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# RiskResource

FIRST EDITION, 2013

A HEALTHCARE PROFESSIONAL LIABILITY RISK MANAGEMENT NEWSLETTER

## In this issue:



### Upcoming Events

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- California Society for Healthcare Risk Management Annual Conference
  March 6–8 | Napa, CA
  *presentation: "Maximizing EHR use in physician practices to minimize risk"*
- PLUS Medical PL Symposium
  April 10–11 | Chicago, IL
  *presentation: "Exploring allied health providers: New risks and opportunities"*
- ASHRM Academy
  April 15–18 | Dallas, TX
- Crittenden Medical Insurance Conference
  April 16–18 | Boston, MA
  *panel: "Liability risks of electronic health records"*


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## Prevention of perioperative wrong site, wrong person, wrong procedure errors


By Sharon A. McNamara, BSN, MSN, CNOR and Charlotte Guglielmi, BSN, MA, CNOR


Prevention of wrong site, wrong person, and wrong procedure (WSP) errors in the perioperative setting is one of the priority initiatives in a majority of operating rooms and procedure around the globe. We as healthcare professionals have battled this problem historically through many professional and regulatory programs (see Table I) and we can't get it right. Why not?

### The Problem

WSP occur in many settings: hospital, ambulatory settings, and physician and dental offices. Frankel and Leonard discuss the "limited interdisciplinary training of the various disciplines – surgery, anesthesia, nursing, and technician – that promote hierarchy and undervalue core team characteristics. Also, historical perceptions about the roles of physicians, nurses, and ancillary personnel have not kept pace with the changing nature of care delivery."[1p263] The Culture of Safety movement has progressed from the groundbreaking 1999 Institute of Medicine report that led to an awareness by the public and business to the state of quality and safety problems in our healthcare system to the current environment that values the precepts of a Culture of Safety which include:

- **Reliability** – achieving the desired outcome repeatedly
- **Continuous learning** – multidisciplinary practitioners come together routinely to examine operational and clinical issues, including near misses for improvement
- **A just and fair culture** – individuals understand they are accountable for their actions but they will not be held accountable for system flaws
- **Teamwork** – behaviors that address culture issues through improved communication tools such as briefings, debriefings, huddles, checklists, and surgeon statements, giving the team members the freedom to speak up for safety

## Risk Factors

Multiple risk factors for WSP have been identified in the literature, but specific risk factors that relate to the individual patient and procedure should be evaluated with each intervention. Potential risk factors for WSP include:[2,3]

**Scheduling process**

- Failure to validate the correct patient and information when scheduling the patient for a procedure
- Failure to use closed loop communication in the case booking process (intake with read-back every time)
- Illegibility of case booking forms
- Inaccurate information in scheduling process (laterality not identified)
- Unacceptable abbreviations used ("R" instead of "right")
- Possible deficiencies in the electronic system or lack of attention to detail by the scheduler could result in the wrong patient being chosen

**Transitions of care**

- Failure to validate the correct patient and information at every transition of care
- Communication breakdown involving team members, family, and the patient
- Distractions

**Pre-operative process**

- Lack of verification of the patient with two identifiers, the procedure, site, and laterality
- Various breakdowns in the patient preparation process (incomplete/inaccurate/missing assessments/H&P; consent issues; inappropriate radiology/cardiology/lab results)
- Incomplete/inaccurate documentation
- Failure to engage the patient in identification of the correct site and marking
- Failure to notify the OR when changes are made in the consent
- Production pressure focused on turnover time

**Intra-operative process**

- Absence of a fully standardized process
- Emergency procedures
- Multiple procedures/multiple surgeries
- Failure to consult X-Rays/images, consult reports
- Reliance on the surgeon only for identification of the correct site
- Site marking defects (mark not visible after draping, team does not verify the site mark)
- Elements of the "Time Out" are not verbalized with all team members attentive
- Time pressures
- Staffing changes (breaks, end of shift)
- Environmental considerations
- Distractions
- Workload
- Room changes
- Position changes
- Equipment placement as related to laterality of the procedure

**Patient factors**

- Morbid obesity
- Physical anomalies
- Language or cognitive barriers
- Sedation or confusion regarding the procedure

