OR Manager Inc

**OR Manager**
Vol. 29 No. 2
February 2013

**Patient safety**

# Safer surgery: Is your scheduling process as accurate is it could be?

*Ten elements of safer surgery. Second in a series.*

Much of the effort to ensure correct-site surgery focuses on preoperative verification. But scheduling is where it all begins. Capturing complete and accurate information when the case is booked is key to preventing errors down the line.


Scheduling flaws are a common barrier in preventing wrong surgery, according to reports from 2 states where reporting of these events is mandatory.

In Minnesota, breakdowns in initial scheduling, such as missing or incorrect information, were one root cause for events reported in 2011.

In a survey of Pennsylvania facilities, access to accurate information before the patient's arrival in the preoperative holding area was one barrier to adopting evidence-based recommendations to prevent wrong-site surgery, reports the Pennsylvania Patient Safety Authority. (The recommendations are at www.patientsafetyauthority.org.)

"The earlier you can align all of the information about the patient, the less the chance of error," says the Authority's clinical director, John Clarke, MD, who is also professor of surgery at Drexel University in Philadelphia.

"If you wait until a nurse is rushing around in the preoperative holding area, the chance of error is greater."

## Strategies for accuracy

In the Pennsylvania survey, 47 facilities named 80 strategies they used to meet the goal of having 100% of documents complete, correct, and in agreement on initial verification when the patient arrives in the preop holding area.

The most common strategies:

- verification and reconciliation of information prior to the day of surgery by the OR schedulers and/or preadmission nurses
- use of preoperative verification checklists
- embedding verification in an electronic scheduling form
- making phone calls to patients the day before surgery.

Phoning patients the day before surgery, while not the most common method, seemed to be effective because it entails active verification, Dr Clarke notes. Unlike with an automated call, a nurse who calls patients is able to probe and elicit responses to confirm information.

## Foster close communication

Close communication with surgeons' offices is an essential link in a safe scheduling process.

Dr Clarke notes key points that can aid this process:

- Agree with the surgeons' offices that a minimum set of information will be required to schedule surgery, such as the patient's identity, procedure, and surgical site.

## *Ten components for safer surgery*

The components of Advocate Health Care's Safer Surgery initiative:

1. Perioperative governing body
2. Single path for surgical scheduling
3. Preanesthesia testing (PAT) with standardized protocols/hospitalists
4. Document management system for scheduling and PAT
5. Excellence in sterile processing
6. Crew resource management
7. Implementation of World Health Organization Surgical Safety Checklist
8. Daily huddle
9. Error reporting
10. Just culture

- Agree that when possible, patient information, the consent, and the history and physical (H&P) will be obtained by the surgeon in the office when the decision for surgery is made.
- Have experienced OR schedulers who are firm yet respectful in communicating with offices.
- Audit the process for receiving information from the surgeons' offices to make sure the process is working as expected. For example, track 5 to 10 cases monthly.

"See if you're doing what you think you are doing," Dr Clarke suggests. "If not, ask, 'What are the barriers?'"

Tips and a checklist template for surgeons' offices for preventing wrong surgery plus a monitoring tool are available on the Authority's website (www.patientsafetyauthority.org).

## Booking errors 'alarming'

An in-depth analysis of surgical booking for more than 4,500 patients in an 8-OR ambulatory surgery center (ASC) turned up errors that were "quite alarming," says the administrator, Thomas Halton, BSN, RN, CNOR. He is the assistant director of nursing for the Stony Brook Medicine ASC, affiliated with Stony Brook University in New York.

The project's aim, he says, was to "affirm the hypothesis that the preprocedural verification process currently in place was effective in identifying potential wrong-site/wrong-side errors."

The project examined variables from the booking sheets, H&Ps, surgical schedules, consent forms, and staff interventions for all cases over 7 months.

In all, 241 (5.3%) discrepancies were noted on the booking sheets. Of the total, 62 were wrong-site or -side documentation errors on preop paperwork and booking sheets from the physicians' offices.

Orthopedics, ophthalmology, and plastic surgery had the highest percentages of discrepancies, but no service or surgeon had error-free booking information.

## Preverification effective

The analysis confirmed that the preprocedure process was effective in preventing errors from reaching the OR. Halton says the facility has not had any wrong-site or -side errors, which he attributes to the preprocedural check. The steps include:

- confirmation of correct patient information in the booking process
- verification in the preop clinic
- the nurse's preop phone call to the patient the day before surgery
- final verification with the patient on the day of surgery by all disciplines (preop nurse, anesthesia provider, OR circulating nurse, and surgeon) before entry to the OR.

A time-out is then performed in the OR before the first surgical instrument is passed.

Halton presented the data to all surgical services and the patient safety and OR committees as well as the hospital QA committee.

"We received a lot of support from the hospital after the data was presented," he says.

## Interventions underway

Stony Brook is working on interventions to prevent booking errors. An electronic booking process with required fields is in the trial phase. Once this is in place, offices will enter their own booking information, avoiding transcription errors by the facility.

"Offices will have the ability to send the booking. We can review it and send it back for attestation," Halton says.

