Free case study about wrong site surgery under a sentinel event

Technology, Internet

Introduction

A sentinel event involves the occurrence of an unexpected event that may involve death, a serious physical/psychological harm or a big risk thereof. A serious injury in this case may involve a loss of an organ such as limb, hand or a particular function. A sentinel event may also involve severe temporary injury that may require intervention to sustain life. Such events are referred to as sentinel because their occurrence calls for a quick response as well as investigation.

A wrong sight surgery (WSS) is one of the sentinel events in healthcare. A wrong site surgery refers to a surgery procedure that is carried out on the wrong or incorrect site (Banja, 2005). A surgery is considered a wrong site surgery once it is identified any moment after the commencement of the surgery and which results in the need for additional surgery on the appropriate site. A wrong site surgery can occur mainly under three subcategories namely incorrect side, correct side but wrong location, and both correct side and location but wrong surgery operation (Fraser & Adams, 2006). This paper will focus on the occurrence of wrong site surgery from the legal and ethical perspective as well as the actions being taken to arrest the rising cases of wrong site surgery.

Wrong Site Surgery (WSS)

Wrong site surgery cases are considered as sentinel events and reporting of such cases to the Joint Commission is on voluntary basis (Banja, 2005). As such, it is estimated that only 10% of all wrong site surgeries are reported, with the number of wrong site surgeries reported to the Joint Commission

being lower than other wrong site surgery statistics from other sources. Despite this, the number of wrong site surgery cases reported has been increasing over the years. Although WSS have been rare events for many years, their prevalence is increasing in recent years. Since the inception Joint Commission Sentinel Event program, the number of WSS reported increased from 15 cases in 1998 to 592 reported cases in 2007. Statistics indicate that most of WSS occur in general surgery, orthopedic procedures, neurosurgical procedures and urological procedures. According Joint Commission Center for Transforming Healthcare there is an average of forty WSS occurring every week in United States. These include performing surgery on wrong site, wrong side and the wrong patient as well as performing wrong surgery procedure (O'reilly, 2013). This number was attained through the Robust Process Improvement methodology, which is a systematic, fact-based, and data driven approach that uses methods and tools from change management and six sigma strategies.

Most medical errors occur because of human errors in the course of healthcare provision, which accounts for about 80% of all medical errors (Banja, 2005). Most medical errors commonly arise due to inexperienced nurses and physicians, urgency of healthcare, use of new procedures, and the extremes of age. Other issues that result to medical errors include poor communication, poor nurse-to-patient percentages, and improper documentation. Faulty systems and poorly designed healthcare processes contribute to the occurrence of medical errors.

Causes and consequences of WSS

Most wrong site surgery cases occur due to the deficiency in a formal system that can be used to ascertain the appropriate site of surgery or the inefficiency of the system utilized to verify the suitable site of surgery. The Joint Commission undertook the wrong-site surgery project in July 2009 and identified 29 major causes of wrong site surgeries (Becker's healthcare, 2011). These causes were identified through a root-cause analysis process aimed at establishing the major underlying organizational factors and causes that resulted in a wrong site surgery. Of the causes identified, the leading causes of wrong site surgery were communication failures 70%, procedural noncompliance 64%, and leadership failures 46% (Mulloy & Hughes, 2008). The leading risk factors that contributed to wrong site surgeries were multiple surgeons, obesity, emergency cases, time pressures, deformities, multiple procedures, room changes, and unusual equipment.

Wrong site surgery has negative consequences, both to the patient as well as the surgical team and healthcare providers (Banja, 2005). Wrong site and wrong person surgeries are both considered compensable under healthcare malpractice claims. For instance, 79% of all wrong site surgeries of the eye and 84% of all wrong site orthopedic surgeries were compensable after being filed as malpractice claims. Some state licensure boards have introduced heavy penalties to surgeons responsible for wrong site surgeries (Mulloy & Hughes, 2008). Some health insurers are also taking action by not paying providers for wrong site surgeries and wrong person surgeries. They are also not paying providers in the event a foreign object is left within a patient's body following a surgical operation.

WSS and legal system

There has been a rigorous effort to end cases of performing surgeries on wrong patients or wrong body parts. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the body that is mandated to accredit hospitals in the United States and has played a big role formulating guidelines for preventing WSS. In 2003, the Chicago-based commission launched the Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. The Universal Protocol was developed and integrated as a key requirement for National Patient Safety Goals for all Joint Commission accredited healthcare organizations.

