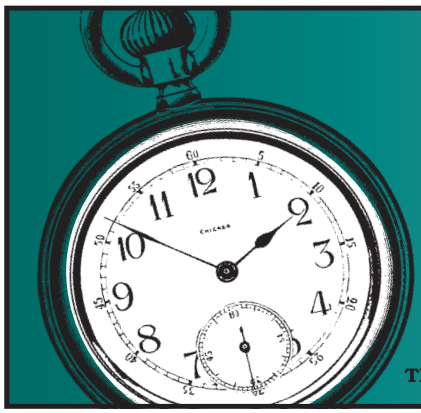
Valuable links to wrong-patient/wrong-site resources



Same-Day Surgery®

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Government to surgery providers: `Be perfect, or be very afraid'

Criminal charges for documentation mistake has field in uproar

(This is the first part of a two-part series on avoiding liability with documentation, see story, below. This month, we discuss the case of a surgeon who was charged and jailed regarding mistakes he made in the medical record that did not impact billing. Next month, we'll cover the specific lessons that can be learned from the case.)

Members of the outpatient surgery field are outraged that a Chicago surgeon was charged and jailed after he made a mistake in his operative reports that resulted in no difference in the billing. It is unprecedented to hold medically imprecise, disfavored, or even false statements in an operative report to be a crime in the absence of billing fraud, the Association of American Physicians and Surgeons (AAPS) said in a brief filed in the case. To do so "is a breathtaking expansion in government interference with medical practice, and the resultant chilling effect is detrimental both to efficiency and to the ability of physi-

SDS offers best tips: Don't get sued

In this special annual issue of *Same-Day Surgery*, we have gathered the best tips from legal experts and your peers for avoiding liability. Our cover story tells you about a surgery provider who was jailed after he made a mistake in the patient record. In this issue, we also tell you about how to avoid legal risks with cutting-edge technology. Another story explains how to ensure compliance with OSHA regulations. We also tell you how Johns Hopkins reduced alarms up to 74% in some units, which cuts the risk of alarm fatigue. Our Same-Day Surgery Manager columnist tells you lessons he has learned on liability. We've also gathered the latest data on how to successfully avoid wrong-site surgery and medication errors. We hope you enjoy this special issue of *Same-Day Surgery*!

cians to speak freely about their own work," AAPS said.

Jane M. Orient, MD, AAPS executive director, says, "The government explicitly wants to send a message: Be perfect, or be very afraid," says "Doctors are the scapegoats for Medicare failures. More doctors will retire, avoid Medicare, avoid tough cases, or become employees and follow protocols."

Here are the details: In November 2012, John Natale, MD, of Chicago, a cardiothoracic and vascular surgeon, went to federal prison on charges related to difficult, life-saving operations on several patients performed nearly 10 years ago. The patients survived and did well despite a mortality rate of up to 90% with the procedure. Natale was accused of Medicare fraud because of billing under a CPT procedure code representing a more complex operation than the one he did. He was acquitted by the jury on all counts related to fraud. However, he was convicted on two counts of making false statements, and the judge decided a prison sentence was needed to send a message to all physicians about the importance of accurate reporting for the financial stability of the Medicare program, Orient says.

Natale routinely worked from 5:30 a.m. until late at night, and he habitually was behind in dictating his operative reports. He incorrectly stated that he had used a bifurcation or Y-graft in repairing an abdominal aortic aneurysm, instead of the straight tube graft used. This statement made no difference in the billing, and there was no evidence that Natale "knowingly" and "willfully" made a false statement to violate the law, Orient says.

AAPS argues that the trial court erred in expanding the statute far beyond its legitimate scope, sweeping in misstatements "lacking materiality, lacking fraud, and lacking any proof of willfulness." In other words, there was no proof of a mens rea, or criminal intent. "False statements can be found in any voluminous body of work, but that does not make them federal crimes," Orient says. Natale and the AAPS have asked the Court of Appeals for the Seventh Circuit to reverse the conviction, but at press time, no decision had been made.

The impact of this case may be significant, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI, "The absence of a requirement in this criminal case to establish intent, as is true for other criminal cases, can have a chilling effect on physician practice of medicine on complicated operations or cases," he says. "It is outrageous that this judge has, for all intent and purpose, established a new threshold for establishing or proving guilt for an alleged criminal act."

This case illustrates what might have been unin-

EXECUTIVE SUMMARY

A surgeon was charged and jailed regarding mistakes in medical records that did not impact billing.

- A subsequent care provider may rely on the dictated operative note, so mistakes could results in a medical error and untoward outcome.
- Have policies that require operative reports to be dictated by the person who conducted the procedure within a specific time period.

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Editorial Questions
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tentional dictations of faulty facts due to the time that elapsed between the procedure and the dictation, says **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, of The Kicklighter Group, which is a Tamarac, FL-based consulting group that specializes in risk management, patient safety, infection prevention, and loss prevention in ambulatory settings. The patients, for the most part, had good outcomes, she points out. "This case was not about practicing medicine below the standard of care; rather it related to documentation," Kicklighter says.