Another fail-safe: A huddle is held at 1 pm each day to review and verify the next day's schedule.

"It's a team approach," Halton says. On hand with him are the surgical schedulers, the OR head nurse, the preop nurse, the sterile processing supervisor, materials manager, anesthesia director, and OR service clinicians.

In one telling example of how errors are caught, a patient—himself a physician—came in for orthopedic surgery. The schedule and consent said the right side. The patient had signed the consent for the right side on the day of surgery. But during preoperative verification, the preop nurse asked the patient to confirm the site/side. "No, it's my left," the patient said.

"That puts it in perspective—the nurse did her job," says Halton.

## Single path to scheduling

A single path to surgical scheduling helps avoid booking inaccuracies for Advocate Health Care, a Chicago-based system with 10 hospitals.

For a case to be added to the schedule, the surgeon's office must submit a written form with a minimum set of data elements completed. The form is faxed to the scheduling office, where it enters an electronic file and is routed to the appropriate places.

Previously, surgeons scheduled in multiple ways—by phone, fax, or dropping by the scheduling office.

"Once we looked at the whole process, we decided it was best to have a written document," says Cindy Mahal-van Brenk, MS, RN, CNOR, executive service line leader for surgery at Advocate Lutheran General Hospital in Park Ridge, Illinois.

The most crucial part of the implementation was working with the surgeons' offices, she says.

"It took a lot of face time. We held breakfasts, went to their offices, and had sidebar meetings if they had questions. We asked for feedback on what could be better about the form."

Explaining the rationale for the change helped.

"We talked with them about good catches and what went wrong based on the process we had," she says. They pointed out that everyone loses if a case has to be canceled or a sentinel event occurs because of a flaw in scheduling.

Requiring a written document has made a difference, she notes.

"Almost daily, a doctor might say, 'That wasn't how I scheduled this.' We can say, 'Let's look at the fax form.' Then the doctor will say, 'Oh, I guess I did.'"

## *For surgeons' offices: What you can do to prevent wrong-site surgery*

- When scheduling an operation, include the correct patient name and procedure. Include the side or site if pertinent. Do not use abbreviations. Write out all numbers.
- When obtaining the consent, include the correct procedure. Include the side or site if pertinent. Do not use abbreviations. Write out all numbers. Make sure the patient has signed the consent before the patient next presents to the surgical facility.
- The history and physical should give the preoperative diagnosis, including the side or site if pertinent. It should also state the planned procedure, including the side or site if pertinent, without abbreviations. Pertinent supporting information uniquely found in the office records should be included in the history and physical, or copies should be attached.
- If relevant, laboratory results, imaging studies, and/or pathology results should be included in the preoperative documentation.
- When information leaves the surgeon's office, check to make sure the name of the procedure on the scheduling slip, consent, and history and physical all match. All discrepancies should be reconciled as soon as possible.

Advocate Lutheran General also holds a daily huddle with representatives from anesthesia, nursing, preadmission testing, and sterile processing to review and confirm the schedule and key information for the next day's cases.

## Physician signature required

Only signed orders—not verbal orders—are accepted to schedule surgery at Cayuna Regional Medical Center, a critical access hospital in Crosby, Minnesota.

The policy change is part of a 6-month quality improvement project to streamline and improve scheduling accuracy.

The hospital faced several challenges with scheduling:

- Required preop tests were sometimes missed.
- Unapproved abbreviations were used at times.
- Multiple forms for a single patient, each with partial information, were circulated through the facility.

To document errors that had occurred, the director of surgical services, Deb Moengen, RN, CPAN, compiled folders of scheduling forms with errors and gave them to the medical director.

Examples were missing signatures and unapproved abbreviations.

After reviewing the folders, the chief of the medical staff decided verbal orders would no longer be accepted, Moengen says.

A multidisciplinary work group has introduced other changes:

- a new scheduling form with required information
- a policy to standardize abbreviations.

As a handy reference for abbreviations, the hospital installed software purchased from www.medabbrevs.com on desktops.

The new scheduling form will be incorporated into the electronic medical record software. Eventually, physicians' offices will be able to schedule procedures electronically, though there is a challenge of working with different types of electronic records.

Moengen's advice on improving the scheduling process:

- Engage physicians from the beginning.
- Involve the IT department if your facility is moving to an electronic system.
- Collect data on errors to document the need for change.

Most of all, have patience, Moengen says.

"You think it's a form, but it's not. It's the whole process." ❖

*—Pat Patterson*

## References

Clarke J. What keeps facilities from implementing best practices to prevent wrong-site surgery? Barriers and strategies for overcoming them. Pennsylvania Patient Safety Advisory. 2012;9(Suppl 1):1-15. www.patientsafetyauthority.org

Minnesota Alliance for Patient Safety. Surgery Scheduling and Verification Pilot Project. Project tools. www.mnpatientsafety.org/index.php?option=com_content&task=view&id=88&Itemid=0

Minnesota Department of Health. Adverse Health Events in Minnesota. 8th annual public report, January 2012. www.health.state.mn.us/patientsafety/ae/2012ahereport.pdf



 