Minnesota Patient Safety Alert Regarding Surgery/Procedure Adverse Health Events

June 30, 2016

Key trends noted in the adverse health event reporting system
Although Minnesota hospitals, health systems and surgical centers have been working diligently to reduce wrong site/wrong body part and wrong procedure adverse events, we experienced a high number of events in year 12 and may experience an even higher number of these events this year unless best practices are reviewed and consistently implemented.

Total number of wrong body part/wrong site procedure events

Wrong site/wrong body part events:
- Spinal procedures continue to be the most common type of wrong site/wrong body part event, possibly resulting from the difficulty of identifying vertebrae in the thoracic region.
- There has been an increase in the number of minimally invasive procedures. These types of procedures make it difficult to visualize the intended surgical site.
- Organizations reported that although Time Out was conducted in 82 percent of cases, all the steps of Time Out were completed in only 68 percent of the cases.
- Most commonly missed steps in the Time Out include:
  - Staff stopping all activity during the Time Out.
  - Staff using appropriate source documents to verify the surgery and procedure location.
  - Staff visualize the site marking and its location with verbal confirmation.
Wrong procedure events:
- Incorrect implants remain the most common type of wrong procedure events, accounting for 60 percent of wrong procedure cases.
  - Incorrect implants include ocular lenses, drains, catheters and feeding tubes.
- Organizations reported that although the pre-procedure Time Out was conducted 100 percent of the time, all the steps of Time Out were completed only 60 percent of the time.
- Most commonly missed steps in the Time Out include:
  - Using source documentation to verify the procedure prior to the procedure start.
  - Each team member engaged in a verbal/active role during the Time Out.

Executive leadership actions
In order to ensure the safety of patients, families and communities, it is essential that senior leadership take an active role in preventing these adverse surgical events.

Key action steps that you can take now include:
- Partnering with your chief of surgery and operations champion to review current and past events to identify organizational and state trends. Ask:
  - How is your organization sustaining best practice after an event?
  - How is best practice being spread throughout all surgical and procedural areas within your organization (OR, procedural areas such as IR and at the bedside)?
  - How is your organization implementing best practice to prevent future events?
- Meet with the operating room team, procedure teams and patients to discuss current successes and barriers with implementing best practice.
- Ask operating room and procedural staff in areas such as interventional radiology and anesthesia to conduct and share observational audit data with you. This includes the percent of time that all the steps of the Time Out were completed and if the site was marked and visualized prior to the start of the procedure.

Minnesota Hospital Association and Minnesota Department of Health next steps
We know that these events are a safety concern for Minnesota patients, families and communities. We are taking this issue seriously. Using the expertise of the MHA Surgery and Procedure Committee, it is our goal to evaluate and update the statewide Time Out and spine level localization recommendations. These recommendations are intended to assist hospitals, health systems and surgical centers with process improvement to drive practice change and
reduce adverse surgical events. These recommendations will also assist with Time Out sustainability to decrease practice drift.

A safety alert is just one step of this important work, which requires thoughtful discussion and design. Throughout the next year, the MHA Surgery and Procedure Committee, MDH and our partners will work to update and spread these recommendations. Further communication will be forthcoming as these recommendations are updated and disseminated throughout Minnesota.

Thank you for your continued commitment to improve quality and safety for Minnesota patients and their families.

For more information on this alert, contact Tania Daniels, MHA vice president of quality and patient safety, 651-603-3517.