

Project Submission:
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MERCY FITZGERALD HOSPITAL

*“Multi-Specialty Task Force is
Key to Safe Culture Transformation”*

Abstract

An effective Operating Room requires multiple personnel, from various specialties, to work in a cohesive manner to perform surgical procedures that ultimately improve and save lives. Conversely, an Operating Room is an area that has the potential to have errors with disastrous consequences. In addition to processes and policies that steer the patient towards safety and quality care, care areas exhibit a culture from which habits and behavior can form. As a Perioperative culture evolves, it is paramount for the leaders from all specialty areas to be in touch with this environment and ensure safety and quality. Hospitals have personnel resources at every level that are capable of energizing larger groups of individuals to become active participants in the assurance of quality care with maximum safety. At our organization a cross specialty task force with selected personnel was formed to optimize efforts in preventing wrong site surgery and address sponge and instrument count issues. These initiatives were successfully executed within the dynamic Perioperative area. Individuals from physician offices to the Operating Room developed stronger relationships as they learned and participated in effective measures to ensure patient safety. A new appreciation evolved for each others roles. As practical processes evolved, a positive wave occurred in the work areas. Selection of the right, multi-specialty team that can empower others was vital to these successful initiatives.

Multi-Specialty Task Force is Key to Safe Culture Transformation

Over time organizations and work areas can develop into a culture that may need to be adjusted to fulfill their mission. In an Operating Room, the dynamics can lend itself to evolving into behavior that may not be consistent in attaining best efforts to prevent adverse outcomes. Despite processes and policies, the remodeling of a culture in an Operating Room may be the ultimate challenge. It has become evident that each member in the Perioperative area must take ownership when it comes to patient safety.

In the Operating Room at our institution two major areas of concern were apparent. First, as wrong site surgery was studied in Pennsylvania, a dramatic statistic was manifest. Wrong site surgery, a never event, was occurring every 28 days over a thirty month period. Second, a local issue at our institution, we realized that there were an ever increasing amount of sponge miscounts occurring. Additionally, there had been one serious event occurring once a year for the past three years. It was recognized that a dramatic change was needed beyond the existing processes. The culture of the Operating Room needed adjusting to refocus priorities and to include active participation in all safety elements as a patient is guided through the Perioperative areas. This participation includes the patient. Patient safety is embedded in quality care and thus was the focus of a multi-specialty task force to research, plan, and implement process and culture changes of the two large focus areas identified.

Operating rooms involve multiple specialties working together to achieve the common goal of delivering quality care in a safe manner. Each area involves human decisions that a patient relies on to be accurate and correct. One way to attempt to control these conditions is to design the setting for active and interactive participation. The margin of error needs to be minimized to ensure the highest degree of safety for patients processing through a surgical procedure.

Hospitals are filled with intelligent and motivated individuals. Identifying and placing these individuals on a goal oriented task force was vital to changing the existing culture. We employed this strategy and a task force called the Surgical Task Force for Patient Safety and Process Improvement was comprised. This consisted of individuals from the Operating Room, Anesthesia, Department of Surgery, Quality Improvement, Risk Management, Nursing, Short Procedure Unit, the Chief of Surgery, and the Chief Medical Officer. Individuals were specifically selected from each specialty that were known to have a positive influence, possess leadership qualities, and display the ability to foster change in culture and practice. Each committee member has their unique strengths which allowed us to target specific learning needs.

The mission for the task force was to address major safety or quality issues that lead to broad initiatives in process, policy, or work area culture changes. Over a period of twelve months two major initiatives have been successfully implemented. These initiatives were the prevention of wrong site surgery and the reinstatement of a standard and consistent sponge and needle count process.

Our hospital participated in the Partnership for Patient Care (PPC) Wrong Site Surgery Workshop in March 2008 to explore ways to prevent wrong site surgery. Members from the task force attended this conference and brought back ideas and information from many surrounding area hospitals. We evaluated our processes, learned about wrong site surgery, and made multiple successful changes in our practice to attempt to minimize the chances of occurrence at our institution. Most wrong site surgery occurrences originate from errors in the reservation of the procedure, improper pre-op patient verification, or an improper time-out. As a group we focused on seven critical areas in the processing of a surgical patient from the physician's office to the final time-out. These areas are the procedure reservation, pre-admission testing, site verification form, surgical consents, patient pre-op holding area, pre-op sedation, and the "final Time-out". The theme throughout the process is participation. Active participation among the patient, staff, and surgeons has improved compliance and continually reminds caregivers and patients why safety mechanisms are in place. The result of this implementation was a positive reaction that we realized was ultimately the beginning of a change in culture.

