AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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The Australian Commission on Safety and Quality in Health Care can be contacted through its website at http://www.safetyandquality.gov.au/ or by email mail@safetyandquality.gov.au

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The Australian Commission on Safety and Quality in Health Care was established in January 2006. It does not print, nor make available printed copies of, former Council publications. It does, however, encourage not for profit reproduction of former Council documents available on its website.

Ensuring Correct Patient, Correct Site, Correct Procedure

The Australian Council for Safety and Quality in Health Care (the Council) has developed a protocol for the prevention of procedures performed on the wrong patient or part of the body.

Why do we need a Protocol for Ensuring Correct Patient, Correct Site, Correct Procedures?

A large number of surgical, medical, radiology and oncology procedures are carried out in Australia every year. The standard of health services in Australia is very high and in the majority of cases, these procedures are carried out without any problems. But sometimes things can go wrong.

Planned procedures are occasionally carried out on the wrong patient or part of the body. These are known as *patient safety incidents* and are events that can cause serious harm and distress to patients, their families and the health professionals involved in their care. They can be costly to the patient who may require further treatment or medications, as well as to the health provider who has to spend time and resources fixing mistakes.

But with good planning, procedures carried out on the wrong patient or part of the body can be avoided.

Does it happen in Australia?

The Council has developed an agreed National Core Set of Sentinel Adverse Events, which includes procedures carried out on the wrong patient or body part. These types of infrequent, but alarming patient safety incidents occur in all health care systems, including those in Australia.

One Australian state has started to publicly report their patient safety incident data and the Council is working towards national reporting of these events. In one Australian State, 9 procedures were reported as being carried out on the wrong patient or body part in the year 2001/02. While only one state is publicly reporting their incidents, it has been found to happen in others. This number is small but is still considered too high, especially when better ways of doing things can reduce the likelihood of something going wrong.

What is being done to prevent this occurring?

When a procedure is carried out on the wrong patient or body part, an investigation may be conducted to determine why it happened. Results from these types of investigations in one Australian state identified 5 main causes of procedures being carried out on the wrong patient or part of the body:

- Poor checking of patients' identification wristbands;
- Inadequate communication between staff members, including inaccurate recording of a patient's treatment in their medical record;
- Not involving the patient well enough when identifying the correct site for a procedure;
- Having poor procedures in place for patients transferring between hospitals or health centres and health care staff; and
- Insufficient assessment of a patient before a procedure was carried out following a transfer from one hospital or health service to another.

There are a number of reasons why things go wrong. Health care, like any complex industry such as aviation and mining, can be risky. This is because there are so many steps involved in providing care that outcomes cannot be precisely controlled. However, with standardised procedures and protocols in place, unintended and unforeseen effects may be reduced. There is evidence from both the health system and other high-risk industries that having standardised procedures and protocols in place can reduce the likelihood of an error.

Addressing the problem

The Council has produced the *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol to help prevent procedures being carried out on the wrong patient or body part. These have been adapted from those produced by the Veterans Affairs National Centre for Patient Safety (VA NCPS) in the United States.

The *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol consists of 5 steps:

Step 1: Checking the consent form or procedure request form is correct

Step 2: Marking the site for the surgery or other invasive procedure

Step 3: Confirming identification with the patient

Step 4: Taking a "team time out" in the operating theatre, treatment or examination area

Step 5: Ensuring appropriate and available diagnostic images.

Performing some of these steps may feel awkward at first but will become second nature, similar to pilots and co-pilots using a pre-flight checklist and protocol.

The VA NCPS has examined cases of surgery being conducted on the wrong patient or body part and found that a large proportion of these cases could have been prevented if the steps in the protocol were carried out.

Joe Short

Joe Short* was called from the waiting room in a radiotherapy suite to receive his treatment. Unfortunately, Joe Smart*, who had a mild hearing impairment, answered the call and entered the treatment room, where the radiation therapist administered Mr Short's treatment. The error was only later discovered when Mr Short asked the receptionist how much longer he would have to wait until he could be seen after waiting for some time.

The *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol requires staff to ask a patient to state their name and date of birth before a procedure is commenced. If this step of the Protocol was completed, staff would have realised they were about to treat Mr Smart instead of Mr Short, and ensured the correct treatment was then given to both patients. This would have saved both patients time, and for Mr Smart, the worry of receiving the wrong treatment. Many procedures are costly and this error meant that resources were used inefficiently.

What can I do?

Consumers of health services, managers and other staff in many areas of the health care system can contribute to ensuring procedures are not carried out on the wrong patient or body part.

Consumers:

A patient brochure is available that can be given to patients who are about to undergo surgery or other type of procedure, to show them ways they can be involved to ensure they get the best care possible.

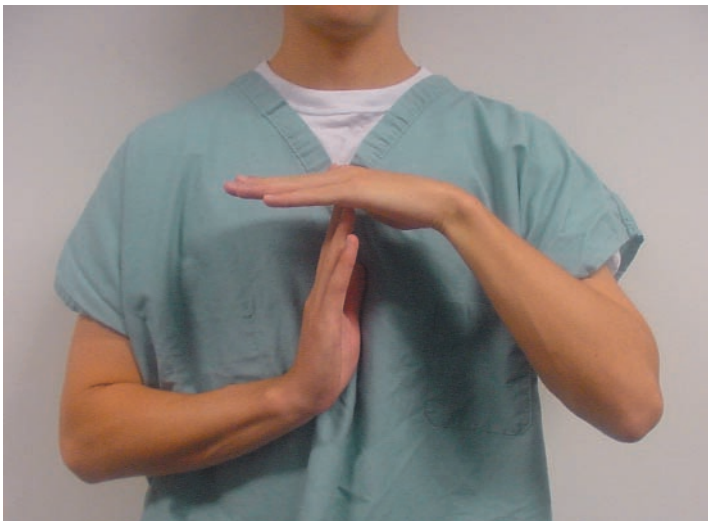
Health Professionals:

All health professionals can help prevent procedures being conducted on the wrong patient or body part. The protocol can be put in place wherever procedures are conducted, such as surgeries, chemotherapy and radiotherapy clinics and medical imaging departments, to reduce the likelihood of procedures occurring on the wrong patient or body part.