### Strategies for Prevention

The perioperative environment is dynamic and complex with healthcare providers interacting with each other and with technology at a rapid pace. This environment requires the development of strategies to improve safety and performance within a culture of safety. The importance of governance and executive leadership prioritizing the culture of safety is as critical as creating a safety-minded workforce at the point of care – both should share the same values. Safety will depend on reliability – doing what is intended consistently, and designing systems to withstand inevitable human errors. Safe systems are characterized by:

- Commitment to safety by leaders and individuals
- Use of formal protocols for communication
- Teamwork where there is shared responsibility and accountability
- Standardization around best practice
- Reporting of problems (including near misses) and errors with analysis for improvement of the system.[4]

Various tools have been developed to support prevention of WSP including checklists, time outs, no interruption zones, and computerized prompt systems. However, these will not be effective without attention to teamwork and communication.[4,5]

A number of organizations have developed checklists to drive a standardized process that include the elements needed to prevent WSP. These checklists are supported by evidence-based practice and contain both technical and cultural components. Examples include:

- ✓ The Joint Commission's Universal Protocol[6]
- ✓ The World Health Organization's WHO Surgical Safety Checklist[7]
- ✓ Association of Perioperative Registered Nurses AORN Comprehensive Surgical Checklist[8]

Of note, as the work of both TJC and the WHO emerged, the members of AORN asked for guidance on how to utilize both

tools in their practice environments. Therefore, the AORN Comprehensive Surgical Checklist was developed not as a unique tool, but rather as a tool that combines the key elements of both the TJC's Universal Protocol and the elements of the WHO Surgical Safety Checklist.

Each of these checklists is designed to be used as a tool to:

- ✓ Confirm that a comprehensive, consistent, effective preoperative verification process has been completed
- ✓ Act as a trigger to start the process and evidence that each of the criteria has been met
- ✓ Provides the practitioner with visual prompts voiding reliance on memory alone

## Components of the checklist

A "one tool fits all" is not the recommendation. Additions and modifications to fit local practice are encouraged and necessary to achieve engagement of the practitioners and meaningful use.[7] Common critical elements that should be included in any checklist are:[6,7,8]

*Pre-procedure process*

- Correct patient, procedure, site with patient involved when possible (use patient speak back)
- Mark the surgical site before moving patient to OR
- Relevant documentation, diagnostics, and radiology reports
- Special equipment, devices, implants are available and on site
- Blood products required

*Intra-operative process*

- Conduct a standardized time out with active communication in which all practitioners suspend activities and focus on the patient and the process
- Confirmation of the correct patient, procedure, and site (point and touch verification of the surgical site mark by the surgeon and scrub person)

*Additional elements* as seen in the WHO[7] and AORN[8] checklists include allergies, anesthesia implications, SCIP measures (antibiotic prophylaxis, beta blocker, venous thromboembolism prophylaxis, normothermia), radiologic images properly labeled and displayed, anticipated critical events verbalized by each of the providers (surgeon, anesthesia provider, nursing team). These checklists also include a sign out before the patient leaves the room which includes: name of the procedure, results of sponge, sharp, instrument count, specimen identification and labeling, equipment problems to be addressed, and any key concerns for recovery and management of the patient. Identifying which team member initiates each section of the checklist, where these activities should occur, and identifying each team member's role in the anticipated critical event area are additional risk reduction strategies.

Research demonstrates that use of checklists can decrease in-hospital mortality rates and post-op surgical complication rates.[9,10] Evidence supports that checklists decrease the proportion of defective cases in the surgical booking process, pre-op/pre-op holding, and Operating Room areas.[3] However, there is an important aspect of risk reduction that combines checklist use with briefing and debriefing processes that promote teamwork and enhance a culture of safety. Teamwork skills should be used throughout the surgical patient experience which involves having shared goals, a shared mental model of the situation, situational awareness to facilitate mutual monitoring and backup as the situation changes, and a flat hierarchy.[4]

## Briefs

Briefs are held for planning purposes. The surgeon should organize a brief discussion with all team members on information essential to the patient and procedure to include:[11]

- Team membership and roles (helps creates a flat hierarchy)
- Plan of care for the patient
- Team goals, pitfalls, or barriers (shared goals)
- Issues affecting team operations – resources available,

equipment issues, timing of breaks and lunch

- A statement by the surgeon informing the team that if they see anything unsafe for the patient they should speak up (also adds to a flattened hierarchy)

