 100.)

REFERENCE

1. Pennsylvania Patient Safety Authority. Clinical Emergency: Are You Ready in Any Setting? PA Patient Saf Advis 2010; 7:52-60. Accessed at [www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7\(2\)/Pages/52.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7(2)/Pages/52.aspx). ■

How to establish a written plan

Avoiding problems during an emergency

What’s the most important facet of addressing emergencies?

“I think the key issue here is dealing with emergencies, you really need to have protocols in place in advance that you’ve covered,” says Chris Lavanchy, engineering director of the Health Devices Group at ECRI Institute. “That’s a fundamental tenet of dealing with emergencies effectively.” ECRI Institute helped conduct a review of 2008 safety events reported to the Pennsylvania Patient Safety Authority.¹

The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC) require a written plan for emergencies. In developing a written plan, ask these questions, the patient safety authority suggested:

- When was the clinical emergency or rapid response plan reviewed?

- Do staff know that a plan exists? Do they adhere to the plan? Is it included in new employee orientation?

- Considering the clinical services and procedures performed on the unit, is the plan current and appropriate?

According to the authority, the written plan should include the following: clinical protocols and details on where and how the emergency care should be delivered. "Protocols should account for the emergency skills of each employee and the assignment of each employee to specific responsibilities," the authority said.

At a minimum, a written plan addresses equipment, supplies, medications, ordering and maintenance, emergency protocols, training and competency of staff, emergency drills, and assignment of responsibility for continued oversight of the process, according to the authority, quoting as its source MAG Mutual Insurance Co.

Designate a location for emergency care and for storing emergency equipment, the authority advises. If your layout makes this step difficult, you can make the emergency portable, such as on a rolling cart, and store in a common location.

According to the authority, components to consider for a written plan include:

- How will staff notify others in the clinical area to a life-threatening emergency?
- Who will contact the code team, the rapid response team (RRT), or EMS?
- Who will bring the emergency supplies to the scene?
- If the patient requires a backboard, is staff trained and competent in how to position the patient?
- Who will initiate cardiopulmonary resuscitation (CPR)? Who will assist?
- Who will document the emergency? In what format is documentation supposed to occur?
- Who will take vital signs?
- What information should be provided to EMS, the code team, or the RRT? Who will assemble that information?
- Who will start an intravenous line, if necessary?
- Who will help set it up?
- Who will administer medications?
- Who will assist family members during an emergency?
- How will staff be educated about the emergency plan?
- How often will practice drills be conducted?
- Who is responsible for the supplies (e.g., inventory and maintenance)?

- Who will manage other patient needs on the floor during the emergency?

REFERENCE

1. Pennsylvania Patient Safety Authority. Clinical Emergency: Are You Ready in Any Setting? *PA Patient Saf Advis* 2010; 7:52-60. Accessed at [www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7\(2\)/Pages/52.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7(2)/Pages/52.aspx). ■

Evaluate Ability to Manage Emergency

9 areas to evaluate

- What is the patient population and age range of the unit?
- What types of procedures are performed in the clinical area (e.g., invasive procedures, cardiac testing)?
- Are injectable drugs administered?
- How comfortable and skilled in emergency care are the physicians?
- Is staff trained in and competent to assist with emergency care?
- What equipment, drugs, and supplies are available? What additional equipment, drugs, and supplies might be required?
- Where are the supplies kept? How often are they inventoried and updated?
- What is the location of the clinical area in relation to emergency care at a hospital, and what is the typical response time for those attending the emergency?
- If the facility is located outside of a hospital, how long does it take the emergency medical services (EMS) in the area to respond?

SOURCES:

- Pennsylvania Patient Safety Authority, Harrisburg.
- Wisehart C. Office preparedness for emergency care. 2004 Oct [cited 2009 Apr 28]. Accessed at www.magmutual.com/mmhc/articles/2004_10_24_office.pdf ■

Ways you can tackle concerns with geriatrics

Geriatric patients can present a host of challenges in outpatient surgery. In addition to concomitant chronic diseases and multiple medications, there might be information literacy issues and concerns about the patient's home care after surgery, says **Kathryn Parrish, RN, MSN**, assistant professor of nursing at North Georgia College and State University in Dahlonega, GA.

