Perioperative Nursing Can Be Risk Business

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Objectives

- Describe the most common factors that contribute to perioperative liability
- Identify the role teamwork and communication play in the promotion of patient safety
- Discuss effective risk management strategies to reduce potential liability

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Medical Professional Liability (MPL)

Standard of Care

- What a reasonable medical professional would have done in the same or similar circumstances

Negligence

- A legal **duty** to provide reasonable care
- A **breach** of duty (an act or failure to act)
- Injury to another (caused harm) that must be proximate (clearly related) cause of injury
- Result is economic and/or non-economic damages
- Being named in a lawsuit does not mean that wrongdoing occurred and injury doesn't necessarily mean that someone is at fault.

Nursing Liability Claims Data

- Location of occurrence is primarily inpatient
- Allegations:
  - Scope of practice
  - Assessment and monitoring
  - Treatment and care
  - Medication administration
  - Patient rights, abuse and professional misconduct
  - Documentation
  - Communication

CNA Healthpro / Nurses Services Organization (NSO)
Closed Claims 2006-2010 (≥ $10,000)

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Demographic and Workplace Factors

- Highest % of claims involved nurses who had worked more than 21 years
- Indemnity payments less for bachelor and associate degree nurses, higher for diploma
- Indemnity payments higher if did not have mentor or preceptor during first two years
- Continuing education associated with decreased average payment
- Disclosure policy = 50% decreased indemnity payment
- Decreased indemnity with exclusively used electronic record
- Good communication with management decreased indemnity

Survey of nurses with and without claims
CNA Healthpro / Nurses Services Organization (NSO)
Closed Claims 2006-2010 (≥ $10,000)

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Nursing Liability Claims Data

- 516 nurse closed claims
  - 91.9% RNs, 8.1% LPN / LVNs

Paid Indemnity	Percent of paid claims
$10,000 to $99,999	56.2%
$100,000 to $249,999	24.8%
$250,000 to $499,999	11.2%
$500,000 to $749,999	2.1%
$750,000 to $999,999	2.1%
$1,000,000	3.5%

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Other Reasons for Lawsuits Against Nurses

Failure to follow standards of nursing care:

- Failure to use equipment responsibly
- Error in specimen handling
- Failure to utilize appropriate fall precautions
- Failure to assess, monitor, or report
- Failure to act as a patient advocate
- Failure to use or follow chain of command
- Failure to follow policies and procedures
- Working while impaired, whether by inadequate sleep or controlled substances
- Negligent or inappropriate delegation and supervision

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Impact of Adverse Events on Nurses

- Emotional trauma
  - Feel personally responsible for the patient outcome
  - Feel incompetent or inadequate
  - Second guess clinical skills and knowledge
- Six stages:
  1) Chaos and accident response
  2) Intrusive reflections
  3) Restoring personal integrity
  4) Enduring the inquisition
  5) Obtaining emotional first aid
  6) Moving on

The Second Victim Phenomenon: A Harsh Reality of Health Care Professions
Susan D. Scott, RN, MSN; May 2011 Patient Safety Network, AHRQ

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Top 10 Safety Issues Identified by Perioperative RNs

1. Preventing wrong site/procedure/patient surgery
2. Preventing retained surgical items
3. Preventing medication errors
4. Preventing failures in instrument reprocessing
5. Preventing pressure injuries
6. Preventing specimen management errors
7. Preventing surgical fires
8. Preventing perioperative hypothermia
9. Preventing burns from energy devices
10. Responding to difficult intubation or airway emergencies

Steelman VM, Graling PR, Perkhounkova Y. Priority patient safety issues identified by perioperative nurses. AORN J. 2013;97(4):402-418.