Problems could have arisen if the patient needed further care, and that care was based on an inaccurate operative report, she says. "Depending on future tests or procedures, if the subsequent care provider is relying on the dictated op note that a certain style/type of graft was used when, in fact, it was another, the patient could suffer a medical error and untoward outcome," Kicklighter says.

The lesson? The dictation and availability of the record to subsequent caregivers must be done in a timely manner, she says. "The longer the delay from the encounter or procedure, the more the possibility to forget salient patient-specific information," Kicklighter says.

In a perfect world, surgery and other cases would be contemporaneously dictated, she says. "In the real world, operative and procedural reports should be dictated at the end of each procedure/surgery," Kicklighter says. The more time that lapses, the more the provider has to rely on memory, so details may be forgotten or less clear, she says. "A busy general surgeon who has done several exploratory laps, appendectomies, tumor removals from the abdomen over a few days may not remember certain aspects of a procedure related to a specific patient," she says.

Hospitals and ambulatory surgery centers usually require that charts must be completed within 30 days of discharge and that surgical and other procedures must be dictated within about 10 days, Kicklighter says. "Those who do not meet those thresholds may be at risk for disciplinary action up to and including suspension," she says.

The Joint Commission says that accredited hospitals must define the time frame for completion of the medical record, which does not exceed 30 days after discharge. Its accredited ambulatory organizations and offices must define the timeframe for completion of the clinical record. The AAAHC Handbook, Chapter 6, requires organizations to enter information in "a timely fashion." "AAAHC does not list a specific timeframe, although 24 hours would be considered timely," says Geoffrey Charlton-Perrin, AAAHC spokesperson. AAAHC specifies what information should be recorded, that it should be legible and, if the patient record is lengthy, that it should contain a summary to facilitate continuity of care, **Charlton-Perrin** says. CMS also has its own similar requirements, he says.

Most policies specify corrective action for physicians who don't comply, Trosty says. Lack of adherence and/or action by a facility when the policy is violated can create enhanced liability in a lawsuit that involves those records, he says. "[Facilities] must adhere to their policies and procedures when it comes to reducing potential liability," Trosty says.

Orient says. "Good medical practice is to dictate ASAP, and errors are less likely … [J]ust recognize that anything in the record — or lacking — can be used against you, whether material to coding or not." *(Criminal charges are being considered against an oral surgeon for his infection control practices. Look for an update in an upcoming issue of* Same-Day Surgery.*)* ■

Robotic surgery problems can involve facilities

(In this first part of a two-part series, we discuss the case of a surgeon investigated for his robotic surgeries and how the facility became involved. Next month, we'll discuss how facilities can manage risks that come with cutting-edge technology.)

A Colorado surgeon is under investigation for 14 robotic surgeries with poor outcomes or adverse events, and the Food and Drug Administration (FDA) is investigating what might be an unexpectedly high rate of problems with surgical robotics. In response, a malpractice attorney is cautioning that high-tech treatments with great marketing potential can lead some facilities to overlook problems on which they might otherwise act.

The Colorado Board of Medical Examiners has

EXECUTIVE SUMMARY

A doctor's performance with robotic surgery is being questioned, and the doctor's facility is entangled because it knew of the problems. The case shows how cutting-edge technology might affect how a facility supervises physicians.

- The Colorado Board of Medical Examiners has charged the doctor with unprofessional conduct.
- The facility suspended the doctor's privileges at one point.
- Risk managers should ensure surgery with high-tech devices receives the same oversight as any other procedure.

charged Warren Kortz, MD, of with 14 counts of unprofessional conduct after failed procedures with the robotic surgery arm owned by Porter Adventist Hospital in Denver. According to the complaint filed by the board, from 2008 to 2010 Kortz cut and tore blood vessels, left sponges and other instruments inside patients after closing, injured patients through improper padding and positioning, subjected some to overly long surgeries, and had to abort kidney donations because of mistakes.

The board also alleges that Kortz failed to properly document some of those problems. The state is asking an administrative judge to suspend Kortz's license to practice medicine. In a related development, the FDA announced recently that it is investigating robotic surgery devices in response to reports of accidents and adverse outcomes. The FDA has received reports of at least five deaths involving robotic surgery since early 2010, but a statement from the FDA says the agency does not yet know if there is any trend or if robotic surgery is responsible for the deaths or other problems. "Since it is difficult to know why the reports have increased, the FDA has elected to talk with surgeons to better understand the factors that may be contributing to the rise in report numbers," the statement says.

The FDA database of problems related to medical devices includes 500 reports since Jan. 1, 2012. Some are duplicates, reported by the hospital and the manufacturer, and there is no evidence that any of the problems were caused by the robot. Many of the reports did not involve a patient injury.

