Taking Steps in the OR to Ensure Patient Safety

If you were to go into the hospital for surgery, you naturally would expect your surgeon and the operating room (OR) team to know exactly on which part of the body the surgery would take place. Unfortunately, even at the most renowned hospitals and under the careful watch of the most skilled surgeons, mistakes can still occur.

Wrong-site surgeries—incisions made in the wrong place on a patient's body—dramatically increased in number in the United States between 1995 and 2008, according to the Joint Commission Center for Transforming Healthcare. In fact, in this country more than 4,000 preventable surgical errors occur annually.

The key word in that statement is "preventable."

In an effort to ensure the highest level of safety and positive outcomes for all patients, in 2015 Sentara implemented a systemwide checklist—known as the "Universal Pause," or UP—to help prevent wrong-site surgeries. The UP process, used by every surgical team in every Sentara hospital, employs best practices from national surgical safety benchmarks, as well as other safety criteria introduced by Sentara team members. Studies have shown a significant decrease in surgical errors and complications when similar checklists are used effectively.

Pausing for Safety

The UP process is designed to ensure that each patient is correctly identified, the correct surgical procedure is performed and the entire surgical team has an opportunity to communicate important elements of each specific case, explains Shawn Craddock, director of surgical services for Sentara RMH Medical Center in Harrisonburg.

"By following the Universal Pause process, our surgical teams can provide the safest care to our surgical patients," Craddock says. "The process involves everyone on the surgical team, so that everyone feels ownership in the care of our patients."

The UP process comprises three components:

1. **Stop in.** This step takes place when the patient is brought into the OR, prior to sedation. The surgical team verifies the patient's name; what procedure will be performed; and the specific site of the surgery, which is then marked on the patient's skin. The OR team also will double-check the patient's allergies and any other pertinent information at this time.
2. **Time out.** Initiated by the surgeon, this step occurs after the patient is put under anesthesia. The team stops once again to verify the patient, the procedure, the correct surgical site and any allergies, also checking to make sure the necessary antibiotics have been administered. Everyone on the surgical team has an opportunity to share concerns and ask questions before the procedure begins. "I use the timeout as an ice breaker to help get the staff talking," says John Carl, MD, a general surgeon at Sentara Martha Jefferson Hospital in Charlottesville. "Hopefully that sets a tone for the rest of the case and makes team members more comfortable with speaking up as we continue the procedure."
3. **Stop Out.** This step focuses on important safety elements at the end of the case, including specimen handling, assessment of blood loss, classification of the wound, a check for all surgical instruments and a general review of the procedure that was just completed. At this stage, the team again is asked to share any concerns or ideas for improving the process in the future.

Leveling the Playing Field

One of the challenges of implementing this type of OR culture change, according to Dr. Carl, is overcoming what is known as the "authority gradient." The surgeon is viewed as the OR team's leader, potentially causing other staff to be hesitant to question the surgeon's actions. The authority gradient also may lead team members, in the event of an unexpected occurrence during a procedure, to assume that the surgeon has a reason for deviating from the plan, or to fail to speak up because

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of a perception that the surgeon has a better understanding of what is happening.

Everyone involved in each surgical case, however, is proactively encouraged to voice concerns. Recently at Sentara RMH, for example, an OR attendant (ORA) helping to prepare for a surgical procedure noticed that latex gloves were laid out and ready to use for the next procedure, despite the fact that she had just overheard the patient talking to another nurse about having a latex allergy. Noticing the potential conflict, the ORA stopped the patient at the door and verified the latex allergy before bringing the issue to the attention of the rest of the surgical team. Together, the team confirmed the allergy, tore down the setup and brought in a new set of latex-free supplies before continuing with the surgery.

"If the playing field weren't leveled, in terms of encouraging team communication, the ORA in that case may not have spoken up and stopped the process," Craddock notes. "That may have led to a less positive outcome for that patient—but since the ORA felt empowered to express her concerns, she took a positive step to advocate for the patient."

"The Universal Pause is not only a tool to prevent wrong-site surgery, but also a springboard into better team dynamics," adds Dr. Carl, who serves as one of the UP coaches for Sentara Martha Jefferson. "That kind of approach improves the way surgical team members work together—and ultimately helps to ensure patient safety and enhance the patient experience."

Coaching the Healthcare Team

General surgeon John Carl, MD, is passionate about creating an open environment in the operating room, in which all members of the surgical team feel empowered to ask questions and raise concerns. That's why he serves as one of Sentara's coaches for implementing the Universal Pause (UP) process. Each Sentara institution has a team of coaches who go into operating rooms to assess each surgical team's performance with respect to UP. Throughout the process, the coaches praise communication techniques that are effective and offer suggestions for improvement, where needed.

"Our goal is to have each person on the surgical team feel ownership of the patient," Dr. Carl says. "By developing strategies for people to communicate well in the OR, and by teaching our staff always to be thinking about the patient and how to make the patient safer, we can help create a better experience for every patient."