Despite the campaign by the relevant bodies to prevent cases of WSS, the rising number of such cases is still alarming. The number of WSS is likely to be higher than reported because not all hospitals are required to report such incidences. In the state of Virginia for instance, there is no legal requirement for reporting of WSS cases to the Joint Commission (Boodman, 2011). The universal protocol declares that, WSS cases are 100 percent preventable. Such cases are directly attributed to human errors and failure to follow the guidelines for procedure verification, site marking, patient identification and lack of teamwork and effective communication. WSS incidences often end with lawsuits filed by patients for physiological, psychological or economical harms that result (Mulloy and Hughes, 2008).

The Universal Protocol is composed of three areas. These areas include pre-procedure verification, identification of the patient and site marking. A team that comprises of doctors, nurses and other aids in the operation room does verification. Verification involves identifying the correct patient and filling the

required patient records and verification of the site for surgery. In preoperative verification, there Universal protocol requires that checklist specifying the correct sequence of procedures should be used to enhance verification. There is no agreed guideline in who should mark the site to be operated. Some institutions require that patients participate in the marking where applicable while in others, the surgeons are responsible for site marking. Time-out is a moment of briefing prior to surgery that involves the participating surgeons, doctors, nurses and anesthesiologists concerning that particular operation. Time-outs have been found to play a major role in prevention of WSS (Mulloy and Hughes, 2008).

Many hospitals have adopted their own protocols for prevention of WSS. Majorly, institutions capitalize on the need to enhance teamwork and effective communication as the primary steps to be taken in reduction of WSS cases (Matzo, 2014). The Universal Protocol was reviewed in 2010 to address the recommendations of various stakeholders. In essence, the revision was mainly to allow for flexibility and to accommodate the patient safety protocols adopted by different healthcare organizations (The Joint Commission, 2014).

For instance, in Florida the board of medicine passed laws concerning WSS incidences that included fines of up to $10, 000 for liable doctors and the healthcare institutions. People and institutions held liable for WSS could also face penalties that include 5 hours risk management education, one-hour lecture of medical community and a 50 hours community service (Trubo, 2014). Missouri is another place where big penalties are considered in case of WSS surgery but resulting to noneconomic damages. However, no Act in

Missouri to cater for the patient to receive compensation in case of pain and suffering, any loss of sight after WSS, loss of mobility or hearing and others. Example of a lawsuit concerning a medical malpractice is a case against SSM Health Care-St. Louis and the local neurosurgeon. The neurosurgeon performed a surgery procedure on the wrong side of woman's brain. The woman required a right-sided craniotomy surgical procedure but instead received a left-side craniotomy bypass. Because of this wrong side surgery, the woman could not speak intelligibly. The surgeons performed the correct side surgery after six days when they realized the mistake. The neurosurgeon was accused of carelessness and negligence, (Showalter, 2008).

In the event that, A WSS has already occurred, the Universal Protocol requires that the involved medical practitioners take the necessary steps in the interest of the patient. If the patient is under general anesthesia, surgeons are required to make operations in the required sites unless there are medical reasons to prevent correction. If the patient is under local anesthesia, the patient must be informed together with the relatives of the patient of what has happened and obtain legal consent to proceed with operation in the appropriate sites (Fraser and Adams, 2006).

WSS and Negligence

Much of the discussion about the reform of the health care system in U. S. has focused on the cost and the factors behind the increasing cost of health care. This has caused the stakeholders to remain ignorant on the issue of reducing as well as eliminating most of the preventable medical errors. In

that context, stakeholders have demanded that patients should be restricted from holding some negligent healthcare practitioners accountable. According to the Institute of Medicine, medical errors have been categorized to be the sixth biggest killer in United States. Statistics by the Centers for Disease Control (CDC) indicate that medical errors cause the death of 98, 000 individuals in America. Despite this, most debates on medical negligence have focused on indirect factors including the doctors' insurance premiums. A medical negligence discussion ignoring preventable medical errors ignores a fundamental problem. When medical errors are prevented, there will be lower health costs and reduced doctors' insurance premiums as well as the health and safety of the patient is well checked after (American Association Justice, 2011).