Facilities and device makers are required to report adverse outcomes related to medical devices, but the increase in reports could reflect only wider use. Intuitive Surgical in Sunnyvale, CA, which makes the popular da Vinci surgical arm, reports that in 2012 there were 367,000 robot surgeries versus 114,000 in 2008. The da Vinci is the only robotic system cleared for soft-tissue surgery by the FDA, but other robotic devices are approved for neurosurgery, orthopedics, and other procedures.

The Denver hospital is entangled in the Porter case partly because it knew of problems with Porter's robotic outcomes, explains **Daniel P. Slayden**, JD, a partner with the law firm of Hinshaw & Culbertson in Joliet, IL, which handles medical malpractice. The hospital issued a statement confirming that it suspended Kortz's robotic-surgery privileges for three months in 2010. The medical board's complaint states that the hospital reported Kortz had complications with 11 surgeries using a hospital robot.

Slayden notes that many of the patient complaints against Kortz related to informed consent, with some claiming that he did not properly explain the risks of the robotic procedure or offer a traditional surgery option. That issue is one for the physician rather than the hospital, he says.

"It could become a hospital issue, though, if the plaintiff shows when the doctor started having too many accidents, too many poor outcomes, a higher return-to-surgery rate and asks why the hospital didn't suspend him until 2010," Slayden says. "If the data show that his rates were higher than the average, and especially if they were higher when using the robotic arm, someone is going to argue that you should have suspended him in 2009. That's when it becomes a hospital risk management issue." ■

OSHA wants to know about your competencies

[This is the second part of a two-part series on compliance with the Occupational Safety and Health Administration (OSHA). Last month, we focused on education and training. This month, we'll discuss sharps safety, personal protective equipment (PPE), hazardous materials, plus more.]

To comply with requirements from the Occupational Safety and Health Administration (OSHA), perform annual competencies on sharps safety, personal protective equipment (PPE), hazardous equipment, employee safety (lifting), chemicals, and hazardous materials, said **Beverly Kirchner**, BSN, RN, CNOR, CASC, president of Genesee Associates, a Dallas-based national ambulatory surgery center development, consulting, and management company. Kirchner spoke at the recent annual meeting of the Ambulatory Surgery Center Association (ASCA).

OSHA compliance is a hot topic. A fine of $68,000 was proposed for a New Jersey surgery center for 10 "serious" violations related to failure to protect workers exposed to bloodborne pathogen hazards.

EXECUTIVE SUMMARY

The number one best thing to do for OSHA compliance is to communicate as much as possible about hazards and potential hazards in your work environment.
- Keep an injury list that includes sharps.
- Include bloodborne pathogens training in a staff person's initial assignment/orientation, within 90 days of any changes to the regulation, and annually.
- While there is not a requirement for circulators to wear eye protection, it is recommended by a source interviewed by *Same-Day Surgery.*

(See "$68,000 proposed OSHA fine for ASC raises *concerns: Is the field complying?"* Same-Day Surgery, *May 2013, p. 49.)*

Sharps injuries have not decreased, despite the fact that they have been regulated for more than 10 years, Kirchner said. The OR is the number one place for sharps injuries, she said.

Based on the Standard Industrial Classification Code for Ambulatory Surgery Centers (8011), ASCs are exempt from keeping the OSHA 300 log. OSHA calls it "partially exempted" because ASCs don't have to keep the log unless requested by OSHA. You do have to keep an injury list that includes sharps, Kirchner said. "Show the exchange of information and the understanding," she said.

Keep detailed minutes of meetings regarding needlesticks, Kirchner said. AORN has a sharps safety toolkit. "You can print off the toolkit, and it's your whole program right there – boom," Kirchner said. *(Editor's note: A sharp's safety checklist is available at http://bit.ly/17Xi4yI.)* Consider putting your sharps boxes on the side of the computer carts. "Nurses love them, and they don't have to take a step to do their job," Kirchner said.

Include bloodborne pathogens training in a staff person's initial assignment/orientation, within 90 days of any changes to the regulation, and annually, Kirchner said. "If a person changes job and it takes them to a different area or hazard, you have to retrain them at that point and time," she said. The regulatory text should be available for all staff, Kirchner said.

When you have an incident, do not give the manufacturer any piece of equipment involved in the incident, Kirchner emphasized. "You have to justify to the OSHA surveyor why you did what you did," she said.

What are you required to have for PPE?

In terms of personal protective equipment (PPE), you can have three to five different types of masks. "It's employee and doctor preference," Kirchner said.

Ensure that PPE is comfortable, so it's not burdensome for your staff, but also meets the rules, she said. For example, use a face shield that touches the chest so no spray can reach under it, she advised. This should be used in the decontamination room or any time liquids are being poured that could be hazardous.

Use heavy gloves in your decontamination room, even if staff complain that they can't feel with them, Kirchner said. "Thin gloves don't work," she said.

There is a "huge debate" over whether circulators should wear eye protection, she said. While it is not required, Kirchner does recommend using it. She recalled an incident in which the nurse was called to the table because the suction was blocked, she said. There was an "explosion" of liquid over her entire face that dripped on her, Kirchner said. "She wore eye protection after that," she added.

