Perioperative Patient Safety: Why "Never Events" Still Happen



Schuering Zimmerman & Doyle LLP
ATTORNEYS AT LAW

Dominique A. Pollara, Esq.
February 28, 2014



Dominique A. Pollara is a partner at Schuering Zimmerman & Doyle, LLP, in Sacramento, CA. Her practice includes representing health care professionals and facilities in medical malpractice actions and before licensing agencies. She has tried approximately 40 cases to verdict, is board certified in medical malpractice by the ABPLA, and is a member of ABOTA, the International Academy of Trial Lawyers and the International Society of Barristers.

EDUCATIONAL GOALS

To identify factors contributing to the ongoing occurrence of “Never Events” in the perioperative setting and to discuss possible strategies to decrease those events

As of June 2013, out of 7440 total voluntary reports:

- 988 were WSS
- 829 were RFB
- 398 were medication errors

In the first 6 months of 2013 out of 446 voluntary reports:

- 60 were of WSS
- 56 were of RFB
- 20 were medication errors

WRONG SITE SURGERY

In July, 2004 the Joint Commission instituted the Universal Protocol

The principal components include:

1. pre-procedure verification of the patient, surgery and side;
2. pre-operative site marking; and
3. a “Time-Out” before surgery starts.

WSS Case Study

- 55 yo female scheduled for L knee ACL reconstruction
- Pt signs consent for L knee ACL reconstruction
- Pt on schedule for L knee ACL reconstruction
- Surgeon sees pt in pre-op holding area and marks L leg on thigh

WSS Case Study (cont)

- Anesthesiologist sees pt in pre-op holding area – interrupted by emergency
- Pt taken to OR before anesthesiologist completes pre-op interview
- OR crew sets up room for R ACL surgery by putting arthroscopy tower on L
- Anesthesiologist enters OR and induces anesthesia
- Anesthesiologist places R femoral nerve block

WSS Case Study (cont)

- Tourniquet placed on R leg by circulating nurse
- R leg placed in leg holder by PA and R leg prepped and draped
- Time Out is performed after surgeon enters room
- R ACL reconstruction performed
- Error discovered in PACU

Why Does This “Never Event” Continue to Happen?

- “It won’t happen here”
- “Not my job”
- Interruptions and distractions
- Confusing or hidden markings
- Going through the motions

Recommendations

- All members of the surgical team must recognize this is a REAL risk and they each have personal responsibility to prevent WSS
- Institute clear policies on how pre-operative markings must be done and enforce those policies
- Limit distractions during patient/site/side verification process

Recommendations

- Involve patient where practical but understand patients under stress may contribute to error
- Consider requiring the surgeon to run the Time Out
- Conduct Time Out before induction of anesthesia where feasible

UNINTENDED RETENTION OF A FOREIGN BODY

RFOs are estimated to occur in one out of 5,500 procedures.

With an estimated 32 million procedures being performed annually in the US, the occurrence rate of RFO equates to approx. 4,000/year or 11/day.

RFO can be left behind in any part of the body; the thorax and abdominal cavity are particularly at risk.

Sponges are the most common RFO followed by instruments.

RFOs can lead to serious complications: sepsis, fistula, bowel obstruction, visceral perforation and death (11 – 35%).

RFO Case Study

- 45 yo female presents for abdominal laparoscopy
- Assistant surgeon fails to show
- Sponge count device MIA
- Sponge count performed at beginning of procedure

RFO Case Study (cont)

- Case proceeds uneventfully
- Sponge count at end of case interrupted – surgeon requires scrub assistance because assistant surgeon is not present
- Sponge count not restarted after interruption
- Sponge count reported as correct
- Pt discharged and readmitted 5 days later – septic
- Sponge discovered and removed

RFO Case Study (cont)

- Investigation reveals team should have restarted count after interruption
- Did not restart count due to unfamiliarity with policy and time constraints
- During count – sponge fell on floor and was counted twice

Why Does This “Never Event” Continue to Happen?

- Emergency procedures
- Deviation from planned procedures
- Abdominal or pelvic procedures
- Patients high BMI

Why Does This “Never Event” Continue to Happen?

- Poor communication amongst team members
- Fatigue, stress and distractions
- A hurried count
- Interruptions during the count
- Counts that occur during or after shift changes

Recommendations

- Implement, reinforce and enforce clear standardized counting procedures
- Implement technology (barcoding, radiofrequency detection) where feasible
- Perform training drills to enhance multidisciplinary teamwork
- Limit distractions

Recommendations

- Encourage methodical exploration of the wound before closure
- Use x-ray detectable items in the surgical wound
- Employ x-ray or other technology as indicated to ensure no RFO remains in the operative field

MEDICATION ERRORS

MED Case Study

- 51 yo male presents for sinus surgery
- Pt one of multiple sinus surgeries that day
- During case immediately before this surgery anesthesiologist runs out of Decadron
- Anesthesiologist asks circ. Nurse to retrieve new vial of Decadron

MED Case Study (cont)

- Anesthesiologist sees nurse go to med cabinet and retrieve vial from drawer where Decadron is stored
- Nurse placed vial on anesthesia cart
- Anesthesiologist draws up medication during Pt's case and administers
- Within brief interval patient Codes and suffers perm brain injury

MED Case Study (cont)

Subsequent investigation reveals:

- Patient administered epinephrine NOT Decadron
- Epinephrine had been erroneously placed in Decadon drawer
- Epinephrine and Decadron in virtually identical vials with similar labels
- Neither nurse nor anesthesiologist looked at label before it was injected

- Medication errors can be devastating to the patient and expensive
- In many instances the error results from a series of errors or the failure of more than one provider to adhere to appropriate safety measures

Factors leading to medication errors include:

- Poor communication
- Inattention by providers
- Unclear or unenforced policies and procedures
- Time pressure
- Improperly labeled medications

Factors leading to medication errors include: (cont)

- Inexperienced or inadequately trained staff
- Staff work load and fatigue
- Improper drug storage
- Confusing drug nomenclature, packaging and labeling

Recommendations

- Medications and solutions on and off sterile field should be labeled
- Have a specific policy regarding labeling
- Actively communicate the medication name, strength, dosage and expiration date when passing medications
- Confirm verbally and visually all medications delivered to the provider

Questions?