To address the issues of caring for geriatrics, the Association of periOperative Registered Nurses (AORN) has released a position statement on care of the older surgical patient (www.aorn.org/PracticeResources/AORNPositionStatements/OlderAdult). Consider these points from that statement:

- **Cognitive decline may limit older adults' ability to participate in informed consent and the identification verification processes.**

Don't assume all older adults are confused, says **Bonnie G. Denholm, RN, BSN, MS, CNOR**, perioperative nursing specialist at the Nursing Department, AORN.

"Give them the benefit of a doubt," Denholm says. "But if they're confused about which side, give them some basic mental checks: time, date, place, where are you." If the patient exhibits any confusion about this information, that's a red flag, she says.

Have an informed consent policy that addresses what happens when the patient doesn't appear to be informed about what's happening, she says. This aspect of care shouldn't be different than with any other patient. The goal should be to not show prejudice against older adults, Denholm says. "There should be the same type of assessments with every patient," she says.

- **Slowed motor skills, limited range of motion, and a decline in strength and coordination increase the risk for injury from falls or positioning.**

Be attentive to the possibility of falls, especially in patients having eye surgery where their vision will be impacted, Denholm advises.

Be aware of a patient's history of bone loss, and change positioning or transferring procedures as needed, Parrish says. Assess the patient's stability, Denholm says. If the patient was walking with a cane upon admission or describes occurrences of dizziness, these are indicators of a need for further assessment of medication, nutritional status, and

muscle weakness, she advises.

Elderly patients are at a higher risk of fracturing a bone if they fall or are positioned inappropriately, Parrish says. "There are osteoporotic patients who are standing; their hip bone breaks, and they fall," Parrish says. "It's not always related to an actual fall."

For this reason, positions or the way a patient is moved on the OR table can cause an injury or fracture, she says. Some ORs are attempting to go to a "no lift" environment in which the patient isn't moved from the stretcher/table so no transfers or lifts occur that could cause injury to the patient or staff, Parrish says.

- **Changes in the integumentary system put older adults at greater risk for chemical or thermal burns and pressure ulcers.**

Older adults can be injured when skin and muscles aren't as well padded as they should be, Denholm points out. AORN has a positioning recommended practice, she says. (For ordering information, see resource box, p. 102.) That document covers risk factors for falling and patient assessment for pressure ulcers and positioning, Denholm says.

Even in outpatient surgery, pressure ulcers are a risk, Parrish says. "It does not take long for an area to have decreased blood flow due to positioning and begin to cause tissue damage," she says.

Also, the risk is great for geriatrics who have nutritional deficits or have been taking medications that impair skin integrity such as blood thinners and steroids. "Shearing is a problem as well," Parrish says. "Pulling a patient across the sheets or pulling them up in bed causes friction and can create impaired skin."

The amount of time a patient remains in one position in the OR is critical in preventing pressure ulcers, she says. "A change in position should probably be done every two hours," Parrish says. "Also, padding and protecting bony prominences may help."

EXECUTIVE SUMMARY

While not all geriatric patients are the same, staff should be aware of potential issues such as fall potential and information literacy.

- Be alert for any confusion during the informed consent process.
- Be aware of a patient's history of bone loss, assess the patient's stability, and pay attention to positioning.
- Determine whether the patient has reliable home help, and assess hydration and nutritional needs.
- Be aware of medications, interactions, and allergies.

- Decline in functional status may affect discharge planning and recovery needs.

One of the biggest considerations with elderly patients is whether they have reliable help at home, Denholm says. Perform a thorough psychosocial assessment, she advises. “The person having surgery may be a primary caregiver,” she says. The patient might be the person who runs the household, and there might not be anyone else at home to take care of them.