Look at your workers compensation insurance to examine what it says regarding clothing and shoes, such as clogs without backs, Kirchner said.

You should be doing these drills

Complete safety drills for fires, malignant hyperthermia (MH), cardiac arrest, respiratory arrest, hazardous materials, and disasters, Kirchner said.

Bariatric procedures raise new MH concerns, she points out. "Do you have enough dantrolene for bariatric patients?" she asked. "Thirty-six vials are not enough for some patients."

In terms of fire safety, fire extinguishers are not required in the OR, but where is the no. 1 place surgery providers have a fire? In the OR, Kirchner said.

Extinguishers will not harm the patient, says Kirchner, quoting OSHA and the Association of peri-

Tips for OSHA Compliance

- Make sure you have proper spill kits for hazardous materials in your facility. Train employees about how to handle spills of formaldehyde, because that spill is considered an emergency exposure.
- Ensure you have a blood spill kit, and make sure your staff members have been educated on it.
- Look at your facility to determine where there are dangers of falling, such as in the OR. Most ORs have smooth vinyl floors, but textured floors can be twice as expensive. The advantage is that nurses can run on it and not fall.
- If your center uses stepladders to reach items that are stored high, make sure the ladders have the proper feet so they don't slide.
- Determine whether you have made hand hygiene easy for your employees. For example, can employees easily reach items they need?
- In terms of infection control, conduct surveillance by looking and watching. Hand hygiene programs aren't enough.

Source: Beverly Kirchner, BSN, RN, CNOR, CASC, president, Genesee Associates, Dallas. ■

operative Registered Nurses (AORN).

The number one thing to do to avoid OSHA noncompliance is to communicate, Kirchner said. "You cannot communicate enough about hazards and potential hazards in our facilities," she said. *[See tips for OSHA compliance, p. 77.]* ■

Bedside alarms reduced up to 74% in some units

(Editor's note: This is part 2 of a two-part series on alarm fatigue. In last month's issue we discussed how to reduce alarm fatigue. In this month's issue, we tell you how The Johns Hopkins Hospital reduced alarms up to 74% in some areas.)

A group of nurses, physicians, and engineers at The Johns Hopkins Hospital have significantly reduced the number of distracting, non-critical bedside alarms in some of the hospital's noisiest areas — up to 74% in some cases — in an improvement that has been linked to patient safety.

For its efforts in reducing bedside alarms, ECRI Institute awarded The Johns Hopkins Hospital its Health Devices Achievement Award for 2012.

The effort is an example of how a methodical and carefully analyzed research process can be applied to alarm management and result in a significant improvement in patient care, says **Maria Cvach**, MSN, RN, CCRN, assistant director of nursing clinical standards at Johns Hopkins and leader of the hospital's alarm improvement efforts since 2006. "This project came about because, like a lot of healthcare organizations, we were concerned about how to improve safety with clinical alarms," she says. "One of the top reasons for missing an alarm is alarm fatigue. There are too many alarms, and people are just desensitized to the amount of noise. They either hear it and ignore it, or they don't hear it and don't take action."

Ironically, improvements in monitoring have led to the need to reduce the number of alarms, Cvach explains. "In healthcare we have created the perfect storm with all of these monitoring devices," Cvach says. "Monitor alarm systems are set to be very sensitive and unlikely to miss a true event, but result in too many false positives."

Baseline measures revealed the scope of the challenge for Johns Hopkins' Alarms Management Committee: One 12-day alarm system analysis registered 58,764 alarms, an average of 350 per patient per day. In addition to noise reduction, the quality-improvement project sought to prevent alarm fatigue. "Frequent alarming can cause a 'cry-wolf' effect," Cvach explains.

By collecting baseline measurements, defining and validating appropriate alarm settings, and working with each unit to develop an alarms improvement plan, the multidisciplinary team safely reduced the cacophony from monitors hospitalwide. Reductions ranged from 24% to 74% across units.

Andrew Currie, MS, CBET, Hopkins' director of clinical engineering, says, "Patients and staff need a quiet environment. We are trying to reserve noisy alarms for the most important, actionable events. In some cases, units switched some lower-priority alarms to visual rather than auditory notifications." Currie co-chairs the alarms committee with Cvach and Adam Sapirstein, MD, associate professor in the Department of Anesthesiology/Critical Care Medicine in The Johns Hopkins School of Medicine and also a faculty member in the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

The coordinators of the effort say that partnering with leaders on each unit was essential to their success, because improvements needed to be tailored to individual settings. Currie says, "A one-size-fits-all approach would not have received the kind of support we needed to address this problem."

Before setting out to alter alarm settings, the committee analyzed and rated each alarm based on importance and risk to ensure back-up notification systems were in place for the most critical alarms. Cvach says, "For high-priority alarm conditions, redundancy is important. Our units need multiple ways to ensure audibility of alarm signals and patient safety."