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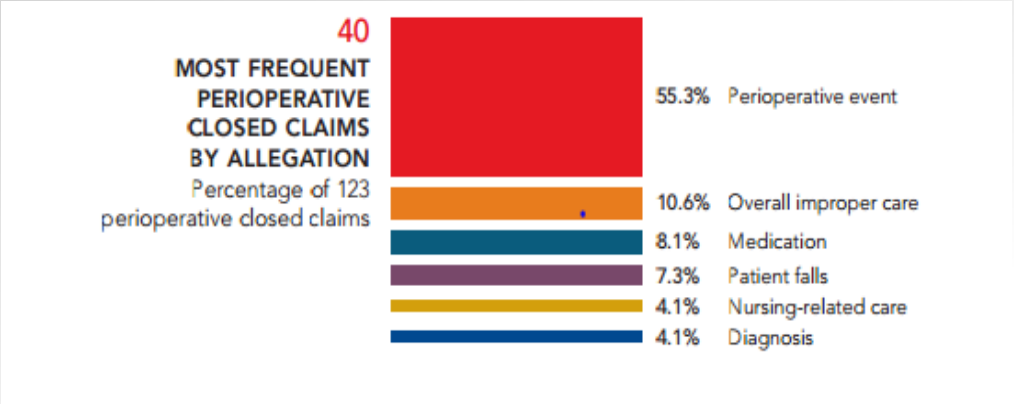
Surgical & Invasive Procedure Closed Claims

Most common - serious adverse events during surgery:

- ✓retained foreign body
- ✓wrong side/site surgery
- ✓improper technique or negligent performance
- ✓improper management of anesthesia outside of OR
- ✓improper positioning
- ✓intraoperative fire



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HIGHEST AVERAGE TOTAL PAID FOR PERIOPERATIVE CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Assessment and monitoring	$19,409	$672,500	$691,909
Credentialing	$76,366	$565,625	$641,991
Medication	$37,748	$217,781	$255,529
Overall improper care	$44,779	$199,385	$244,163
Nursing-related care	$23,701	$210,500	$234,201

CNA Healthpro/Nurses Services Organization (NSO) Closed Claims 2010- 2014 (≥ $10,000)

Surgical & Invasive Procedure Closed Claims

- Assessment and monitoring and credentialing allegations represent low frequency, but incur the highest average severity
- Permanent injury is the most frequent outcome
- Death is the most costly

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FREQUENCY OF PERIOPERATIVE CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 123 perioperative closed claims

37.4% Permanent injury

31.7% Temporary injury

30.9% Death

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AVERAGE TOTAL PAID FOR PERIOPERATIVE CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$64,759	$315,311	$380,070
Permanent injury	$37,520	$206,821	$244,341
Temporary injury	$21,497	$111,543	$133,040
Overall	$40,855	$210,128	$250,983

CNA Healthpro/Nurses Services Organization (NSO) Closed Claims 2010- 2014 (≥ $10,000)

Other Perioperative Risks

- CAUTI, CLABSI, surgical wound infection
- Medication safety
- Pressure ulcers
- Sharps safety
- Safe patient handling, patient falls
- Safe reprocessing/sterilization practices
- Cultural awareness
- Equipment maintenance and competency
- Environmental cleaning

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Importance of Teamwork

- TeamSTEPPS – evidence based training endorsed by AHRQ, Crew Resource Management (CRM), Simulation training
- Benefits include: common language, tools, tips and strategies to promote teamwork
- Example: Two-Challenge Rule, empowers all team members to *“stop the line”* if they sense or discover an essential safety breach