Also emphasize hydration and nutritional needs, Denholm says. “They might be depleted going into surgery,” she says. Afterward, they might not have as good an appetite, Denholm says. They might not have things ready to eat after surgery, and they don’t always drink enough, she says.

Ensure elderly patients understand the discharge planning and instructions, Parrish says. An information literacy assessment is helpful to determine what the patient knows, what the patient doesn’t know, whether they can review or access information and resources, and if they know what to do with the information, she says.

- The aging process may affect pharmacokinetics and pharmacodynamics (e.g., absorption, distribution, metabolism, excretion), putting older adults at risk for adverse drug events.

Avoiding adverse drug events basically comes down to understanding the patient’s medications, understanding what new medications are coming, and knowing what the interactions might be, Denholm says. “In the outpatient setting, you don’t always have a pharmacist to help you determine that,” she says. In some cases, anesthesia staff can help, Denholm says. Regardless, staff need to be aware of the patient’s medications and allergies, she says.

Provide the patient with a copy of the drug information, Parrish advises.

Keep in mind that with elderly patients, one size doesn’t fit all, Parrish says.

“A healthy geriatric patient will differ from one that has chronic diseases,” Parrish says. “As long as we do adequate patient teaching, and the patient understands and follows directions, the less likely we are to have an adverse event.” ■

RESOURCES

Perioperative Standards and Recommended Practices, 2010 Edition is available from the Association of periOperative Registered Nurses (AORN) in book, CD-ROM, and e-document formats. Go to www.aorn.org/PracticeResources/AORNStandardsAndRecommendedPractices.

Same-Day Surgery Manager



Let’s take a relook at old procedures

By Stephen W. Earnhart, MS
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There is an interesting thing happening, seemingly nationwide. Outpatient surgery is off — way off! Some centers are reporting as much as a 23% decrease over last year.

The first thing that comes to mind is that, for the most part, much of outpatient surgery is elective. If you don’t have a job, you’re worried about losing a job, or you don’t want to take time off because some backstabbing office creep will take your job as soon as you take sick leave, you might postpone surgery. On the flip side, inpatient surgery is up over the same time period.

So, let’s find a way to get more surgery into your hospital or surgery center from procedures that you might not have been attracted to before. Below are some real questions from clients:

Question: We have been approached by a group of dentists that want to use our surgery center to provide routine dental care to children and adults in the community. They tell us that many patients need general anesthesia for the more basic and routine dental care, including cleaning, fillings, extractions, and the like. We are skeptical and don’t know if we want to do this. Do you know of any others that are doing these types of cases, and are they financially viable?

Answer: Yes. We know of many centers that are providing this service. Some things you need to know though. Since almost all of these cases are under general anesthesia, they need to be done in the operating room, not a treatment room like the group told you.

While the overall supply cost is low, often under \$45 per case, you need to factor in the cost of the general anesthesia drugs and gases. Reimbursement, especially under the “special needs programs,” generally are funded through

Medicaid, and payment varies greatly from state to state. Because it is difficult to attract providers to perform these important cases, often the reimbursement can be profitable. One difficulty is finding anesthesia providers willing to do the cases.

Question: We have shied away from doing urology cases at our center because of the low reimbursement and the need for a “wet room.” We understand that a wet room with the floor drain essentially restricts cases that can be done in that room, which is a real issue for us. What have you found around the country when it comes to urology cases?

Answer: Actually, you are missing the boat by not looking at urological procedures, of which there are many! The issue of the “wet room” is solved a couple of different ways that eliminates the need for that floor drain, thus eliminating the restriction for other cases. One method is a collection method that turns the fluid into a jell-like substance that is tossed at the end of the case. The other method is using a self-contained drainage table.

Many of the urology cases are quite lucrative in reimbursement. Ask the urologist for the CPT or ICD-9 codes, and look up the reimbursement. I think you will be pleasantly surprised.

Question: Is lap band still a viable surgical procedure for the OR? We have surgeons asking for equipment, but we don't want to get sucked into buying more equipment and no one using it.

