



Ensuring correct patient, correct site and correct procedure in Radiology, Nuclear Medicine, Radiation Therapy and Oral Surgery

Throughout the healthcare industry internationally and in Australia, the failure to correctly identify patients and correlate that information to an intended clinical intervention continues to result in wrong person, wrong side or wrong site procedures, medication errors, transfusion errors and diagnostic testing errors.

The role of policy and protocol in reducing patient safety risk is well established. Policy sets the regulations for practice in an organisation and provides instruction for the use of clinicians. Protocols provide specific targeted instruction on particular forms of healthcare intervention and help reduce variability in practice between individual practitioners or teams.

In 2004, the Australian Council for Safety and Quality in Health Care and the Royal Australasian College of Surgeons jointly developed the Ensuring Correct Patient, Correct Site, Correct Procedure Protocol which provided a national focus on patient/procedure mismatching. Health Ministers agreed to implement the protocol in their jurisdictions.

While this protocol applied broadly to all invasive procedures, including radiology and oncology, most of the focus of implementation was on its use in operating theatres. However it has been known for some time that mismatching between patients and their care is common outside surgery as well. Information from a number of States and Territories indicates that take-up of the original protocol outside the surgical environment has been limited.

Because of the continuing occurrence of patient identification incidents and near misses across a range of procedures and processes, a number of healthcare providers are now looking for support materials for other types of diagnostic and therapeutic activities similar to the surgical protocol. In response the Commission, in conjunction with clinician experts and major clinical groups, developed these additional protocols. The Commission would like to thank NSW Health for allowing use of their Correct Patient/Procedure/Site Safety Toolkits in the development of these national protocols.

1. Evidence

Over the three years that sentinel events have been reported nationally in Australia, the proportion of “wrong patient/wrong body part” has risen from 41% to 62% of all sentinel events. This rise is predominantly due to a steady increase in the reporting of non-surgical incidents as a focus has grown on the importance of these events. Emerging Australian data suggests that over 70% of all patient mismatching events may be in areas other than surgery such as imaging, laboratories and medication administration.

This picture is also evident internationally with over 80% of all patient identification root cause analyses reviewed by the US Veterans Administration occurring in areas other than invasive procedures and surgery.

2. Need for action

Fortunately many of these non-surgical mismatching cases cause little direct patient harm however there are instances of significant morbidity and even mortality as a result of such mismatching. In addition, mismatching can expose patients to a number of unnecessary risks including radiation risk, risk associated with delay in treatment or treatment that is incorrect, risk to patient trust and financial risk to the organisation and individual practitioner.

These events occur not because our healthcare workers are careless or disinterested but are a result of the way our healthcare systems are organised. The provision of health care in our modern hospitals is a very complex business.

Every day, the processing, transporting, treatment, testing and general caring of patients is being done by thousands of staff, clerks, orderlies, nurses, allied health workers and doctors – each of whom will come into contact with dozens, if not scores, of different patients.

The potential for confusion and error is enormous. With an appropriate organisational and individual focus on correct patient matching, these wrong patient, wrong site, wrong procedure events can be prevented.

3. Protocol structure and scope

These protocols address the specific areas of radiology, nuclear medicine, radiation therapy and oral surgery however the principles behind all of these protocols can, and should, be applied to other areas of clinical intervention.

The protocols follow a four step model of:

1. **Verification** of patient information
2. **Matching** that information against the request form (or the consent form where appropriate)
3. **Time out** immediately prior to the procedure
4. **Post-procedure** confirmation and documentation

The implementation of these protocols will need to take into account the particular circumstances of each healthcare service and therefore local policies and procedures will need to be crafted to bring these protocols into use. The Commission recognises that there are already existing guidelines and standards that address patient identification (such as the Royal Australian and New Zealand College of Radiologists Standards of Practice). These protocols should be used in the context of these existing requirements.

4. What can I do?

Patients and their families can make sure that each time they are about to have a treatment, investigation or test that the health professional directly involved knows exactly who the patient is. Each time a new health professional becomes involved in the process this needs to be repeated.

Health professionals can make sure that they adopt and follow these protocols for every time they are undertaking a procedure or investigation regardless of how well they believe they know the patient. Performing some of these steps may feel awkward at first but will become second nature, similar to the operating room staff and to pilots and co-pilots using a pre-flight checklist and protocol.

Managers can ensure that the necessary policies and procedures are developed and implemented in their organisations that will require and support the use of these protocols. A planned and monitored project approach to implementation should be undertaken across the entire organisation with regular reporting of compliance indicators to the organisations governing bodies.

Organisations should learn from their own experience of implementation of the original Ensuring Correct Patient, Correct Site and Correct Patient Protocol in operating theatres and seek the experience of other organisations in actively addressing the potential barriers.

MORE INFORMATION

Further information, along with copies of the protocols, this document and answers to commonly asked questions is available from:

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