Realizing up to 1/3 of wrong site surgery occurrences can be traced to the booking of a case, the first action was to standardize the patient reservation form. Many physician offices were using a multitude of forms that were revised and collected over the years. We engaged the office managers and secretaries over a series of breakfast forums and explained the importance of the improvements. As for pre-admission testing, there was an inconsistent pattern of information flow from the surgeon offices to the hospital. In the manner of the reservations, we reached out to the surgeon offices with minimal kickback to enforce time guidelines for relevant information transmission. Reaching out in this manner we found that new relationships were beginning, communication was improved, and the overall hospital to surgeon office flow improved.

Enforcing the rule that consent forms must be accurate and complete prior to a patient being transferred from the Short Procedure Unit to the Operating Room literally obliterated the consent errors. We felt this crucial to implement as it kept patients geographically away from the Operating Room until the consent was complete.

Active participation with the patient occurs as they enter the hospital. Patients are educated on safety mechanisms such as identifiers and site verification. The overall patient

response to this was positive. To enhance involvement in the verification process, the Anesthesia Department, using clinical discretion, withholds sedation until the patient enters the Operating Room to facilitate site confirmation and team introductions.

To improve our time out process, the “Final Time-out” was reformatted to allow complete participation from the team performing the case. Similar to having a role in a school play, each member of the team has a role in the time out. The Circulating Nurse calls for the time out, the CRNA begins with patient identification, the surgeon announces his procedure, and the circulating nurse reads the remaining elements. All members must agree and have the opportunity to verbalize questions or concerns. When all are in agreement, the scrub technician passes the scalpel to the surgeon. Using the school play analogy we found that members of the surgical team were actually looking forward to their part in the time-out. This structured time-out is active, participative, and results in attention and compliance.

The patient verification process resulted in a new, simplified site verification form that has since been adopted throughout the institution. To complete this endeavor, the Universal Protocol Policy has been updated with the changes.

The final step in the participation theme was to communicate these changes to all involved. The committee realized that proper implementation was the key to success. We ensured that prior to “go-live” that every surgeon, staff member, and office staff had known and understood the issues surrounding wrong site surgery and our plan. This communication was accomplished by in-services, presentation at grand rounds, office manager meetings, and formal letters from the Chief of Surgery, and direct calls to office staff. Additionally, each Operating Room member signed off on training and a mock case was completed.

The next major initiative was focused on our counting processes. Sponge miscounts could lead to the retention of a foreign object in a patient which is classified as a never event on the National Quality Forum list. For this initiative it was decided to convene a smaller task force of Operating Room Nurses with various degrees of experience, surgical technicians, surgeons, CPD representatives, and members of the Anesthesia Department to evaluate our processes and proceed with appropriate adjustments. The multi-specialty “participative” approach again proved to be effective. The group realized that there was a lack of appreciation on the work of each others specialties. Things like excess noise, not announcing the count, and ineffective communication were part of the issues. Other areas needing to be addressed were non-standardized counts, inappropriate casualness in the Operating Room, lack of assertiveness of the circulator, and archaic training issues such as outdated processes being passed forward.

The multi-specialty committee was vital to the success of the process changes. The group

met regularly over a period of eight weeks and quickly gained an understanding of how each other execute their job. This new understanding paved the way for successful process changes that all parties complied and appreciated. This committee recommended policy and process changes to the Surgical Task Force and, in the same fashion as Wrong Site Surgery prevention, rolled out new processes. Policy changes included AORN practices, proper hand off communication, standardization of trays, surgeon participation, count announcements, no distraction and noise stop, and all activity stops if discrepancy occurs. Since implementation we have had no lost items or serious events.

These two major initiatives described were successfully implemented within a dynamic Operating Room area. The success is attributed to a team of multi-specialty health care professionals who were seen as having the ability to help foster positive, appropriate change. This team was able to pool skills and effectively communicate the issues and need for changes to all perioperative personnel. The appreciation for each others jobs, perspectives, and responsibilities helped in fostering solid ideas and dramatically improved compliance. As the new methods evolved and developed in a pragmatic fashion, much like positive attitudes are contagious, care givers in the perioperative area wanted to be part of the wave. This is how a renewed culture began in the operating room at our institution.

Policy or process changes that involve patient care must not be unilateral or accomplished in a “silo”. If there are multiple specialties involved in the care of a patient, then all must actively participate in the solution. Health care organizations are filled with very bright, highly educated and capable individuals. Selecting the right team for critical issues like preventing wrong site surgery and retaining of foreign objects is essential for buy-in, compliance, and long term success.

These methods require the resource of personnel who possess the leadership qualities that can invigorate, energize, lead, and cultivate positive change attitudes. Hospitals throughout the region have many individuals who may, or may not, be in traditional leadership roles. Leaders can easily identify and empower key individuals to come together to collaborate and guide a unit’s culture in a better direction. Amazing transformations will occur with some perseverance, participation, and role-modeling.