Answer: Welllllllllll ... look up the gastric sleeve procedure. It is rapidly gaining in popularity. Unlike the reversible gastric bypass or the lap band with which you lose weight rapidly but can cheat, the gastric sleeve (vertical sleeve gastrectomy or VSG) results in removal of two-thirds of your stomach. The result is that your stomach cannot stretch anymore, and you don't overeat. The weight gain is slower than with the other two methods, and a plus from that slow weight loss is the avoidance of saggy skin. So before you invest, ask them about this procedure.

While this might not increase your overall surgery from last year, any time you have the chance to look at a new procedure, you increase your opportunity to perform more cases. [Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Tweet address: Earnhart_EAI.] ■

Study shines light on malpractice causes

Patient expectations often at the root of problems

A benchmarking report on some of the major causes of surgical malpractice cases has provided information that hospital quality managers and risk managers can use to improve performance and reduce adverse events.

For example, among its findings is the fact that risks are inherent in all stages of the surgical process, from issues related to preoperative decision-making, to technical issues in the operating room, to those that occur postoperatively such as recovery management and communication. It also highlights that errors leading surgery patients to allege malpractice primarily are due to narrow clinical judgment, poor technical performance, or miscommunication among team members.

However, it does more than point out causes of malpractice cases, says **Larry Smith, JD**, senior vice president of risk management for Columbia, MD-based MedStar Health. “This report represents what I hope is an indication of a new way for all of us in health care, including those who work in claims programs, to look at the causation of these events differently than we have in the past so we can do something to stop these preventable adverse events from happening,” Smith declares.

The report, titled *Annual Benchmarking Report: Malpractice Risks in Surgery*, was produced by RMF (Risk Management Foundation) Strategies, a division of CRICO/RMF, the medical malpractice insurer for the Harvard medical institutions. Based on data from 3,300 surgery-related medical malpractice cases that closed from 2003 to 2008, it is designed to provide facilities nationwide with insight into areas of medical malpractice across the surgical spectrum so that leaders, physicians, and surgical staff can identify areas of vulnerability and implement programs to improve patient safety.

Bob Hanscom, JD, is vice president of loss prevention and patient safety at RMF and the driving force behind RMF Strategies' Comparative Benchmarking System (CBS), which published the report. “Malpractice cases are a very small tip of the iceberg, but below the surface are a lot of vulnerabilities,” he says. “The tip is a ‘divining rod’ guide to where the risks are. You can actively use the analysis of these cases and help drive change.”

Key findings of the report

A recently release benchmarking report on some of the major causes of surgical malpractice cases found that risks are inherent in all stages of the surgical process, from issues related to pre-operative decision-making, to technical issues in the operating room, to those that occur postoperatively such as recovery management and communication. It also highlights that errors leading surgery patients to allege malpractice are primarily due to narrow clinical judgment, poor technical performance, or miscommunication among team members.

It “really relates to this whole ‘allegation’ category of technical error,” says **Bob Hanscom**, JD, vice president of loss prevention and patient safety at RMF Strategies, a division of CRICO/RMF, the medical malpractice insurer for the Harvard medical institutions and the driving force behind RMF Strategies’ Comparative Benchmarking System (CBS), which published the report.

“Of course [provider error] is alleged in a lot of malpractice cases, but when you look at the facts, you’re not always sure it occurred,” Hanscom says. “What you do see are outcomes the patient or family was simply not expecting.”

Sometimes patients could not distinguish

between a normal risk of complication or an error, he says. “It may have been covered in informed consent, but done in such way that most patients or families do not understand how much risk there really is,” says Hanscom. “Communication really needs to happen with patients ahead of time, so they are much more aligned with the reality of what they are undergoing.

Some procedures are much more risky than they understand them to be.”

The second key point raised in the study is that “there are errors that occur, which we believe are quite preventable,” Hanscom says. While some can be traced back to training or skills, he says, “there are a number of distractions in the operating environment that pull skilled surgeons away from concentrating on the procedure.” This raises “important opportunities for training or thoughts about the environmental factors surgeons operate under,” he says.