The group's other efforts include testing new equipment, assessing alarm management alternatives, developing new policies, creating and assessing training efforts, and considering new alarm technologies. Three postoperative care units, including an outpatient cardiac unit, are reviewing alarm management alternatives, Cvach says.

All hospital units have instituted processes including altering their alarm parameters, so they are receiving only "actionable" alarms, Cvach says. The units also implemented secondary alarm notification, so they are advised of alarms if they aren't at the bedside, she says.

A pilot study tested use of an alarm integration system to send high priority alarm signals to cell phones or pagers carried by nurses, who, with the press of a button, can escalate the alarm to a back-up if they're unable to respond. On one unit, high priority messages are sent to a pager that each nurse carries. On another unit, there is a single pager for the charge nurse. The investigators compared the frequency and

duration of alarms. "We found a significant difference in the alarm frequency and duration when each nurse carried a pager versus just the charge nurse," Cvach says. "There was a 23% reduction in average alarm duration time when each nurse carried a pager. When just a charge nurse carried a pager, we still saw a reduction, but just a 13% reduction in average alarm duration time." ■

Same-Day Surgery Manager

Don't sue me! 5 tips to stop it from happening

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Houston, TX

Most of us cringe at thought of someone suing us. How rude! But it does happen, and we all need to be reminded of what to do to protect ourselves.

In the healthcare industry, it seems like we have a big 'ole bulls eye on our back and someone is just waiting for the opportunity to take our savings and our homes away from us because we messed up on something. Because of what we do and where we work, we are more prone to litigation from some event — much more so than if we worked in an office or some other profession. We need to have a better understanding of how to avoid it.

I am not an attorney, and I am sure they have much better advice, but I do have some practical and helpful ideas on how to avoid the whole mess:

• Be friendly!

Strange as it sounds, people who like you are much less likely to sue you. Most of us have little time in the surgical area to get to know our patients. What is our interaction time? Thirty minutes? An hour? But during that timeframe is probably the greatest risk for something to happen to the patients that they feel was wrong, inappropriate, or harmful to them. They, or their families, are going to make it right in their eyes by suing us. Not every lawsuit is frivolous; some probably are justified, and we do not want to be caught in that trap.

• Make an impression upon all patients, and treat them in a helpful manner.

Go out of your way to make them feel safe and secure. That is not sucking up; it is a big part of our job as caregivers. When the attorney is meeting with the patients and asking about details of whatever the event was that spawned the suit, you want that patient to say to the attorney, "Mary (you) was so nice to me, I don't want her included in suit. She made me feel good." Corny? You bet! But it is also true: It is difficult to sue someone you like or who did right by you.

• Know your boundaries!

The greatest protection we all have is to practice and stay within our policies and procedures. The governing body of every healthcare organization dictates what we can and cannot do in our jobs. Read your policies and procedures. Make sure they are updated and that you understand what they mean. You have protection from liability if you stay within the guidelines of the governing body, which approved them. If you step outside those policies, you are on your own when and if something happens as a result of it.

For example, your policies procedures say that every patient must have a responsible adult drive them home after surgery. Your governing body approved that, so did your state, and so did your accrediting agency (The Joint Commission or AAAHC). But, a situation comes up when it is late and you have a patient that has been waiting for a long time in your recovery room for a ride home. You and everyone else want to go home. The patient, who was sedated hours ago, insists that he is fine and can drive home. "I just live just down the street," he says. You say "OK, but be careful!" The patient crashes into another car and kills an occupant. (This is a true story). Who do you think the lawyers and the family went after? Know your rules and stick by them!

• Work within the parameters of your job description.

It is OK to say, "Sorry! That is not in my job description!" You were hired to do a job based upon your skills, background, and education. If you think you can do more, have it added to your job description so you can rightfully perform those tasks. If your boss won't add it, there is probably a reason, so don't do it.

An example is transferring a patient. You were never trained to do it properly, but everyone else is busy, and you know you can move the patient from one stretcher to the other and save a lot of time for everyone. The patient falls between the table and the stretcher and breaks her hip. The number one question the attorney will ask you in front of the jury is, "When were you trained on the technic of transferring a patient off an operating room table sir?" Gulp!

Don't work outside the scope of your license.

A big issue with nurses and other licensed professionals in the hospital or surgery center is doing things your state says you cannot do. Every state is different, so make sure you read and understand the regulations. Remember that the regulations change from time to time, and it is your responsibility to stay on top of them. There are many times when all of us have been asked to do something that we probably shouldn't have in our job. Sometimes we are pressured by the surgeon or anesthesia to push a medication we know we are not authorized to do, or we are asked to do other things that there is no one else around to do. Often the easiest course is just to do it. You think nothing will go wrong, but if it does, you are on your own. Be careful.

The bottom line: Use your judgment when and if these situations come up, and act accordingly. Typically, if you did everything right and were just caught in a widely cast legal net that included everyone in the room or the facility (which often happens), you eventually will be exonerated because you acted accordingly and within the legal structure of your organization.