### Debriefs

"Debriefs are most effective when conducted in an environment where honest mistakes are viewed as learning opportunities not by assigning blame or failure to an individual."[11p15] Team members must be empowered to speak up if there is a problem. They should be short and initiated and facilitated by the surgeon as leader. Debriefs should include:[11]

- Accurate accounting and documentation of key events related to the procedure
- Discussion on what worked and what didn't
- Discussion of lessons learned and how they will alter the plan next time
- Implementation of a formal method to follow up on issues and information from the debrief

A debrief is meant to be a process improvement tool but there may be times when the issues reoccur and require a complete process review and system redesign. It is at these times a thorough defect analysis may be required.

"Research demonstrates that new procedures and technologies work only when accompanied by efforts to improve the safety culture of the hospital, the involvement of the healthcare team, and the collection of data to demonstrate to clinicians that the tools (and processes) actually work."[5p2] Feedback is necessary to engage practitioners and empower them to strive for higher quality. All practitioners on the team are accountable for their role in risk reduction, monitoring compliance of the standardized process to prevent WSP, identifying inconsistencies in real time, and applying team skills to support improvements and quality care for the patient.

**TABLE I[2]**

| Date | Organization | Initiative |
|---|---|---|
| 1994 | Canadian Orthopedic Association | *"Operate Through Your Site"* Campaign. Educational program for surgeons targeted at reducing wrong-site procedures. |
| 1997 | American Academy of Orthopedic Surgeons (AAOS) | AAOS Council on Education task force to research the prevalence of WSP and develop recommendations for prevention. |
| 1997 (revised 2008) | AAOS | Advisory Statement on Wrong Site Surgery advocating for:<br>• Surgeon marking the surgical site with his/her initials in consultation with the patient<br>• Use of permanent marker<br>• Operating through or next to initials<br>• Spine surgery should include an additional radiological verification of vertebral level<br>• Institutional protocols should involve the surgical team who participate in a time out to confirm the patient's identity, correct procedure & site, implants, equipment before starting the procedure. |
| 1998 | Joint Commission for Accreditation of Healthcare Organizations (JCAHO) | Issued Sentinel Event Alert #6 *Lessons Learned: Wrong Site Surgery*. It identified factors contributing to WSP and focused on communication issues as the leading cause. Risk reduction strategies recommended; marking the surgical site, oral verification of the site by the team, use of a safety checklist |
| 1999 | Institute of Medicine (IOM) | *To Err Is Human: Building a Safer Health System.* Report that informed the American public and Health Care System about the numbers of patient deaths from preventable medical errors. WSP among them. |
| 2001 | North American Spine Society (NASS) | *SMaX Campaign* encouraged surgeons to Sign, Mark, and X-Ray surgical sites. |

*continued*

| Date | Organization | Initiative |
|---|---|---|
| 2001 | IOM | Crossing the Quality Chasm: A New Health System for the 21st Century. A call to action to redesign the healthcare delivery system. Aimed at: safe, effective, patient centered, timely, efficient, equitable patient care. |
| 2002 | National Quality Forum (NQF) | Published "Serious Reportable Events in Healthcare" identifying 27 never events, preventable events that should never happen. WSP included. |
| 2002 | American College of Surgeons (ACS) | Statement on ensuring correct patient, correct site, and correct procedure surgery (ST-41) |
| 2003 | TJC | Held Wrong Site Surgery Summit resulting in the Universal Protocol for WSP. |
| 2003 | AAOS | "Sign Your Site: A Checklist for Safety" tool. |
| 2004 | AORN<br>Annual National Time Out Day 2006 - present | "Patient Safety First Campaign"<br>Inaugural National Time Out Day<br>Correct Site Surgery Tool Kit |
| 2006 | TJC International Center | Developed International Patient Safety Goals #4 is to eliminate WSP |
| 2007 | Council on Surgical & Perioperative Safety (CSPS) | Endorsed a core principle "that measures will be used to ensure correct patient, correct site, correct procedure, including implementation of the Universal Protocol of TJC is recommended and support of the Time-Out prior to surgery or initiation of an invasive procedure." |
| 2008 | World Health Organization (WHO) | Second Global Patient Safety Challenge, Safe Surgery Saves Lives.<br>WHO Surgical Safety Checklist launched. |
| 2009 | WHO | International research pilot study (2007-2009) supports use of WHO surgical checklist. Results show:<br>• Major complications fell from 11% to 7% 33%<br>• Inpatient deaths fell from 1.5-0.8% (40%)[3] |
| 2010 | AORN | AORN Comprehensive Surgical Checklist |
| 2012 | WHO | Research supports implementation of WHO safe surgical Checklist reduced in-hospital 30-day mortality from 3.13-2.85%. Outcome depended crucially on checklist compliance. [4] |
| 2012 | The Joint Commission (TJC) Center for Transforming Health Care | Targeted Solutions Tool for Wrong Site Surgery offers a step by step process to identify measure and reduce risk in WSP processes. |