In addition, notes Hanscom, surgeons could be helped greatly by a much more team-based environment.

“Many surgeons go into a room that has just turned over, with a team of nurses or techs whose names they do not know, and they try to do very high-level procedures,” he explains. “To me, I hope this study gives rise to having a much more structured way of getting surgeons and the people who help them aligned with each other; the data scream out for interventions along these lines.” ■

Smith is excited about the approach the report has taken.

“I may be appropriately accused of exaggeration, but I think this report is an indication of a revolution in the way we are using our claims data,” he says.

Smith notes that in April 2010 he made a presentation at a meeting of the Risk and Insurance Management Society (RIMS) about the “causation factors” that are now embedded in the claims management software his system uses.

“When cases are closed or mature enough for us to know enough about them, we are able to take the information and code causation into three categories: individual factors, or things individuals are responsible for; systems problems, where most quality folks have been focused for the last 10 years; and patient problems, such as noncompliance, where patients do something to cause their own outcome,” he says. “What I like about this approach is that we have gone from the ‘90s, looking at blaming individuals, to the 2000s and

blaming the system. Finally, in the next decade, we will focus on the fact that causation is complex, that it involves individual and systems failing and patients and their failings. And unless we look at it in this complex fashion, we lose the opportunity to put in place interventions to reduce and, hopefully, eliminate many of these errors.”

The report takes a similar approach, he says. “We took our data and ran the same analysis they ran for this report, and I was thrilled to see that when you take the elements there, their results are virtually identical to ours,” Smith says. So, when he looked in the report at clinical judgment, technical knowledge and skill, and communications -- three of the key factors leading to claims that fall under the “individual” findings -- the report data and his system data were virtually identical, Smith says. “For example, clinical judgment appeared in about 60% of the claims for the group they studied,” he notes. “When I look at our data for six years, it was anywhere from 54% to 79% of the cases, but the average came out to 60%.”

This way of looking at data “can help us look benevolently at innovation,” Smith says. So, for example, looking at individual failures is important, “because if you look at surgical preventable injuries, our individual clinicians are day in and day out asked to make critical decision about what route to take, what process to use, tests to order, how to treat certain conditions, and in 60% of malpractice cases that judgment is in question. It is a target for malpractice claims,” notes Smith. “So the question is, what can I do about that? I can do simulation training to get better and better and better at knowing what to do when faced with an emergency. I can do didactic teaching and e-training to help them understand the clinical judgment

issues faced in practice.”

The report also allowed him to bring to his board this information and say to them he believes he is on the right track, he says. “These data have more validity and say to me the focus we’re talking about on how to prevent errors is headed in the right direction,” says Smith, “and I can now garner more resources.”

[For more information on the surgical report, see stories on p. 105 and p. 106. The surgical report is available for free at www.rmfm.harvard.edu/files/documents/2009_annual_benchmark.pdf. For more information, contact Hanscom at (617) 679-1519; E-mail: rhanscom@rmf.harvard.edu.] ■

Report offers case studies, strategies

A recently released benchmarking report on some of the major causes of surgical malpractice cases is more than a gathering of statistics. There are suggestions of strategies that could help many health care facilities, including:

- the use of a surgical safety checklist;
- developing a unified curriculum and standards for simulation-based team training;
- creating interactive workshops using malpractice cases to help surgeons better communicate realistic expectations to patients and families.

The checklist was developed by Harvard’s Atul Gawande and the World Health Organization (WHO) about two years ago, says **Bob Hanscom, JD**, who is vice president of loss prevention and patient safety at RMF (Risk Management Foundation) Strategies, a division of CRICO/RMF, the medical malpractice insurer for the Harvard medical institutions and the driving force behind RMF Strategies’ Comparative Benchmarking System (CBS), which published the report.

“It’s not rocket science. A lot of industries do this to help reduce human error,” Hanscom says. “It makes sure that all of the I’s are dotted and T’s are crossed in terms of the interoperative and postop phases of care. It does not take a huge amount of time for a surgeon to be sure he or she adhered to protocols and did not leave anything undone.”