If you remember nothing else, try to stop and think, "Hmmm. How would I explain what I am getting ready to do to a jury?" *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

6 tips to avoid wrong-site surgery

A patient needed repair of a right hip fracture. The site was marked by the patient, and the OR team performed a surgical pause. However, the patient's left hip was draped and prepped, and the surgery proceeded on that side. After the incision had been made, the error was realized. The incision was sutured, the patient was repositioned, and the surgery resumed on the right side.[1]

This actual event reported in Pennsylvania is not rare. An analysis of the first 500 wrong-site surgery events reported to the Pennsylvania Patient Safety Authority between July 2004 and August 2012 found that physicians initiated an intended procedure at an incorrect site on the correct patient in 433 (86.6%) of the 500 event reports. The authority recently released its analysis.

The report makes these recommendations:

• Preoperative documentation of the site of surgery should be specific enough for all OR team members to anticipate the correct location of the mark.

Staff members might not designate the side on the paperwork, or they might designate a general location, such as lumbar spine or cervical spine, without noting the particular disc involved, says John R. Clarke, MD, editor of the Pennsylvania Patient Safety Advisory and clinical director of the Pennsylvania Patient Safety Authority, both in Harrisburg, and professor of surgery at Drexel University, Philadelphia.

This problem is particularly prevalent with surgery involving fingers and toes, because the staff might not note which part of the finger or toe is being operated on, Clarke says. With fingers, "there are three sections, so there is the opportunity to get into the wrong part, even though it's on the right finger," he says.

• Having the patient state two identifiers to verify their identity appears to be effective in preventing wrong-patient errors.

Patient identification often is not done properly, Clarke says. For example, a staff person may say, "Mrs. Jones?" and the patient replies "yes." "They assume that is the correct identifier," Clarke says.

Staff should ask patients so they receive an "active voice response," he says. Instead of asking, "Are you Mrs. Jones?" the staff person should ask, "What is your name?"

There was a near miss in Pennsylvania in which the only difference between a patient in the computer system and patient showing up for surgery was the middle initial and the month of birth, so the date of the month and year of birth, as well as the first and last names, were the same. The preop nurses caught the difference by checking the patient's wristband, Clarke says.

• Marks should be made as close to the intended incisions as possible. The exact location of skin and subcutaneous lesions should be marked.

With surgery on fingers and toes, for example, don't put an arrow pointing to the correct appendage, Clarke warns. "People might say it's pointing to the first or second toe," he says. Instead, the mark should be exactly where the incision will be made, he says.

With surgery on skin lesions, a patient might have multiple moles or bumps/lesions. You should have a mark around the exact lesion that's being removed, Clarke says.

• The most likely wrong-site error, by far, is a wrong-side error. Bilateral structures, especially extremities and eyes, are most likely to experience wrong-side surgery. The most common wrong-side

error is the anesthetic block, accounting for 34% of all wrong-side errors and 21% of all wrong-site errors in the OR area.

About one in five persons becomes confused over his/her right and left, Clarke says. That confusion is magnified when looking at a different person, he says. Additionally, patients may be turned over, so the left and right sides are reversed, Clark says.

• **Some wrong procedures may result from surgeons becoming distracted during the operation.** The OR team should maintain situational awareness of the intended procedures throughout the case, not just at the start of the case.

One typical example is bilateral ear tubes and adenoidectomy. "Most of time when an ENT surgeon is operating on a child, it's a tonsillectomy, so the automatic thinking is to immediately go for the tonsils," Clarke says. Another typical area of confusion is a hysterectomy, because a surgeon is accustomed to taking out the ovaries at the same time.

Often the scrub tech is the one who notices the mistake, based on the surgeon's request for equipment, and reminds the physician this case is different. "Sometimes surgeons are inherently taciturn," Clarke says.

• **Wrong-level spinal procedures represent 13% of all wrong-site procedures.** Intraoperative misperceptions were reported nine times as often as errors based on misunderstandings of information available preoperatively. The prevention of wrong-level spinal procedures requires intraoperative verification of the correct spinal level.

Almost all surgeons are doing some form of intraoperative verification with fluoroscopy or X-ray, Clarke says. Mistakes can happen when a surgeon marks a vertebra, for example, and the X-ray shows that mark is one vertebra too high. Rather than mark the correct vertebra, the surgeons often say, "I'll just go one further away," but they mistakenly can go two vertebrae away, Clarke says.

Physician compliance is one of the biggest hurdles for wrong-site surgery, he says. Anesthesia blocks are among the biggest problems. Physicians are trying to be as efficient as possible, Clarke points out. "They're not really stopping and taking the time to go through all the steps in an optimal fashion, he says. "They need to slow down."

Wrong–site surgery is like wearing seatbelts in that some physicians can't be bothered with the prevention, and adherence comes only from a bad experience, he says. That lack of adherence is unfortunate, Clarke says. "It's not that to numb the wrong part of the body is necessarily the worst bad outcome you can have happen, but it's not something you can easily excuse.