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# TechnologyBytes

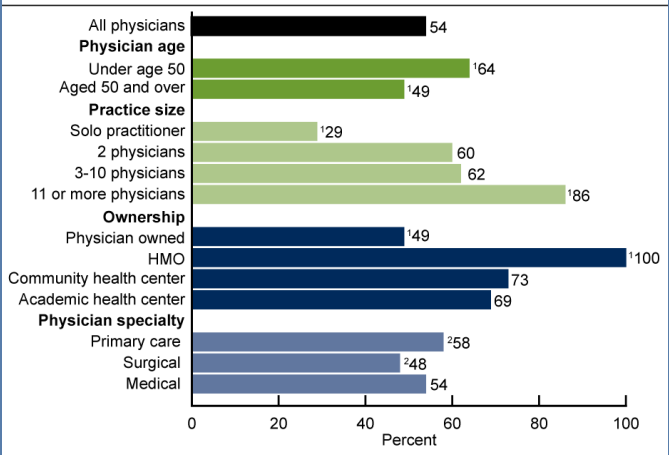
BY ANN GAFFEY RN, MSN, CPHRM, DFASHRM

## Electronic health records in the physician office practice setting

With the Meaningful Use incentive money now flowing as a result of the HITECH Act provisions, the use of electronic health records in the physician office practice setting continues to grow by leaps and bounds. Implementation of EHRs in this setting has taken many paths, including a gradual implementation as an office transitions from a paper, to a hybrid, to a fully electronic record, all the way to an "all in," where the practice implements an EHR all at once and puts paper behind for good.

As noted in Figure 1 below, data from the CDC/NCHS 2011 Physician Workflow study reports the number of physician offices across the country that have implemented some or all elements of an EHR is 55%.[1] This number has grown significantly over the past five years, likely due in part to the incentive money available for "meaningful users," which amounts to approximately $1 million paid to eligible providers as of June 2012.[2]

*Figure 1. Percentage of electronic health record system adoption, by physician age, practice size, ownership, and specialty, 2011*




*1 Differences in adoption between this category and all others are statistically significant ($p < 0.01$).*
*2 Significant difference between primary care and surgical specialists ($p < 0.01$).*
*NOTES: Adoption consists of physicians who use a health record system that is all or partially electronic (excluding systems solely for billing). The sample includes non-federal, office-based physicians and excludes radiologists, anesthesiologists, and pathologists. HMO is health maintenance organization.*
*SOURCE: CDC/NCHS, Physician Workflow study, 2011.*

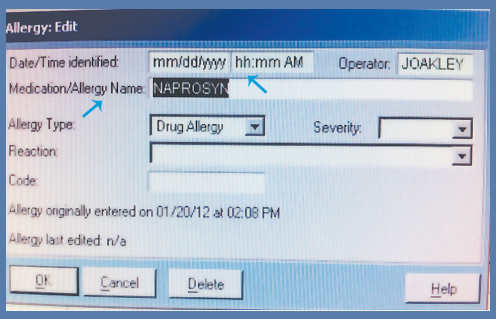
Physician offices are busy places, typically with little non-productive time allocated for non-patient care activities. This includes adequate EHR training time that should be allowed for training of staff who will be documenting patient care in an EHR. The reality of what is occurring in some offices is that staff is trained in a limited period of time, sometimes just a couple of hours, and are shown the basics of what they need to know to document. Understandably, trainers don't want to overload staff with too much at one time, but in many instances there is no follow-up after initial training occurs, thus staff is not aware of how to maximize the use of the various data collection modules and could be leaving pertinent clinical information out of the record. For example, most EHRs have data fields for documentation of patient allergies, as well as fields for the severity of reaction, and type of reaction. Frequently, patients have intolerances to medications that they report as an "allergy," but in fact they can take the medication without any adverse effect. On the other end of the spectrum, patients have life-threatening allergies to medications or other allergens, such as an antibiotic or iodine. When the data collection fields in the EHR aren't used to their full capability, for example documenting a severe allergy to Amoxicillin that causes hives and difficulty breathing, important information necessary for clinical decision making is absent or incomplete.