Surgery is one area in the health care system where preventable medical errors as well as the near misses are likely to occur. According to the Institute of Medicine report, until 1999 there was no any record of the number of surgery-associated injuries, the deaths as well as the near misses. This was because there were no methods of reporting or even tracking such events. The major concern is the Wrong Site Surgery (WSS). WSS has negative impacts on both the patient and the surgery team. State licensure boards in United States have been imposing high penalties on the surgeons for the wrong site surgery (Mulloy & Hudges, n. d.).

Because the cost of health care is rising every day, it is extremely important to focus on preventing medical errors such as WSS as well as their huge associated costs. According to statistics by Institute of Medicine, preventing WSS saves the country health system billions of dollars per year. The savings

achieved from restricting patients' access to justice are usually negligible. However, limiting patients from receiving justice achieve nothing but filling coffers of the malpractice in insurance industry. Research has indicated that although the claims have remained stable for many years, insurance companies have drastically increased the premiums paid by physicians to build huge surpluses. In the States where there are caps on damages, hospitals and insurance companies have been making millions of dollars without cutting the prices that they charge the patients and health insurers. Meanwhile, cost of health care has continued to rise day-by-day (Saxton & Finkelstein n. d.).

Liability of the Hospital and liability of the physician in WSS

Although it is simple to prove the occurrence of a wrong site surgery, it is complicated to assign liability to the correct culprit. It is obvious that WSS result from failure of a health institution. It means one person or a number of people in a given clinic failing to act in accordance to some laid procedures. As mentioned earlier, res ipsa loquitor, or " res ipsa" is the legal term that apply whenever there is wrong sight surgery. Res ipsa case result when an injury that occurred could have been prevented. It means the injury occurred due to negligence. For instance, if a patient has the left arm amputated instead of the right hand. In this case, it can be seen that WSS resulted from somebody's negligence.

Most of hospitals, clinics and care providers in United States are provided with checks. These checks are in place to ensure that there no WSS occurring in these health institutions. Any time that a WSS occur, it means

that somebody somewhere was negligent of his duties. In most cases, actual surgeon or the team of surgeons are held liable. In other cases, nurses, anesthesiologists and other medical staff members like surgical preps staffs are held responsible. For a hospital to be held liable in case of a WSS, it depends on two factors. It depends on the relationship between the professional surgeon performing the surgery and the hospital. The second factor is the laws of the jurisdiction where the wrong site surgery occurs (Pelczarski, Braun & Young, 2010).

Joint Commission (JC) measures on hospitals for not following the policy

The primary mission of the Joint Commission is to improve the quality as well as the safety of the health care delivered to the public. It is the work of the Joint Commission to review how hospitals respond to sentinel events during its accreditation process. Joint Commission regulates hospitals by ensuring patient safety. This is done by offering education, the advisory services as well as accreditation and certification. Joint Commission refers to the sentinel event as unexpected occurrence where there is a serious injury, death or a big risk. Occurrence of sentinel event indicates a requirement of immediate response and thereafter investigation. In case of sentinel event, organizations accredited by Joint Commission are required to make immediate root cause analysis. They are also required to make various improvements to prevent any other risk occurrence. Institutions are also required to monitor effectiveness of the improvements that they make (American Association Justice, 2011).

Integrating accountability measures into accreditation

Accountability measures can be defined as the quality measures meeting certain criteria designed to give greatest impact on the patient outcomes when the health institutions show improvement on them. These criteria are research, proximity, accuracy and the adverse effects. Research means that there is scientifically proven evidence that a certain practice improves the health care outcomes. Proximity means that the process under measurement is in close contact to the outcome that it influence. Accuracy in this case means that the accountability measure accurately assesses the evidence-based process is accurate while adverse effects means that the measure construct with its design can minimize the unintended adverse effects. In an effort to ensure excellent service delivery, the Joint Commission assists health institutions to improve their performance on accountability measures. Therefore, the Joint Commission will eventually eliminate the measures that do not prove to work well. It will also include working accountability measures in the ORYX program (Joint Commission, 2014).

Conclusion

One primary function of Joint Commission in responding to continued WSS sentinel events reported is to prevent or eliminate occurrence of wrong site and wrong patient as well as wrong procedure surgeries. To eliminate WSS, there is need for robust systems in verifying the correct surgery site. Stakeholders such as surgery centers and hospitals managers should formulate their procedures concerning WSS to ensure the correct markings to ensure no occurrence of WSS. Every health professional involved in

surgery procedures should be aware of universal protocol and be ready to adhere to proper patient identification, the correct surgery site marking and the importance of time-out.

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