Insight into Preventing Wrong-Site Surgery (Continued)

Appendix: Hospital F

Scheduling	Scheduling for ambulatory and hospital patients is done electronically from the surgeons' offices. There is no quality control of the process. Errors are not identified until the day of surgery.
Consent	The consent should be obtained in the surgeon's office. The offices are encouraged to scan the consents and send them to preadmission testing (PAT). Sometimes the consent is obtained in the admitting/holding area. The patient cannot leave the admitting/holding area without a valid consent.
Verification and Reconciliation	The PAT nurse practitioners check that the consents and history and physical examination (H&P) are done and do preoperative testing. Patients in the ambulatory surgical facility get pamphlets explaining the time out process, in response to concerns that the patients did not understand why the OR staff did what they did. A trained desk clerk checks to make sure all necessary documents are present for patients on the next day's hospital and ambulatory OR schedules. However, the clerk does not check for or reconcile any discrepancies. The admitting nurse verifies the patient's name with two identifiers and applies an armband. The nurse verifies the consent, schedule, and H&P with the patient and checks for recent illnesses. Any discrepancies must be resolved by the surgeon before the patient leaves the admitting area. The preoperative nurse also verifies the patient's name with two identifiers and checks the consent, schedule, and H&P for discrepancies. The surgeon marks the operative site if not done already. The preoperative nurse and the certified registered nurse anesthetist have a preoperative briefing to verify the reconciliation and the site marking. This briefing catches one to two discrepancies or deficiencies per week.
Site Marking	The attending surgeon must mark the site with his or her initials, in consultation with the patient and medical record, before a patient can enter the OR. The site can be marked in the surgeon's office, the inpatient units, or the preoperative/holding area. The site must be marked prior to any regional block. The markings must be visible when the patient is prepped and draped. If both sides are being done, neither side is marked. The anesthesia department monitors the site markings.
Anesthetic Induction Area	Regional blocks are done in the preoperative holding area. The anesthesiologist conducts a time out with the patient and a "regional anesthesia nurse."
OR and Time Out	The surgeon leads the time out. The circulating nurse records the time out. The anesthesia department monitors the time out. The time out is a more detailed preoperative briefing. Most surgeons do the time out from memory, but some use a checklist. There is no problem getting members of the OR team to focus on the time out. The operation does not start without acknowledgement of the time out. Everyone can speak up. There is not supposed to be any change in OR team members between the time out and the start of the procedure. If there is a second procedure, a second time out is done before that procedure.
Verification of Spinal Level	The surgeon verified the vertebral level by radiograph, marking it with a needle after exposing it. Confirmation was done by the surgeon, but not verified by a radiologist.
Specimen Management	Not observed.
Other Observations	The OR team members communicate with each other. Some surgeons run two rooms, although the attending surgeon must mark the site before a patient can enter the OR. When running two rooms, the staff tries to do all the left-sided procedures in one room and right-sided procedures in the other room when possible. Sometimes the H&P that is in the system from a previous procedure is accessed by mistake.
Impression	Inaccuracies during the scheduling of procedures were perceived as an area of weakness in the system by the facility's staff. The OR team members were attentive to the surgeon-led preoperative briefings/time outs. Observed comments include the following: "If it's not on the consent, it's not going to happen in the OR." After completing a procedure on the right ear, the surgeon did an examination under anesthesia of the left ear. When the nurse said that the examination was not part of the procedure, the surgeon said, "Actually, I always examine both ears. [The patient] is signed up for bilateral [procedures] if necessary." The schedule (and consent according to the OR supervisor) clearly said "right ear [procedure]" only. "I need permission to put you to sleep. The risk is not zero, but it's not prevalent, either. Before I put you to sleep, we're doing your left ear, right?" The anesthesia provider was relieved by another. A complete handoff was done, and the first provider stayed for the time out. "There is some reluctance to speak up." "This is ridiculous," said the attending surgeon. "You're wasting my time! This [diskectomy and vertebral fusion with a bone graft] is only going to take 20 minutes." Someone said to the surgeon, "That was preop. The next patient has [a contact allergy]." The surgeon responded, "What does that mean for me? Is that going to slow me down?" Five minutes after making the skin incision, the surgeon asked "What time did we start this case?" When informed that it was five minutes ago, he said, "It's turned into a marathon already." Two minutes later, having exposed the vertebra and identified it with a needle, he asked, "Where's my x-ray? Did [the radiography technician] come back yet?" Later he said, "Can you pull that x-ray up? What's going on? It's not done yet. Can you call up? There it is." The surgeon confirmed the vertebral level. As the observers left the OR room, a nurse said, "He's always that way."