Patient Safety in Operation Room

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Improving patient safety is an increasing priority for hospitals since sentinel events can be catastrophic for patients, caregivers, and institutions. Patients who undergo a surgical or an invasive procedure are at increased risk of suffering an adverse event since the environment is complex and pressurised. Thus unintentional adverse events may occur leading to serious harm comes to patients. Therefore patient safety is recognised as important approach to improve the quality and safety of care in operation theatre. At facilities where surgery and invasive procedures are performed, specific steps must be implemented in order to reduce the likelihood of incorrect surgeries.

Steps to Improve Surgical Outcomes

Following steps must be taken to ensure that the indicated surgical procedure is performed on the correct patient, at the correct site, and if applicable, with the correct implant. The steps are as follows:

- Scheduling
- Informed consent
- Patient identification
- Verification of the procedure to be performed
- Site marking (as required related to level, laterality, multiple structures)
- "Pause for the cause" or "Time-Out" briefing.
- Review of imaging data.

A. Scheduling

The physician or his/her designee notifies the procedure area with:

- Patient name and medical record number (when available) or birth date
- If minor, name of parent or legal guardian
- Patient date of birth
- Surgeon or practitioner name
- Date of procedure
- Name of procedure(s) – minimise use of abbreviations
- Site of procedure(s) – laterality, level and/or multiples

Diagnosis

- Any special needs – e.g. precautions, specialised equipment, interpreter.

B. Informed Consent

Informed consent is obtained for all planned and possible invasive or high risk procedures. To assure correct site procedure, informed consent documentation includes:

- Patient's name (and medical record number, if available)
- Date
- Treatment / procedure recommended
- Site of procedure – including laterality, level, and/or multiples.

While consent is being obtained, the patient must be awake and alert and have the capacity to understand the details and implications of the procedure. Consent must be obtained in a language that the patient understands or through an interpreter. The consent protocol can, however, be waived in emergency cases with threat to life or limb.

C. Patient Identification

The circulating nurse should be responsible for identifying patients prior to bringing them into the OR. They should ask the patients to verbally state their full name and father's name or date of birth, and to identify his/ her operative site. The patients' responses should be checked against the signed consent forms, the patients' identification bands, as well as to the marked sites.

In cases where the patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a family member, should be asked to state the name of the patient and the site to be operated on. The staff member who performed the identification must stay with the patient until the patient is transported into the OR.

D. Verification

This consists of verifying the correct patient, site and procedure at every stage from the time a decision is

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made to operate to the time the patient undergoes the operation.

Prior to sending the patient to OR, the clinicians involved in the care of the patient prior to and during the procedure (e.g., pre-op nurse, other nurse teams, radiology personnel, and/or anesthesia care providers) separately verify the:

- Patient's identity (using two identifiers)
- Procedure to be performed
- Site of the procedure by comparing relevant documentation, diagnostic studies, and the verbal response (when able) of the patient/legal guardian.

This will be documented by each person, at each point of the verification process, and recorded in the patient record.

E. Site Marking

1. Mark all the site or sites to be operated including those on the midline, face and groin. Use of a special-purpose wristband should be done in cases where the site is awkward or problematic such as the perineum.

2. Any controversy related to site marking (including procedure, level, laterality, or documentation) needs to be resolved prior to site marking.

3. Marking involves laterality, multiple structures (e.g. fingers, toes, ribs) and multiple levels (e.g. vertebral column).

4. Procedures not requiring marking:

- Single organ procedures where laterality is not a factor (e.g. Caesarean section, cardiac surgery, endoscopies, rectal/vaginal procedures)
- Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g. cardiac catheterisation)
- Teeth – but, do indicate tooth names on documentation or mark the operative tooth (teeth) on the dental radiographs or dental diagram
- Premature infants for whom the mark may cause a permanent tattoo.
- Minor procedures not requiring signed consent
- Procedure sites that cannot be marked due to physical location (e.g., rectal or vaginal procedures) or do not involve an incision or injection (e.g., cystoscopy, bronchoscopy, laryngoscopy).

5. Special Considerations related to marking:

- Site sensitive areas may be marked above or lateral to the procedure site (e.g., scrotal surgery sites will be marked on the groin area on the appropriate part of the body, breast sites will be marked on or above the breast on the upper chest area).
- If a patient refuses to have a site marked, an alternative process (e.g. a drawing) is used and the patient's wishes are documented in the record.

6. Complete the marking while the patient is alert and awake, as the patient's involvement is important.

7. Site marking should be unambiguous, clearly visible and made with a permanent marker so that the mark is not removed during site preparation.

8. The mark is placed so that it is visible in the operative field after the site is prepared and draped.

9. The site is marked by the clinician performing the procedure using his/her initials. Do not mark non-operative sites. Do not use stick-on labels.