REFERENCE

1. Clarke JR. Quarterly update: What body parts and procedures are associated with wrong-site surgery? P*ennsylvania Patient Safety Advisory* 2013; 10(1):34-41. Web: http://bit.ly/17G1GUR.

RESOURCE

• The Pennsylvania Patient Safety Authority has **educational tools to prevent wrong-site surgery**. Go to web: http://bit.ly/nTXLxH. ■

Meds still being given to the wrong patients

Is your staff following the '8 rights'?

When you look at wrong-patient medication errors and compare current and past reports, one point is obvious: These events still are occurring, says **Rodney W. Hicks**, PhD, RN, FNP-BC, FAANP, FAAN, professor in the College of Graduate Nursing at Western University of Health Sciences, Pomona, CA.

Hicks spoke on the topic of medication safety at the recent Ambulatory Surgery Center Association (ASCA) annual meeting.

The Pennsylvania Patient Safety Authority recently released a report saying 813 wrong-patient medication errors were reported between July 1, 2011, and Dec. 31, 2011. Many errors were reported in transcribing (38.3%, n = 311) and administration (43.4%, n = 353). While the authority acknowledges that many factors contribute to medication errors, the most common factors were two patients being prescribed the same medication, improper verification of patient ID, and similar room numbers. The most common types of medications associated with wrong-patient events were anti-infectives, insulin, and anticoagulants.

The fewest errors were reported during dispensing (5.2%, n = 42) and prescribing (12.1%, n = 98).

Improvements in prescribing is one of the success stories, says Hicks, who was the lead author of a 2008 USP/MedMarx data report titled "A Chartbook of Medication Error Findings from the Perioperative Settings from 1998-2005." In that 2008 report, 29.6% of errors were reported in prescribing, Hicks says. The improvement in those statistics might reflect the increased use of electronic prescribing, he says. However, when physicians have the ability to go into an electronic system and select a patient, there is

always a danger, he says. "The biggest threat to that is what do you do when you have patients with multiple same names, like Smith? How do you make sure you get the right Smith?"

If the physician is not next to the patient or the physician is writing the orders remotely, that is a risk point, Hicks says. "When we rely on memory, as providers, we think we're doing the right things, but humans are fallible and make mistakes from their memory," he says.

Have a "name-alert" policy for how your facility handles patients with similar or the same name, Hicks advises. Also, expand the former nursing adage of the "5 Rights" before medication administration, which are right patient, right time, right drug, right dose, and right route. Now, nurses must follow the "8 Rights," which includes the previous five, plus right indication, right documentation, and the right to refuse. Tips offered by the Pennsylvania authority are ensuring proper storage of medications and patient-specific documents, using healthcare technology fully, limiting verbal orders, and improving patient verification throughout the medication-use process.

Also, providers should ensure proper storage of medications and patient-specific documents, and they should empower the patient to prevent and detect medication errors, the authority says. Some additional tips offered by Hicks are to assess staff impact on medication errors. Minimize cross-coverage, and minimize floating staff, he advises. Additionally, look at distractions specific to your facility, Hicks suggests.

"In day surgery, you typically don't have high volumes of patients, so being able to explain why the wrong person got the medication is baffling," Hicks says.

RESOURCE

To obtain the advisory from the Pennsylvania Patient Safety Advisory titled ***Wrong-Patient Medication Errors: An Analysis of Event Reports in Pennsylvania and Strategies,*** go to http://bit.ly/12p1GIX. ■

Rising number of claims filed by obese patients

In a recent multi-specialty review of claims, The Doctors Company, a Napa, CA- based medical malpractice insurer, noted an increase in the number of claims filed by patients who were overweight or obese, reports chief patient safety officer **Robin Diamond**, JD, RN.

Based on the findings, The Doctors Company decided to perform an in-depth analysis of some of the claims related to postsurgical risks of obese patients. "The analysis found several claims in which patients with either a suspected or known diagnosis of obstructive sleep apnea suffered severe respiratory depression during the post-op period," says Diamond.

Additionally, the use of opioids in these patients greatly increased the risk of harm in these patients. Diamond says these risk-reducing practices were identified from the claims analysis:

- Include a focused history and calculation of Body Mass Index (BMI) and neck circumference in the preoperative evaluation.
- Consider a sleep apnea study prior to surgery.
- Use continuous oxygen monitoring and carbon dioxide monitoring.
- Prescribe opioids only with the greatest care, and consider the use of non-opioids.
- Do not assume that the obese patient needs higher levels of medication to control pain.

"It may be just the opposite in obese patients, who may be unable to metabolize these medications as effectively as a patient of average weight," says Diamond.