In addition to inadequate training is inconsistent training and a failure of the trainers to follow-up with providers and staff when upgrades to the EHR software occur. The inconsistent training and lack of follow-up translate to records in the office practice that are not complete, and may lead providers using the data to presume information is not available, when in fact it may be in a different location in the EMR, or a staff person may not have been aware of the availability of the data field to document findings. In short, having a clearly written plan for EHR implementation, training, retraining, and communication about data field changes or additions as a result of upgrades in imperative to ensuring EHRs in the physician office practice are used consistently and to their full capacity.

In an effort to improve electronic documentation in the office practice, consider the following risk reduction strategies:

- Identify a process carried out in a physician office, such as medication reconciliation, and "trace" the process through the EMR. Identify all the possible data input fields that should be used to allow for complete documentation, and identify which are consistently completed and which are not.
- Engage three or four staff members in the practice and ask them separately to walk through the EHR, demonstrating how they complete the documentation for the process you have selected. Identify inconsistencies among them in how they complete the process, or data input fields not being used that should be completed.
- Collaborate with the practice EHR trainer to develop consistent training modules, as well as a consistent communication process to ensure all staff is updated on any upgrades or changes at the same time. Consider use of

screen shots to demonstrate where in the EMR the changes are, showing drop down menus, etc. See example below:




- Educate office practice managers in how to assess high-risk processes vis-à-vis the EMR, such as tracking and reconciling lab and test results, medication reconciliation, and so forth. Set up an audit schedule and conduct random audits to ensure data is collected and documented consistently.

[1] NCHS Data Brief, Number 98, July 2012. Physician Adoption of Electronic Health Record Systems: United States, 2011. Accessed November 8, 2012 at: http://www.cdc.gov/nchs/data/databriefs/db98.htm

[2] American Medical News, Hospitals get revenue boost from meaningful use money. August 29, 2012. Accessed November 8, 2012 at: http://www.ama-assn.org/amednews/2012/08/27/bise0829.htm

## Ann Gaffey named SVP, healthcare risk management and patient safety

Sedgwick announced that Ann Gaffey has been appointed the company's senior vice president of healthcare risk management. In her new role, she will direct Sedgwick's risk management and patient safety consultation practice serving hospitals, physician groups, healthcare systems, insurance companies, and other healthcare organizations.

"Ann Gaffey brings to our world-class healthcare risk management and patient safety consulting practice a wealth of expertise and a commitment to customizing solutions that meet each client's unique needs," said David A. North, president and CEO of Sedgwick. "Appointing a seasoned professional of Ann's caliber to direct our healthcare risk management practice underscores our commitment to excellence as a leading provider of comprehensive claims and risk management services for the healthcare industry."

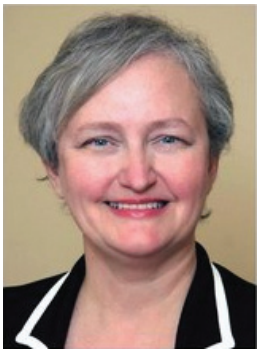
*Read more: www.sedgwick.com/NewsRelease/Gaffey_HCRM.pdf*

## SUCCESS STORY: Pressure ulcer reduction program limits liability and enhances patient safety and quality

Teresa Campbell Wallace will never forget a patient she met and the caregivers who worked hard to keep her comfortable while serving as a patient advocate many years ago in Michigan. This patient had a deep and debilitating bed sore – deep enough to fit an elongated Q-tip – that complicated the care she needed for her underlying medical condition. The image made an impression on Ms. Campbell Wallace and inspired her to make a difference.

