Insight into Preventing Wrong-Site Surgery (Continued)

Appendix: Hospital D

Scheduling	Offices and surgeons request cases to be scheduled by telephone or fax, or in person using handwritten entries on preprinted cards. The information in the cards includes the patient's name, procedure, diagnosis, surgeon, and time. The side or spinal level is entered under comments. The handwritten information is entered into three electronic systems. If a deficiency or discrepancy is identified, the surgeon's office is called. Office personnel "occasionally" call back. The schedulers "need complete information" to include the procedure in the surgeon's block time on the OR schedule. The original card remains part of the medical record. Verification is done using both the card and the schedule.
Consent	The consent is usually obtained in the surgeon's office. It may be obtained by the surgeon or someone else in the preadmission testing or the admitting/holding area. The preoperative nurse can obtain a consent if the surgeon has spoken to the patient.
Verification and Reconciliation	A hospital service makes sure that the consent, history and physical examination (H&P), orders, and lab values are present and in agreement by at least the day before elective surgery. If any deficiency or discrepancy is identified, the surgeon's office is called. The admitting area receives the consent, H&P, orders, and lab values the day before any elective procedure and verifies the information with the operating room (OR) schedule. An anesthesia provider sees the patient for the first time on the day of surgery. Patients cannot be taken to the OR until they are seen by the anesthesia providers. No sedation is given prior to either a regional block in the induction area or the OR itself. Different nurses said they used different documents for verification, from the patient's name, date of birth, and procedure to the consent, H&P, OR schedule, and x-ray. Any discrepancies are resolved by the surgeon. Some, but not all, surgeons see the patient in the admitting/holding area. The circulating nurse may repeat the verification in the admitting/holding area before taking the patient to the OR.
Site Marking	Sides are marked with "YES" on the correct side, right or left. Spinal levels are also marked as cervical, thoracic, or lumbar near the area of incision. The preoperative nurses mark the operative sites with input from the patients. At the request of the surgeons, they place the mark within the operative field, but not over the site of the incision. Our observations were that they were not always successful in their attempts to make their marks within the operative field. Some surgeons do the site marking themselves in the admitting/holding area, either in lieu of or in addition to any marking by the nurse.
Anesthetic Induction Area	Anesthesiologists conduct a time out before doing a regional block in the induction area, but it appears to be more of verification, with little reference to documentation. The blocks are done after the patient is marked.
OR and Time Out	There are two time outs. The first is when the circulating nurse, the anesthesia provider, and the attending surgeon are first together with the patient in the OR, before anesthesia is administered. This time out is similar to the initial verification by the circulating nurse, upon entering the OR, at other hospitals. The second is after the patient is prepped and draped. Each room has a white board with space for the patient's name, the type of procedure, and the names of the OR team members for that procedure. The white boards were filled out inconsistently: some sparsely, some completely.
Verification of Spinal Level	All procedures on cervical vertebrae are preceded by a needle localization of the vertebral level. Needle localization is not done uniformly for procedures on lumbar vertebrae.
Specimen Management	The surgeons are only nominally involved in the specimen handling process. Labels left in the OR from a previous operation were the most frequent source of labeling errors.
Other Observations	The OR supervisor has noted failures of empowerment, such as reluctance of a new nurse to speak up and intimidation by a surgeon that serves to discourage a time out. Surgeons did not run two rooms in this hospital. Everyone, including aides and transport orderlies, has been taught to identify patients correctly with two identifiers (i.e., name and date of birth) using the armband for verification.
Impression	The members of the OR team appeared to work together. The distinction between "verification" and "time out" was blurred. Observed comments include the following: "If I am not around to hear patient say the side, I [always] check the consent." The certified registered nurse anesthetist (CRNA) looked at the patient's armband and said, "Your armband says [the patient's name]?" The patient said, "Right." The CRNA said, "You're [gives patient's age]?" The patient said, "Right." The anesthesiologist asked, "How are you doing today? Right leg?" The CRNA said, "Right." The anesthesiologist then proceeded with the block. The circulating nurse started the time out saying, "Time out." The surgeon turned to scrub tech and said, "I need a 10 [scalpel with a no. 10 blade]." The circulating nurse said, "We are doing [the name of the procedure] on [the patient's name]." The surgeon was already making the skin incision. The circulating nurse asked, "Do you agree?" When the surgeon who was operating did not respond, she repeated, "Do you agree?" The surgeon responded to the second query and said, "Yes, I agree. All in favor?" (Editor's note: The last comment was said in jest.)