Hanscom acknowledges that there are other checklists out there, although he advocates the WHO checklist as the one that ought to be used. “People

have come up with shortened versions, and it’s kind of frustrating and a little amusing,” he says, “But we hope that wherever this lands, you really do have a safety net so patient care does not somehow fall through the cracks. That’s where we see the biggest problems arise: jumping over a step or failing to do something.”

Hanscom says the Harvard system already has used unified curricula and standards for simulation-based team training. The staff members, he says, were very enthusiastic and embraced the new approach. “Essentially it teaches all providers how to communicate in such a way that they do not lose information,” he says. “Every voice is heard, and everyone is accountable for follow-through on what they need to be doing. It’s a much more highly coordinated environment.”

The process involves role-playing, where a number of scenarios are acted out, he says. “Its experiential learning versus didactic learning, and the information seems to have much more ability to be embedded with the learner, and they learn much faster,” Hanscom says. “We are now trying to replicate that curriculum in the OR.”

He concedes that the OR environment is challenging, because it is very hierarchical. “Still, every voice needs to be heard, and that’s tough culturally,” Hanscom says. “But it involves open communication and a team-based environment, and if a ‘lowly’ tech sees something worrisome, they can speak up and be heard.”

Creating interactive workshops using malpractice cases “to help surgeons better communicate realistic expectations to patients and families” is part of this whole process, Hanscom explains. “We bring together all the players with malpractice case studies in front of them and use them to open discussion and analysis.” ■

Procedures, technology can prevent retained items

Retained items in surgery are a constant risk in the OR, and there still is no perfect solution. The best strategy is to combine more than one prevention method and tailor the effort to the particular type of surgery, experts say.

Despite designation as a never event, retained items are estimated to occur in one of every 1,000 to 1,500 abdominal surgical procedures, according to the Association of periOperative Registered Nurses (AORN), the Denver organization representing OR nurses. The costs to remove a retained foreign body can run up to \$50,000 per case, making it a substantial liability risk simply for the additional costs of surgery, not to mention the medical malpractice risk.

Though there have been sensational cases in which large objects, such as a 13-inch retractor, were left in patients' abdomens, the most common items left behind include sponges and towels, instruments and sharps, and device fragments, including pieces of wire or tubes.¹

The liability for such an error can be extensive. According to AORN, "the 'captain of the ship' doctrine is no longer assumed to be true, and members of the entire surgical team can be held liable in litigation for retained foreign bodies."

At press time, AORN was about to release its "Recommended Practices for Prevention of Retained Surgical Items," which has generated significant comment from members about its multidisciplinary approach to preventing retained surgical items and the introduction of adjunct count technologies, according to a statement from Ramona Conner, RN, MSN, CNOR, manager of standards and recommended practices.² The new recommended practices include multidisciplinary interventions and activities for the perioperative RN circulator, the scrub person, the radiologist, the surgeon first assistant, the surgeon, and the anesthesia care provider, she says. The

RESOURCES

For more information on improving patient satisfaction, contact:

- **Bruce Boissonnault**, President and CEO, Niagara Health Quality Coalition, Williamsville, NY. Telephone: (716) 250-6472. E-mail: bruceb@nhqc.com.
- **Michele Dye**, Clinical Relations Director, ClearCount Medical Solutions, Pittsburgh, PA. Telephone: (412) 931-7233. Web: www.clearcount.com.

recommended practice was last revised in November 2005.

AORN's inclusion of counting technologies acknowledges that more is needed than just a simple count by a nurse, says Michele Dye, senior clinical programs coordinator with ClearCount Medical Solutions. ClearCount, based in Pittsburgh, makes radio frequency identification (RFID)-enabled surgical sponges that can be detected by a wand. If a sponge is missing, the surgeon can use the wand to determine where it is, whether it is in the patient or lost in the folds of a sheet, Dye says. If it is still not found, the circulating nurse can use the wand to look for the sponge in the soiled linen or trash.