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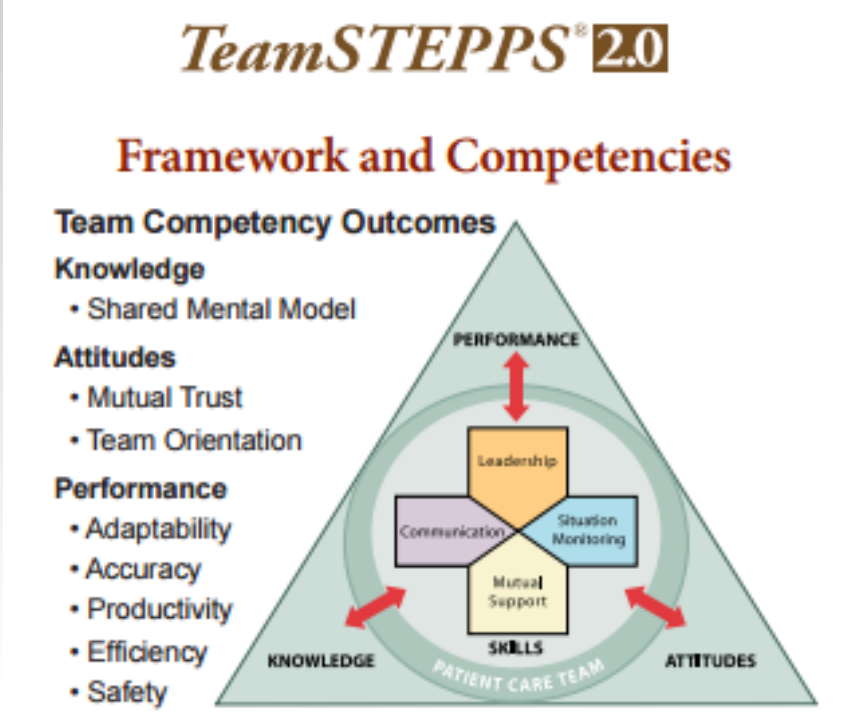
Leadership & Communication Tools

- Brief
- Huddle
- Debrief

- SBAR
- Call-Out
- Check-Back
- Handoff – I PASS
- CUS (concerned, uncomfortable, safety issue)
- DESC script (conflict management)



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Transfer of Patient Care: Safety Through Communication

- Hand-off/over:
  - Transfer of information (along with authority and responsibility) during transitions in care across the continuum;
  - Includes an opportunity to ask questions, clarify and confirm.
- Perioperative Phases of Care
  - Pre-Operative (Holding)
  - Intra-Operative (OR)
  - Post-Operative (PACU)
  - Transfer to unit or discharge to home

Critical Activities for Each Phase

- Select important communication processes
- Develop safe and consistent practices
- Educate all team members
- Implement the tasks

www.cspsteam.org

Effective Communication Techniques:

- Use standard terminology
- Use cross talks, share thoughts out loud
- Hand-off/over partner to do solid read backs
  - Acknowledge
  - Repeat
  - Ask for clarification
- “Speak up” and advocate for the patient through prescriptive reporting communication tools
- Use keywords or phrases to convey pertinent facts (“I’m concerned”, “I’m worried”)

Managing the Risks

- Ensure Universal Protocol, including time out is done properly
- Perform and document patient assessments
- Effectively communicate any changes in condition
- Listen to and evaluate concerns expressed by patient and family
- Encourage all team members accept accountability
- Ongoing staff education, cross training
- Use of critical thinking skills

Surgeon Operates on Patient's Wrong Side

- **An experienced surgeon at Beth Israel Deaconess Medical Center operated on the wrong side of a patient this week**
- **CEO sent e-mail to staff notifying them of the event and has posted information on his blog as well.**
  - **Dear BIDMC Community,**
    This week at BIDMC, a patient was harmed when something happened that never should happen: A procedure was performed on the wrong body part. With the support of all our Chiefs of service, we are sharing this information with the whole organization because there are lessons here for all of us.