F. "Pause for the Cause" or "Time-out" Briefing

1. The pause for the cause is defined as an active pause as near to the start of the procedure as possible. This pause includes the final confirmation of the patient's identification, the procedure to be done and the site of the procedure when necessary.

The pause calls for all members of the team involved with the procedure to actively agree that it is safe to proceed.

In many cases the patient will be under sedation or unconscious when the time-out briefing occurs and is not expected to participate in this process. Documentation of the pause and other elements is required.

2. Just before the actual procedure begins, a final verification ("pause for the cause") is performed by all clinicians present (e.g. in the OR: surgeon, anaesthesia care provider, surgical technician and RN circulator). Using active verbal participation, members of the team verbally verify the following:

- Patient identity
- Procedure to be performed
- Site of the procedure, noting the position of the patient
- Presence of images (properly labelled and displayed)
- Presence of required implants and any special equipment.

3. If an implant is used final verification prior to implant should include:

a. Implant specification/type

b. Size

c. Laterality

4. The clinician identified as accountable for recording verifies the information with the record and documents the "pause for the cause" in the patient record.

5. In cases where multiple unrelated procedures are to be performed, the "pause for the cause" (pause and verification) is repeated prior to each incision or injection.

6. In cases where the procedure is exploratory or unexpected findings occur during the procedure that results in a change in the procedure or original site (e.g. cancer is identified while doing an exploratory), the following applies:

- The change in procedure or site must be within the parameters of the signed consent form and verified.
- All personnel involved in the procedure must stop to perform an additional verification, noting the change in procedure and/or site.

7. If, at any point in the process, a discrepancy is discovered in the site marking or verification process, the clinicians involved in performing the procedure are notified. The procedure is stopped and does not continue until the discrepancy is reconciled.

G. Imaging Data

Pre-existing radiological images should be referred before giving an incision. Two members of the OR team are required to confirm that the images are correct, properly labelled (name and side of anatomy), and properly presented and oriented (right or left and up and down). The surgeon, resident, and nurse circulator should view the radiological image separately and ascertain what elements of the image they reviewed.

H. Reporting

Any episode of wrong patient, wrong site or wrong procedure should be immediately reported.

Conclusion

All nurses have significant contribution to make in protecting and improving patient safety. As the health care provider she spends the greatest amount of time with patient overseeing, coordinating and providing care. The nursing perspective on reducing errors and improving systems must be part of a collaborative approach involving the public, other health care providers, employers, educators, administrators, researchers and government at all levels of the health care system.

References

1. Novello Antonia C. Surgical and Invasive Procedure Protocol [Online]. 2006 September Available from: https://www.health.ny.gov
2. Review of Patient Safety in the Operating Room in VHA Facilities [Online]. 2007 Feb 28; Available from: URL:http://www.va.gov/
3. Patient Safety Initiative: 2008 Summary Report [Online]. (link to http://www.nj.gov/health/ps/documents/ps_report_2008.pdf)
4. Site Marking & Verification for Invasive and/or High Risk Procedures [Online]. 2006 May; Available from: https://www.mnhospitals.org/
5. WHO Patient Safety, WHO Guidelines for Safe Surgery 2009 Safe Surgery Saves Lives [Online]. 2009 Available from: www.who.int/patientsafety/safesurgery

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आपको मासिक पत्रिका टीएनएआई बुलेटिन मिलने में शिकायत तो नहीं है

टीएनएआई के कुछ आजीवन सदस्यों से हमें यदा कदा शिकायत मिलती रहती है कि उन्हें मासिक बुलेटिन की प्रतियां नहीं मिल रही हैं। सभी आजीवन सदस्यों को अधिसूचित किया जाता है कि मासिक टीएनएआई बुलेटिन की प्रतियां नियमित रूप से भेजने की व्यवस्था है। आपको यदि इसकी प्रति नहीं मिल रही है तोः

1. स्थानीय डाकघर में पूछताछ करें और प्रतियां नहीं मिलने की शिकायत दर्ज करें।

2. यह सुनिश्चय करें कि टीएनएआई मुख्यालय को दिया गया आपके नाम और पता के विवरण में कोई त्रुटि नहीं है और यह संपूर्ण है। इसमें पिन कोड का उल्लेख किया जाना अनिवार्य है।

मासिक बुलेटिन की सभी प्रतियां मुख्यालय से महीने के पहले सप्ताह में भेज दी जाती हैं। फिर भी किसी माह की प्रति आपको नहीं मिलती है तो उसी माह की 15 तारीख तक मुख्यालय को आवेदन करें, यदि संभव हुआ तो हम इसकी प्रति दोबारा भेजने का प्रयत्न करेंगे। याद रहे, उक्त तारीख के बाद मिली शिकायतों पर विचार नहीं किया जाएगा।