Bed sores (now more commonly called pressure ulcers) can be a result of poor or inattentive care, but they can also occur in patients with poor nutritional status or those who may have illnesses or injuries which make repositioning difficult. Although the Centers for Medicare and Medicaid Services has identified some pressure ulcers as "never events," limiting the reimbursement associated with their care, it is clear that often pressure ulcers occur not because of staff negligence, but rather due to a combination of many circumstances.

Although many organizations focus on the reimbursement or liability issues associated with pressure ulcers, Ms. Campbell Wallace approached the problem by proactively designing a comprehensive program to educate staff on pressure ulcer prevention and management and to identify and utilize the best available technology to assist in their management. This included gaining a commitment from leadership to purchase new mattresses equipped with special technology to reduce pressure on skin. In addition, special padding was also purchased for gurneys, OR tables, and patient lifts where compromised patients may also find their skin integrity compromised.



As the Director of Health Care Risk at Sutter Health, Ms. Campbell Wallace has led the multidisciplinary "PUP" – or pressure ulcer program – for nearly a decade. The program has set a goal of a zero rate for pressure sores and provides staff education through webinars, newsletters, and direct mentoring. The program continues to report superior results and to initiate and implement new quality and safety enhancements to provide further improvements in patient outcomes and system losses.

Sedgwick is proud to be a partner of Sutter Health and we are inspired by its commitment to innovation in healthcare risk management. "They have been groundbreaking in the scope of their project and long-term dedication to it," said Chris Mulcahy, VP Specialty Operations, PL Management for Sedgwick. "Teresa can be a resource for anyone in the country. They can share this program with anyone in the country and help them save money, save lives, and save litigation."

Ms. Campbell Wallace was chosen as a 2012 Risk Innovator by *Risk & Insurance Magazine* for her work on the pressure ulcer program for Sutter Health. Congratulations on your recognition, Teresa, and thank you for your continued work toward improving patient health and safety.

## How can healthcare risk management and patient safety help you?

## Learn more about the TeamSTEPPS program.

St. Joseph and Redwood Memorial Hospitals in Humboldt County, CA recently recognized several hundred of their medical and clinical staff members who have completed TeamSTEPPS training, a national teamwork training program aimed at improving patient safety.

Sedgwick's healthcare risk management and patient safety consultants provided the TeamSTEPPS Champion training and implementation planning for this client and they have really taken it to the next level. "Our organization's awareness of reporting, ownership of data and outcomes, timely plans of correction, and our front-line staff's awareness of Hospital Acquired Conditions is now at a level never before realized in our organization in my 21 years as a staff physician and physician leader," said Dr. Matthew Miller, Chief Medical Officer and Patient Safety Officer for the two hospitals.

Sedgwick consultants spent two days on site providing training for the change team and guiding the development of an action plan and communication plan for implementation. Monthly webinars conducted by Sedgwick help sustain the momentum, providing ongoing support for TeamSTEPPS concepts. These webinars also serve as a forum for St. Joseph, Redwood, and other participating hospital medical teams to share challenges and successes in the use of information, people, resources, and communication tools to ensure patient safety and achieve the best clinical outcomes for patients.

### TeamSTEPPS helps achieve real-world patient safety goals

TeamSTEPPS is an evidence-based training system, scientifically rooted in more than 20 years of research and application, designed to build communication and teamwork skills among healthcare professionals.

The program provides higher quality, safer patient care by:

- Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients
- Increasing team awareness and clarifying team roles and responsibilities
- Resolving conflicts and improving information sharing
- Eliminating barriers to quality and safety

The training and reinforcement continues internally at St. Joseph and Redwood. "It's standing room only!," said Dr. Miller.

**To learn more about the successful TeamSTEPPS program and how Sedgwick can implement this training program for you, call us at 866-225-9951.**

## About Sedgwick

Sedgwick is the nation's leading provider of technology-enabled claims and productivity management services. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

Are you concerned about a lack of teamwork in your perioperative area affecting patient care, possibly leading to retained foreign objects or wrong-site surgery? Our demonstrated success in reducing perioperative risk through assessments, team training, coaching, and ongoing education may be the solution for you. Please contact us today for a customized approach to your perioperative risk management and patient safety challenges.

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