2008

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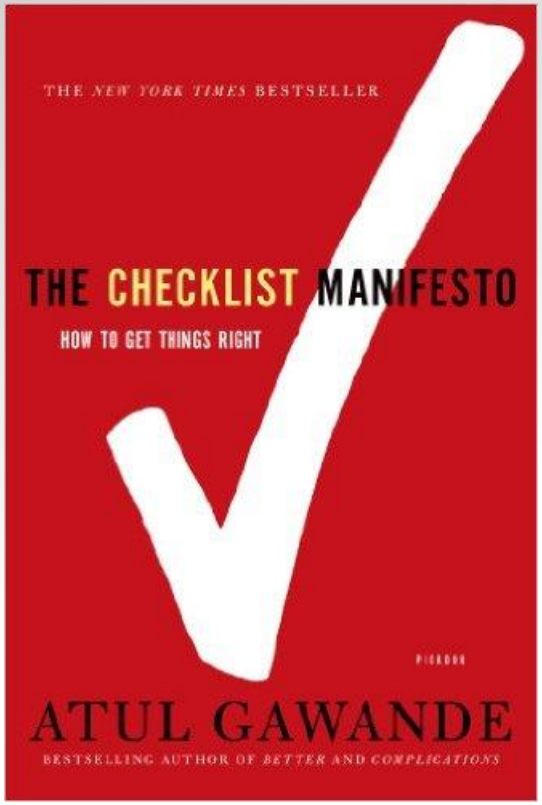
Time-Out

- Patient was brought in for hip surgery. The circulating RN started the timeout. The surgeon was busy talking to the resident, and the anesthesiologist was intubating the patient and therefore was totally distracted. Even the scrub nurse was busy setting up and had her back to the circulating RN. Yet this timeout proceeded, with the circulating RN basically talking to himself, and this was documented as "Time out completed."
- Would you want to be this patient?

Grena Porto, Principal
QRS Healthcare Consulting, LLC

The Checklist Manifesto



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Key Decisions for Checklists

- Define clear pause point at which the checklist is supposed to be used (unless moment is obvious)
- Define "DO-CONFIRM" vs "READ-DO": DO-CONFIRM - Checks after tasks are done, often done separately by different team members, READ-DO: Carry out tasks as they are checked off
- Checklist cannot be lengthy. Rule of thumb: 5-9 items. Depends on context/situation. After 60-90 seconds checklist becomes a distraction, people begin shortcutting. Focus on "killer items", steps most dangerous to skip and sometimes overlooked. Most difficult part of checklists: managing tension between brevity and effectiveness.
- Wording: simple and exact, familiar to profession
- Look matters: ideally fits on one page, free from clutter, un-necessary colors, use upper and lower case for ease of reading, maybe sans serif like Helvetica.
- Test in real world and simulate. Checklists should and can be modified to fit local procedures, processes and language. The goal is not to check boxes. Goal is to embrace culture of teamwork and discipline.

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The WHO “Safe Surgery Checklist”

- The first attempt at checklist was too long, unclear, and a distraction.
- Checklist distilled down to 19 steps, 7 before anesthesia, 7 after anesthesia, and 5 after the procedure/operation.
- DO-CONFIRM chosen to give people greater flexibility in performing their tasks.
- Checklist was then tested using limited WHO budget with baseline collected beforehand at 4 major developing world and 4 developed world hospitals. In implementation, they were careful not to force usage.
- **Major complications for surgical patients fell by 36 % after introduction, deaths fell by 47 percent.**

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AORN Surgical Checklist

COMPREHENSIVE SURGICAL CHECKLIST

Blue = World Health Organization (WHO) Green = The Joint Commission - Universal Protocol (JC) 2013 National Patient Safety Goals Orange = JC and WHO

PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
In Holding Area	**Before Induction of Anesthesia**	**Before Skin Incision**	**Before the Patient Leaves the Operating Room**
Patient/patient representative actively confirms with Registered Nurse (RN):	**RN and anesthesia care provider confirm:**	**Initiated by designated team member** All other activities to be suspended (unless a life-threatening emergency)	**RN confirms:**
Identity □ Yes Procedure and procedure site □ Yes Consent(s) □ Yes Site marked □ Yes □ N/A by person performing the procedure **RN confirms presence of:** History and physical □ Yes Preanesthesia assessment □ Yes Diagnostic and radiologic test results □ Yes □ N/A Blood products □ Yes □ N/A Any special equipment, devices, implants □ Yes □ N/A Include in Preprocedure check-in as per institutional custom: Beta blocker medication given (SCIP) □ Yes □ N/A Venous thromboembolism prophylaxis ordered (SCIP) □Yes □ N/A Normothermia measures (SCIP) □ Yes □ N/A	Confirmation of: identity, procedure, procedure site and consent(s) □ Yes Site marked □ Yes □ N/A by person performing the procedure Patient allergies □ Yes □ N/A Difficult airway or aspiration risk? □ No □ Yes (preparation confirmed) Risk of blood loss (> 500 ml) □ Yes □ N/A # of units available _____ Anesthesia safety check completed □ Yes **Briefing:** All members of the team have discussed care plan and addressed concerns □ Yes	Introduction of team members □ Yes **All:** Confirmation of the following: identity, procedure, incision site, consent(s) □ Yes Site is marked and visible □ Yes □ N/A Relevant images properly labeled and displayed □ Yes □ N/A Any equipment concerns? **Anticipated Critical Events** **Surgeon:** States the following: □ critical or nonroutine steps □ case duration □ anticipated blood loss **Anesthesia Provider:** □ Antibiotic prophylaxis within one hour before incision □ Yes □ N/A □ Additional concerns? **Scrub and circulating nurse:** □ Sterilization indicators have been confirmed □ Additional concerns?	Name of operative procedure Completion of sponge, sharp, and instrument counts □ Yes □ N/A Specimens identified and labeled □ Yes □ N/A Any equipment problems to be addressed? □ Yes □ N/A **To all team members:** What are the key concerns for recovery and management of this patient? _____ _____ _____ _____ _____ _____ _____ _____ June 2013 AORN

The JC does not stipulate which team member initiates any section of the checklist except for site marking.
The Joint Commission also does not stipulate where these activities occur. See the Universal Protocol for details on the Joint Commission requirements.

2016 Hospital National Patient Safety Goals

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers
- Improve the safety of using medications
- Reduce the harm associated with clinical alarm systems
- Reduce the risk of healthcare associated infections
- The hospital identifies safety risks inherent in its patient population
- Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

The Seattle Times
seattletimes.com
3, 2005

Settlement to be used for hospital training in labeling medicines

By Carol M. Ostrom
Seattle Times staff reporter

Even in death, Mary McClinton, a tireless advocate for the disabled, poor and Native Alaskans, will continue her legacy as a teacher.

McClinton, 69, died last year at Virginia Mason Medical Center after being injected with an unlabeled — and deadly — fluid during a procedure to fix a damaged blood vessel.

As part of a legal settlement with McClinton's family, Virginia Mason will use her case to help teach medical staffers the importance of proper labeling of medications.

"One of our major issues, our concern throughout the whole thing, is that it doesn't happen to anybody else," said William McClinton, one of her four sons.

It's some comfort to him, he said, that his mother's death will be a learning experience for others. "Helping others — that's synonymous with my mother. Even in her death, she's able to do that."

The settlement includes money from Virginia Mason, the amount of which is confidential, said Lawrence Kahn, the family's lawyer. Virginia Mason has apologized publicly and admitted liability for McClinton's death Nov. 23.

The medical center also has agreed to make contributions to charities, including the Mary McClinton Foundation established by her family, to advance medical safety "and to honor her memory," said Dr. Robert Caplan, Virginia Mason's medical director of quality.

"Our organization has been forever changed by this preventable medical error," Caplan said. "It has increased our commitment to improving patient safety by open and honest communication about mistakes in medicine, and to the important work we have before us in making sure medical labeling is perfect."

Kahn said McClinton's family believes Virginia Mason was truly sorry for the error and is sincere in its vow to improve patient safety.

Since McClinton's death and several other high-profile cases, the Joint Commission on Accreditation of Healthcare Organizations, as part of its 2006 National Patient Safety Goals, is asking hospitals to label all medication containers and solutions in procedure areas.

McClinton's family, Kahn said, has "found great purpose in spreading the word nationwide that labeling is a must in hospitals, and failure to do so is just unforgivable."