"This is different from X-rays, which are only used to determine if the sponge was left in the patient," Dye says. "Nine times out of ten, the sponge somehow got tossed out in the trash or the soiled linen. If the X-ray doesn't show the sponge in the patient, you're still not 100% sure it's not there, unless you actually find the sponge."

Counting technologies are needed simply because humans are imperfect even under the best circumstances, and the risk of an error greatly increases with the pressure of an emergency surgery or a long and difficult procedure, Dye says.

"It's not a matter of whether nurses can count. We know they can count," she says. "But in the real world, people get distracted by the needs of the surgeon, the needs of the patient, and errors slip through." (For more on counting technologies, see "Ensuring no retained items is a shared responsibility," *Same-Day Surgery*, September 2009, p. 90.)

Avoid 'last stitch' delay

Risk managers should be aware that operative teams sometimes use a tricky maneuver to avoid reporting missing surgical items, says **Bruce Boissonnault**, president and CEO of the Niagara Health Quality Coalition in Williamsville, NY. Boissonnault's group studies quality of care at hospitals across the country and promotes patient safety.

The surgeon often will delay the last stitch, so that the patient is not officially closed and the procedure completed while the rest of the team completes the count, Boissonnault says. Once the team is satisfied that the count is correct, the last stitch is completed. That process is normal and harmless, he says.

But sometimes when there is a miscount, meaning a discrepancy between the number of items that went in the patient and the number that came out, the last stitch is delayed for a considerable period until the missing item can be found with X-ray or other means, Boissonnault explains. If the missing item eventually is found, the last stitch is completed, and the team does not have to report a retained item, he says.

Even if everything turns out fine for the patient, that practice is disingenuous, because it makes miscounts seem less common than they actually are, he says. That denies the risk manager and other administrators of data on what is essentially a near miss, he says.

“Delaying the last stitch in a patient’s surgery so surgeons don’t have to report one of these events is not uncommon,” he says. “However, when that requires a delay in getting a patient to recovery, it means that something has gone wrong, even if the surgical team determines there was a miscount and the patient has no retained foreign body. The act of delaying the final close is an event in itself that

hospital staffs should see in the same way they view other near-miss events like medication error near-miss events or wrong-site surgery near events.”

Boissonnault also encourages risk managers to think of retained items as a medical error, not a separate class of problem. “Retained items are a medical error, plain and simple, and we do ourselves harm by trying to talk about them as if they are somehow different than other medical errors,” he says. “We have to report them as you would any other error, and that means reporting the near misses. Those occasions when the patient was not harmed can be the best learning opportunities.”

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1. Jaspen B. Technology cuts risk of surgical sponges: Objects left in patients expensive to remove. *McClatchy-Tribune Regional News*. Jan. 1, 2008. Accessed at www.bcbs.com/news/national/technology-cuts-risk-of-surgical-sponges-objects-left-in-patients-expensive-to-remove.html.
2. AORN. 2007: Recommended practices for sponge, sharp, and instrument counts. *Standards, Recommended Practices and Guidelines*, 493.

Video targets communication

Joint Commission offers resource

The Joint Commission and Department of Health and Human Services’ Office for Civil Rights have released a video titled “Improving Patient-Provider Communication.”

According to the organizations, the video highlights what is required by Joint Commission standards as well as federal civil rights laws with respect to patients who are deaf/hard of hearing or limited English proficient.

It includes a list of resources and tools that health care organizations can use to build effective language access programs.

To access the video, go to www.jointcommission.org. Under “Patient Safety,” select “Hospitals, Language, and Culture.” Select the hyperlink with the video name.