Managers:

Make sure the *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol is implemented in your work area.

The *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol kit contains workplace posters, and patient brochures. For further information please contact the Office of the Safety and Quality Council on (02) 6289 4244 or see our website www.safetyandquality.org. The Protocol, as well as other useful resources may be downloaded free from our website.



Kylie

After many months of waiting, Kylie* was admitted to hospital for an adenoidectomy. Kylie's mother Jan* was asked to sign the consent form prior to the operation, but unfortunately a staff member misread the title and had Jan sign a consent form for adeno-tonsillectomy instead of adenoidectomy. Jan did not realise the error as she assumed that adeno-tonsillectomy was the name of the operation her daughter was to undergo.

The operating theatre had an extremely busy day, however Kylie's identification band was checked against the consent form in the theatre and she had both her tonsils and adenoids removed during the operation. Jan was extremely distressed when she was told about the error and demanded explanations as to why this had been allowed to happen.

The *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol requires the patient, or their guardian (Jan in this case) to state their name, date of birth and type of procedure they are about to undergo just before they enter the operating theatre or treatment room. If this step had been carried out, both Jan and the staff would have realised the error, ensured the correct consent form was signed, and Kylie's tonsils would not have been removed.

Robert

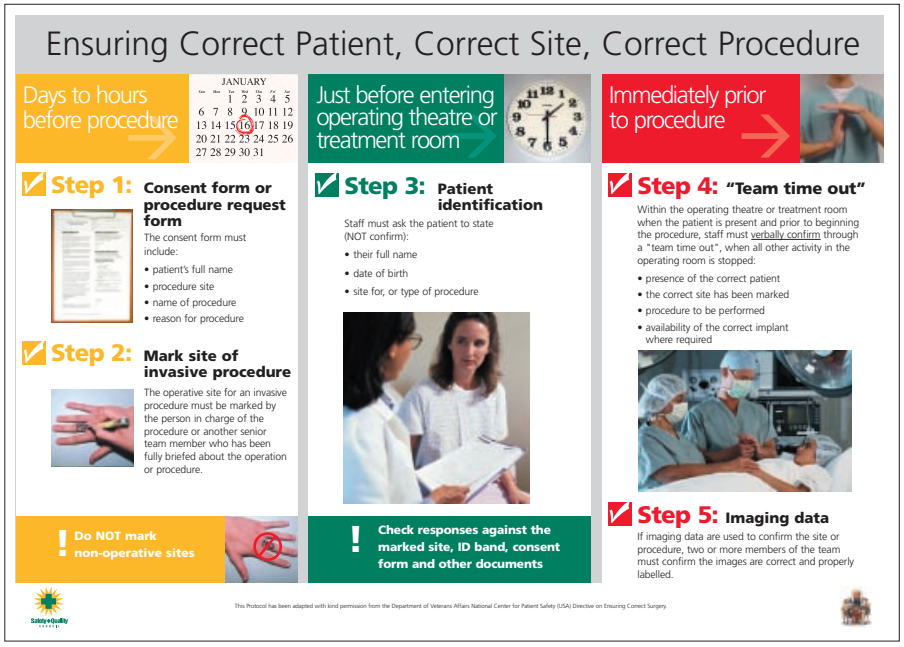
Robert was admitted to a day surgery unit for a knee arthroscopy and repair of a posterior horn tear. He signed his consent form, spoke to staff about the procedure and arranged for his wife Angela to collect him later that day. He was taken to theatre, the right-side knee was prepared for surgery and the arthroscopy was started on the right-side knee.

No tear was discovered in the right knee, so the surgical team reviewed Robert's medical record and recognised that the arthroscopy should have been performed on the left knee. The surgeon proceeded to perform the arthroscopy and repair on the left-side knee.

Robert was angry at the team who allowed this to happen, especially as it was likely to delay his return to his work as a courier by several days, and he would have to rely on Angela to drive him places until he fully recovered. Angela had left work early to collect Robert and was annoyed at having to wait for several hours in the hospital until he could see his doctors about the mistake before he went home.

The *Ensuring Correct Patient, Correct Site, Correct Procedure* Protocol requires the patient's surgical site, or other site for an invasive procedure to be marked with a pen that will not easily wash or rub off. This is to be done in consultation with the patient. If the site had been correctly marked in this case, the patient's right knee would not have been operated on, and additional pain and inconvenience would not have been caused to Robert and Angela.

*** Names have been changed to ensure confidentiality**



This Protocol has been adapted with kind permission from the Department of Veterans Affairs National Center for Patient Safety (USA) Directive on Ensuring Correct Surgery.

Safety+Quality COUNCIL

Further Information

Copies of Council publications or further information on the work of the Council including upcoming events and consultations is available at

www.safetyandquality.org

or by contacting:

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