

Introducing a Safe Surgery Initiative to the Operating Room

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Objectives

- Rationale/Support for initiative
- Development of policy
- Trial period
- Findings
- Recommendations

Rationale / Support

- National Adverse Publicity
- Our Lady's Hospital for Sick Children Report
- WHO Safe Surgery Saves Lives Campaign
- The Joint Commission
- Association of Operating Room Nurses
- American College of Surgeons
- World Alliance for Patient Safety
- National Patient Safety Agency
- American Academy of Orthopaedic Surgeons

Development of Policy

- Risk Manager contacted Surgical Sub Group and CNM III Theatre
- Approached JCI Accredited Hospitals
- Determined potential barriers including:
 - Seen as "nurse initiative"
 - Documentation of Time Out
 - Medico legal considerations

GO LIVE

- Go Live Date: 5 August 2008!
- Posters
- Intranet
- Bulletins



- And a nice gift from Cadbury's

Trial Period

| Area | # SUBMIT | # AUDIT | Surgeon Present | | | Anaesthetist Present | | | 3 Nurses Present | | | Patient Marked | | | | | |
|-----------------------|-------------|------------|-----------------|----------|----------|----------------------|----------|-----------|------------------|------------|-----------|----------------|-----------|------------|-----------|------------|----------|
| | | | Y | N | ? | Y | N | NA | ? | Y | N | NA | ? | | | | |
| Day Surgery | 225 | 45 | 45 | 0 | 0 | 18 | 0 | 25 | 0 | 24 | 18 | 0 | 3 | 17 | 0 | 26 | 2 |
| Theatre 1 & 2 | 70 | 31 | 31 | 0 | 0 | 31 | 0 | 0 | 0 | 31 | 0 | 0 | 0 | 11 | 2 | 18 | 0 |
| Theatre 3 & 4 | 191 | 89 | 88 | 0 | 1 | 86 | 1 | 0 | 2 | 82 | 3 | 0 | 4 | 78 | 1 | 6 | 7 |
| Theatre 5 & Burns | 153 | 75 | 75 | 0 | 0 | 67 | 0 | 8 | 0 | 74 | 1 | 0 | 0 | 58 | 6 | 11 | 0 |
| Theatre 6, 7 and Endo | 193 | 79 | 78 | 0 | 1 | 69 | 1 | 8 | 0 | 64 | 10 | 0 | 5 | 39 | 0 | 39 | 0 |
| Theatre 8 & 9 | 102 | 48 | 44 | 4 | 0 | 43 | 4 | 0 | 1 | 43 | 4 | 1 | 0 | 37 | 4 | 7 | 0 |
| Theatre 10 & 11 | 134 | 71 | 71 | 0 | 0 | 69 | 0 | 2 | 0 | 70 | 1 | 0 | 0 | 45 | 0 | 23 | 3 |
| Total | 1068 | 438 | 432 | 4 | 2 | 363 | 6 | 43 | 3 | 388 | 37 | 1 | 12 | 285 | 13 | 130 | 6 |
| | | | 99% compliance | | | 99% compliance | | | 91% compliance | | | 97% compliance | | | | | |

Findings

- 1,064 patients' procedures were preceded by the Time Out process
- Over 60 surgeons participated in the 438 surgeries audited
- At least three near misses of wrong site surgeries were identified
- One surgeon has refused to participate in time out
- Rationale was given for 8 of 13 site markings not carried out
- Compliance with policy has proven to be high
- Documentation of Time Out process was incomplete in 26 cases

Recommendations

Immediate Term

- Continue with this policy and amend based on trial period.
- Implement as hospital document.
- Extend list of exemptions for marking (e.g. extensive burns).
- Include Nurses and Surgeons as joint "owners" of this policy.
- Write to one surgeon to inform him about indemnity issues
- Ensure rationale is given when site marking is indicated as "no"
- Ensure documentation of time out process is complete
- Ensure "N/A" is indicated when marking is not applicable

Medium Term

- Include documentation of "Time Out" on SAPHR
- Consider implementing Surgical Safety Checklist

Thank you

The implementation of this policy would not have been possible without the hard work, diligence and cooperation of the nurses, doctors and anaesthetists of St James's Hospital.