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester’s activity with the December issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

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CNE/CME QUESTIONS

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
 - **Describe** how current issues in ambulatory surgery affect clinical and management practices.
 - **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.
9. What is the most successful practice for ensuring rapid access to emergency equipment and supplies, according to Franchesca J. Charney, RN, MSHA, CPHRM, CPHQ, CPSO, FASHRM, director of educational programs at the Pennsylvania Patient Safety Authority?
 - A. Monthly assignment of this duty to staff personnel.
 - B. Weekly assignment of this duty to staff personnel.
 - C. Daily assignment of this duty to staff personnel.
 10. According to the Pennsylvania Patient Safety Authority, components to consider for a written plan for emergency include which of the following?
 - A. How will staff notify others in the clinical area to a life-threatening emergency?
 - B. Who will contact the code team, the rapid response team, or EMS?
 - C. Who will bring the emergency supplies to the scene?
 - D. All of the above
 11. When assessing geriatric patients, what medications should you be aware of that impair skin integrity?
 - A. Blood thinners
 - B. Steroids
 - C. A and B
 - D. None of the above
 12. When adding general anesthesia cases for basic/routine dental care, what can be one difficulty, according to Stephen W. Earnhart, MS, CEO of Earnhart & Associates?
 - A. Finding anesthesia providers willing to do the cases.
 - B. They must be done in a treatment room, not an operating room.
 - C. The overall supply cost is high.
 - D. The reimbursement isn't usually profitable.

Answers:

9. C 10. D 11. C 12. A .

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Emergency Crash Cart Checklist (2010)

		YES	NO
1.	Are the emergency crash cart(s) and emergency bag(s) conveniently located near the emergency treatment area(s), treatment room(s) for allergy injections or treadmill stress testing area(s)?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do the emergency crash cart(s) and emergency bag(s) have an inventory of the medications, equipment and IV fluids that is kept with the cart(s) or in the emergency bag(s)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is there an inventory of medications, equipment and IV fluids listed by the contents of each draw in the cart(s)?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does the inventory of medications and IV fluids contain the name of the drug, strength of the drug, the amount of drugs and the expiration date?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is the inventory checked monthly to account for all medications and IV fluids and to check their expiration dates?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Are expired medications replaced prior to the expiration date?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Is inventoried equipment checked monthly, i.e. do laryngoscope batteries working?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Is the medication and equipment inventory documentation updated when changes are made to the emergency cart(s) or bag(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Is the emergency crash cart(s) locked or have an integrity seal?	<input type="checkbox"/>	<input type="checkbox"/>
10.	When the lock is opened or seal broken is the reason for opening the cart documented including the date, time, individual's initials and new lock or seal number?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Is the lock number or integrity seal number documented?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Is the defibrillator checked daily?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Is the defibrillator check documented daily?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Is the written print out of the joules discharged verified with the digital read out on the monitor?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Is there regularly scheduled maintenance program for the defibrillator in accordance with the manufacturer's recommendations?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Are all maintenance records maintained in a file that is kept with the emergency crash cart?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Does the routine maintenance include a dated, written record of the actual 200 J, 300 J and 360 J discharge?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Is staff trained in ACLS?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Is a copy of the ACLS certification record maintained in the credentials files?	<input type="checkbox"/>	<input type="checkbox"/>

		YES	NO
20.	Are the emergency crash cart(s) and bag(s) accessible only to individuals with current ACLS?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Are all oxygen tanks secured to the crash cart, wall or in portable stands?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Is the oxygen tank pressure or level of all oxygen tanks checked on a weekly basis?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Does the check documentation include the date, the pressure or level of oxygen in the tank, and staff initials?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Are all tanks serviced on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
25.	Is service documented?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Are quarterly code drills conducted for staff?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Are drills evaluated and documented?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Are the drill participants provided with performance feedback?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Are actual emergency responses evaluated?	<input type="checkbox"/>	<input type="checkbox"/>
30.	Are lessons learned from an emergency response discussed openly with staff?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Are process improvement plans implemented to improve the emergency response process?	<input type="checkbox"/>	<input type="checkbox"/>

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More information is available online at <http://www.patientsafetyauthority.org>.

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Clinical emergency: are you ready in any setting? Pa Patient Saf Advis [online] 2010 Jun [cited 2010 Jun 1]. Available from Internet: [http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7\(2\)/Pages/52.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7(2)/Pages/52.aspx).