SAFER SURGERY: DECREASING LATERALITY DISCREPANCIES WHEN SCHEDULING ORTHOPEDIC SURGERY CASES

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Background Information: Errors in surgical events have the potential for creating a devastating impact on patients, the surgical team and hospitals at large. Analyzing near misses in the surgical arena become a necessary practice in High Reliability Organizations to mitigate harm from reaching the patient. Preventing mistakes in surgery is also identified by the Joint Commission as a National Patient Safety Goal.

Over the last year JHBMC has systematically reviewed errors in surgery. From Jan 2013 - 2014, 51 near misses (PSNs) were submitted in the perioperative area related to scheduling discrepancies in laterality. While no wrong sided surgeries occurred, executive leadership identified this number of near misses as high and required action. The highest occurrence of events (15) or 29% of total PSNs were concentrated in the orthopedic department.

Objectives of Project: A project team was formed to study laterality errors in this single department and find solutions to improve accuracy of laterality communication when scheduling OR cases.

Process of Implementation: The Project team was multidisciplinary and represented five areas involved with OR scheduling. Using Lean Sigma DMAIC methodology, the team scoped the project and mapped the process steps for each area. Laterality errors were analyzed and uncovered three key processes: posting, OR scheduling and consent signing.

Creative solutions were identified by applying the site verification process, used in pre-op/OR areas. The project also focused on patients becoming active members of the surgical team. Our Patient and Family Advisory Council provided feedback on improving patient education materials and physician interaction during consent signing.

Statement of Successful Practice: From Feb 2014 to June 2015, this project saw improvements in 2 key areas. Posting errors decrease from 53% to 13% and consent errors decreased from 63% to zero. In July 2015, we also reached our goal of increasing the number of days between laterality near miss events from 60 to 90 days.

Implications for Advancing the Practice of Perianesthesia Nursing: The knowledge and practice of the site verification process used by nurses in pre-op and OR areas can be influential in making significant changes to other pre-surgical processes.

We continue to meet as a team to improve on the physician posting process that has not seen as favorable results as the improvements made with consents and laterality accuracy. In tandem to this effort, laterality error data for the past 3 years is being shared with all surgical departments to raise awareness of trends by area. Additionally, the vulnerable process points prone to laterality errors are also being shared with services to educate all of weaknesses in the scheduling system. Finally, our organization converted to a new electronic medical record (EMR) December 2015, so we are studying the workflow for OR scheduling to determine what processes are different and what workflows remain the same to learn how laterality is communicated and shared in the new EMR.