

Quality and safety issues to prevent wrong surgical site



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Introduction

When a patient has a surgical procedure, it is only expected that one is anxious, nervous, and even terrified. Consenting to a procedure is a huge decision that involves countless factors to consider. But one risk is so callous, that most people don't even consider it to arise. That occurrence is the surgery proceeding at the wrong site. The mistake may be wrong anatomic side/site or even the incorrect procedure completely. Unfortunately, despite all of the safety protocols in place, this unacceptable incidence still surfaces today. In fact, approximately 2, 700 patients are maltreated by wrong-site surgery each year (Collins, Newhouse, Porter, & Talsma, 2014). This course has taught me to be more aware of quality and safety issues in order to prevent them. I currently work at Platte Valley Medical Center as a surgical assistant in the surgery department. The surgery department runs on a tight schedule where efficiency seems to be the top priority. With productivity at the forefront, I feel patient safety may be compromised and wrong surgical site occurrences may be the consequence of the skewed priorities.

QSEN Principles

For every action of patient care, myself and all nurses should utilize the QSEN Principles as a standard for their own practices. Each category is broken up in to three sub categories which include skills, knowledge, and attitudes. All three of the subcategories hit different aspects that are all equally important and a great guideline to allow nurses to effectively and safely perform their job. By utilizing the QSEN principals I can be sure I am doing what is right and safe for my patient, ideally every time.

Communication and continuity of care to Reduce Error

The Surgical time out begins in the pre-op, the nurse will verify and witness the surgeon marking the location of surgery with a skin marker and confirming it matches the patient's consent. Next, the operating room nurse will take over the patients care while also managing the surgical team to ensure everything is ready for the procedure. This is where I believe the importance of continuity of care comes in. Continuity of care defines the quality of care over time. It is the course by which the patient and their physician and care team are communally involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care (Definition of Continuity of Care, 201).

It has been recognized by the Joint Commission that communication breakdowns between staff and departments are the main cause of surgical site error (Collins, Newhouse, Porter, & Talsma, 2014). Knowing that statistics helps us do our job better. That makes it very clear how important communication truly is and that it cannot be compromised to complete other various tasks.

Finding the Error to find Solutions

However, before assuming communication break downs are the only issue leading up to wrong surgical site occurrences it's important to look at the whole picture. The surgical department is characterized to be a chaotic unit. A department with high stakes, a very fast pace, lots of multitasking, and complex equipment- all with multiple teams coordinating together. All of which effects communication and further opens the door to additional human
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error. As one can see, the solution is not just improving communication, but would also need to include addressing all of the other topics as well.

In order to seek out solutions from these issues when an error or mistake occurs, there are quality and safety tools that we can utilize in order to try to pinpoint what led up to it and how it can be successfully avoided in the future. Such system approaches include but are not limited to various, root cause analysis, fishbone diagrams, and the swiss cheese model. These tools allow us to tease out the complex systems and interrelationships that can cause harm to patients. A Root Cause Analysis and fish bone diagrams can identify breakdowns in the processes or systems that contributed to the non-conformance and determine how to prevent it from happening again.

The tool that I believe is most appropriate for this particular issue is utilizing the swiss cheese model. It points out that most accidents result from multiple, smaller errors in environments with serious underlying system flaws, such as the ones mentioned above. This model not only has tremendous explanatory power, it also facilitates the way toward solutions—encouraging personnel to try to identify the holes and to both shrink their size and create enough overlap so that they never line up in the future (Systems Approach, 2019). All of these processes also allow us to eliminate personal bias, theory, and blame in order to successfully come up with real solutions so errors do not re-occur.

Implementing the Surgical Timeout

By utilizing these safety tools and risk management, The World Health

Organization is persistently updating and adding imperative points to what is <https://assignbuster.com/quality-and-safety-issues-to-prevent-wrong-surgical-site/>

titled, the surgical time out. This reduces the incidence rate of wrong site surgery. The surgical safety checklist is now used in three phases of surgery. The phases include: before induction of anesthesia, right before the skin incision, and post-surgery. All three of the safety checklists involve not only confirming the surgical site but also identifying the patient by two identifiers, allergies, and fire-score. A rather recent added key component during this moment, is the entire team must stop what they are doing and participate to ensure the timeout is properly addressed and all teammates are in agreeance.

The surgical time out is taken very seriously, and everyone is held responsible in its success. If a wrong site surgery occurs those safety tools allow us to backtrack to discover where the error occurred and what was missed. Every time a site was missed or even a near miss, we could document it and keep a running record. This would allow us to look back and see if the same mistakes were reoccurring. For example, if the surgical site was initially mismarked by the surgeon, we could implement another step into the process which could include the patient also physically marking the site, so it's always double checked and allows the patient to be a part of their own care.

Conclusion

Although the surgery department is a busy unit that prides itself on efficiency, patient safety is and will always be the priority. The dynamic of the environment itself may never change, but various guidelines and policies may be successfully introduced in order to further increase patient safety. It

is not enough that these guidelines are created, but just as imperative that the nurse instills and fortifies their use to create a culture of excellence!

References

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