Managing the Risks

- Create a quality committee for perioperative services to monitor your safety culture
- Utilize a pre-operative checklist
- Establish and enforce policies and procedures regarding correct-site/side surgery and monitor staff compliance
- Provide multi-disciplinary simulation drills for difficult intubation and/or airway emergencies
- Implement policies and procedures to prevent unintended retained foreign objects
- Maintain a surgical fire prevention and response program
- Consistently apply surgical safety practices throughout all areas of the hospital where invasive procedures are performed

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Preoperative Fire Risk Assessment

1. Is oxygen or nitrous oxide being openly administered?
2. Is an electrosurgical unit (ESU), a laser, or fiber-optic light cable being used?
3. Is an alcohol-based skin prep or other volatile chemical being used:
4. Is the surgical procedure being performed above the xiphoid process?

http:///www.aorn.org/firesafety

Fire Safety in the OR

High Reliability Principles	Fire Prevention Context
Preoccupation with failure	Be aware in any procedural scenario where an element of the fire triangle is present and fire can occur.
Reluctance to simplify	Reject the idea that fire is rare and it can't happen on your watch.
Sensitivity to operations	Be cautious of factors such as rapid turnover time, which can lead to overlooking fire risk assessment and fire prevention practices.
Commitment to resilience	Be committed to the belief that you are the patient's protector and are responsible for doing everything in your power to protect a patient from fire.
Deference to expertise	Call for multidisciplinary education and collaborative teamwork to address fire safety in a comprehensive way that includes a wide range of expert perspectives.

http://www.fda.gov/Drugs/DrugSafety/SafeUseInitiative/PreventingSurgicalFires/default.htm

Managing the Risk

- Assess and Monitor
  - Don’t rely solely on technology
  - Look at and examine the patient
  - Follow policies and procedures that guide practice
- Be a Patient Advocate
  - Listen to the patient and family
  - Speak-up regarding patient needs
  - Use the chain of command

Assessment & Monitoring

- Remind nursing staff of the need to comply with post-procedure orders regarding notification of clinical signs & symptoms/change of condition
- Encourage staff to listen and respond to concerns expressed by patient or family
- Incorporate best practices and evidence-based guidelines when establishing post-surgical and post-procedure monitoring parameters and protocols
- Investigate all incidents in which staff fail to notify the provider or the provider fails to respond to calls or pages
- Provide support to nursing staff who invoke the chain of command appropriately, especially novice staff
- Audit health records to identify quality issues, such as failure to complete an assessment, respond to alarms or obtain vital signs

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Managing the Risk

- Document
  - Timely, individualized, accurate, thorough
  - Patient response
  - Do not chart in advance of treatment or intervention
  - Informed Consent
    - Discussion of the procedure or treatment
    - Risks, Benefits, Alternatives
    - Refusal

Do Not...

- Do not editorialize
  - “This procedure is done by other CVS nurses, but at this hospital we are not allowed to do it.”
- Do not point fingers / criticize
  - “This would not have occurred if the physician had responded in a timely manner.”
- Do not be defensive
  - “There was a delay in responding due to the fact that we had multiple patient’s with high acuity and did not have adequate staffing.”
- Do not be derogatory
  - “Patient is a whiner and complains about everything”
- Do not reference administrative activities
  - “I completed a PSN and referred to my supervisor for disciplinary action.”

Managing the Risk

- Communication
  - Clear and meaningful hand-offs
  - Respectful
  - Two way
  - Use the chain of command, if needed
  - Patient and family centered

Specialty Specific Equipment and Risks

- Bariatric surgery
- Robotic surgery
- Pneumatic tourniquets
- Endoscopic
- Orthopedic
- Neuro
- Cardiac
- Transplant, etc.

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Family sues in operating room fall: Matriarch suffered a fatal head injury

- Catherine O'Donnell fell, buttocks first, through a gap in an orthopedic surgical table on Oct. 6 after a nurse removed a safety strap around her torso as medical staff prepared to transfer her to a hospital bed. Lawsuit was filed on 1/28/2008.

Publication Date:**01/29/2008**
Source: The **Boston Globe**

QUESTIONS?