There is an increased risk associated with an obese patient who undergoes a procedure with accompanying anesthesia, notes Diamond. A 2007 study reported a higher incidence of postoperative complications in obese patients with meningiomas (53%), including deep vein thrombosis (DVT) and pulmonary embolus, than in nonobese patients (18%).[1]

3 tips to reduce your risks

Physicians treat obese patients for a variety of chronic conditions that co-exist with obesity, such as diabetes and heart disease, notes Diamond. "With the rate of obesity increasing, physicians have to address more complex issues with this population." Diamond suggests physicians consider these approaches to reduce legal risks:

- **Physicians should address any negative attitudes or discomfort that they or their staff members have about obese patients.**

Physicians need to speak openly to patients about a characteristic such as obesity that places them at higher risk for an adverse event, she explains.

"This is a difficult issue for anyone to acknowledge. However, everyone has preconceived feelings or impressions about a certain characteristic or stereotype," says Diamond.

- **When the physician performs the history and**

physical, the patient's obesity must be identified as a problem.

"A plan then should be established to deal with it," says Diamond.

• Physicians should fully inform the patient of the risks of obesity related to the current diagnosis, as well as the potential health problems that are more likely to arise. Document these discussions.

The defense attorney then can show through documentation that the physician addressed any health conditions or habits that could increase the patient's risk, says Diamond.

"Even when the patient alleges harm, the defense attorney can more easily demonstrate that the patient was not compliant with the health education provided by the physician, and therefore that the patient's noncompliance mitigated or neutralized the patient's allegations," she explains. *(For more information on caring for obese patients, see "Are you prepared for high BMI patients or just focused on their gown sizes?"* Same-Day Surgery, *January 2012.)*

REFERENCE

1. Aghi MK, Eskandar EN, Carter BS. Increased prevalence of obesity and obesity-related postoperative complications in male patients with meningiomas. *Neurosurgery* 2007; 61(4):754-760. ■

Register for QualityNet now or risk pay cuts

Registering security administrator may take 6 weeks

Between July 1 and Aug. 15, 2013, ambulatory surgery centers (ASCs) that provide services to Medicare beneficiaries must report 2012 volume data for certain procedures and verify their use of a safe surgery checklist during 2012 to the Centers for Medicare & Medicaid Services (CMS), according to the ASC Association. ASCs that fail to report this information will face payment reductions from Medicare in 2015, the association said.

ASCs must report this information via Medicare's QualityNet web site at https://www.qualitynet.org.

Before your ASC can use the QualityNet web site to file the reports required between July 1 and Aug. 15, your ASC must register a QualityNet security administrator, the ASCA said. Responsibilities of the ASC's QualityNet Security Administrator include:

• creating, approving, editing, and terminating QualityNet user accounts within your ASC;

• monitoring QualityNet usage at your ASC to ensure that security and confidentiality is maintained;

• serving as a point of contact at your organization for information regarding QualityNet.

To register a security administrator, ASCs must first complete and return via mail the QualityNet Security Administrator Registration Packet at http://bit.ly/18ZtRx5. The registration process could take six weeks to complete, so now is the time to act if your ASC has not registered a security administrator, the ASCA warned. CMS recommends that each ASC designate two people as QualityNet security administrators: one to serve as the primary security administrator, and the other to act as an alternate.

The QualityNet security administration registration form must be signed and dated before a notary public, and the notary must complete a special section on the form, including a signature and seal. ASCs need to mail these original forms to the QualityNet program support contractor. You will be notified by email when the registration process is complete. For more information on Medicare's entire ASC quality reporting program, go to http://www.ascassociation.org/qualityreporting. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
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CNE/CME OBJECTIVES

- **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.

CNE/CME QUESTIONS

1. What is the lesson from the John Natale case, according to Leilani Kicklighter, RN, ARM, MBA, CHSP, CPHRM, LHRM, of The Kicklighter Group?
   A. The dictation and availability of the record to subsequent caregivers must be done immediately at the conclusion of the day's cases.
   B. The dictation and availability of the record to subsequent caregivers must be done by the conclusion of the week after the procedure.
   C. he dictation and availability of the record to subsequent caregivers must be done in a timely manner.

2. In the case of Warren Kortz, MD, accused of 14 counts of unprofessional conduct after failed procedures with the robotic surgery arm owned by Porter Adventist Hospital, which of the following is true?
   A. The hospital did not take any action in response to poor surgical outcomes.
   B. The hospital suspended Kortz's robotic-surgery privileges for three months in 2010.
   C. The hospital permanently prohibited Kortz from performing robotic surgery in 2010.
   D. The hospital revoked all surgical privileges for Kortz.

3. For compliance with regulations from the Occupational Safety and Health Administration (OSHA), when should you include bloodborne pathogens training, according to Beverly Kirchner, BSN, RN, CNOR, CASC, president of Genesee Associates?
   A. In a staff person's initial assignment/orientation
   B. Within 90 days of any changes to the regulation
   C. Annually
   D. All of the above

4. What is the most likely wrong-site error?
   A. Wrong-side error
   B. Spinal surgery done on the wrong level
   C. Toe or finger surgery done on the wrong appendage
   D. Surgery done on the wrong skin lesion

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