



Patient Safety in the OR: Effective Risk Management Strategies

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By Diane Doherty



An Operating Room

The Journal of Patient Safety¹ estimates that between 210,000 and 440,000 patients die each year in hospitals as a result of preventable harm. While hospital leaders, physicians and other practitioners strive to provide quality care and reduce the overall number of errors, the delivery of healthcare will always contain an inherent measure of risk. This is especially true in busy operating rooms where distractions and interruptions can lead to serious errors or omissions in a matter of seconds.



Even the most common procedures require scrupulous attention to every step of the surgical process. The list of variables that are susceptible to error is long – ranging from patient identification and surgical site validation to instrument counts, patient handoffs and discharge readiness. And it doesn't matter how skilled a surgeon may be, he or she cannot manage all risks alone. It takes a combined team effort of the surgeon,

anesthesiologist, nurses and technicians to avoid shortcuts, communicate thoroughly and operate in a safety-conscious manner.

Beyond the walls of the procedure suite, effective management of operating room risks also requires the specialized intervention of a healthcare risk manager. Risk managers are deft at examining clinical processes, observing workflows, suggesting ways to integrate risk control strategies into day-to-day operations, and conducting ongoing assessments to identify areas needing improvement. There's no better hospital setting than the complex and fast-paced environment of an operating room to illuminate how a risk manager's proactive and strategic actions can help surgical teams focus on critical areas, evaluate current safety practices and ensure maximum patient safety.



Risk Assessment

A risk manager's primary role is to assess clinical settings, then carefully identify areas of potential exposure or concern where staff and the risk manager can together craft solutions. The assessment process starts with a review of written policies and procedures, followed by observation of doctors, nurses and other staff. At each step of the process, risk managers methodically look for evidence of top-down accountability and a culture that promotes safety and respect.

Interviews with key staff members often focus on work flows, reporting relationships, quality improvement programs and risk mitigation measures, such as the timely disclosure of adverse patient events. In fact, according to one study,² healthcare providers commonly withhold information from patients about medical mistakes, and tend to disclose clinical missteps only when pressed. Under the guidance of a professional risk manager, surgical staff can acknowledge mistakes, helping restore strained patient relationships and promote greater transparency regarding safety and quality issues.



Patient Selection

One of the most important questions to ask in a surgical setting: Is the patient an appropriate candidate for the selected procedure? Risk managers help ensure that doctors and patients are communicating effectively in this regard – i.e., that the physician has identified a surgical problem and deemed the patient to be a suitable candidate for the operation. Absent a robust patient selection procedure, inclusive of strict clinical criteria, the benefits of a particular surgery may be

open to speculation – as exemplified in the continuing debate surrounding the benefits of meniscus surgery, which research shows³ is usually no more effective than physical therapy for many patients.



Informed Consent

After confirming patient suitability for surgery, sharing detailed information with the patient about the procedure is integral to a legally defensible informed consent. Risk managers play an important role in educating staff about the benefits of a pre-procedure verification process that helps ensure all relevant information is conveyed to the patient and documented in the healthcare record.



Safety Functions

The idea of critical functions to help mitigate errors in high-risk industries has received a fair amount of attention, first in the aviation world and more recently in the healthcare arena. As a result, risk managers endorse the use of standardized safety checklists designed to help staff identify and resolve problems during the three critical stages of surgery: before anesthesia, before skin incision and before patients leave the operating room. At key junctures in the surgical process, easy-to-follow checklists facilitate staff communication on various high-risk issues, including anesthesia safety, equipment readiness, known allergies to medications and latex, bodily positioning and surgical counts. One of the most widely recognized operating room safety checklists is from the World Health Organization.⁴

Another example of a mandatory safety function is the surgical team “time-out,” which occurs immediately before the start of a surgical procedure. Scheduling a time-out affords the surgical team the opportunity to minimize confusion regarding patient identification and consent, surgical site marking and site verification, along with other pertinent information. Through consistent use of this and other safety-oriented methods, complication rates among surgical patients have been reduced – which is the end game in managing risk.



Patient Handoffs

Standardized handoff protocols facilitate the accurate transmission of information about a patient's care and condition whenever changes occur in surgical personnel, such as when the patient transfers from the operating room to the post-anesthesia care unit. Surgical teams help reduce errors in information transfer by utilizing handoff templates that promote communication and documentation in a structured, thorough and unhurried manner.



Conflict Management

Even in the presence of clinical safeguards designed to promote sound communication, some level of interpersonal friction is inevitable in a surgical group setting. According to one survey,⁵ 26 percent of nurses said that doctors had actually thrown objects at them. Sources of conflict, if left unattended, can slowly undermine both the patient safety process and teamwork dynamics. Granted, stress levels do run high in an operating room, but when conflicts



develop, team members are encouraged to resolve them swiftly and decisively through open communication and respectful dialogue. Here again, risk managers play a central role in assessing the quality of communication within the ranks of their organizations and training staff in conflict resolution principles.



Environmental Safety

Efficiency of movement is an important factor in a well-functioning operating room, which is often the setting of life-or-death situations. With that in mind – and although it may seem

obvious – one of a risk manager's highest priorities is to inquire whether a surgical suite is simply and optimally laid out for patient safety. For example, Is there a traffic flow guideline for managing foot traffic in and out of an operating room? Is staff movement unimpeded by structural barriers? Is there a protocol for the swift removal of equipment not in use? Most hospitals are transforming their spaces to compete for a bigger patient population, requiring risk managers to oversee every step of the renovation and construction process in order to ensure that all insurance concerns – from clinical infrastructure and signage to work design and safety – are sufficiently accounted for.

Discharge Readiness

Many hospitals share the common problem of overcrowding, forcing them to send surgical patients home before they may be clinically ready. With inpatient stays on the decline (currently averaging four and a half days), hospitals are retooling the discharge planning process with an eye toward increasing patient awareness of post-discharge care directives. To this end, risk managers are helping hospital leaders determine the root causes of readmission, enhance the discharge planning process, develop after-hospital care plan templates and monitor post-discharge communication with patients and their significant others.

At Chubb Insurance, we understand that risk managers cultivate an environment of safety every day in busy healthcare settings through sound error-reduction and reporting measures, enhancement of communication skills, and ongoing staff training and education. Let us show you how Chubb's professional risk consulting services can complement your efforts to promote a safer, more responsive clinical environment, while reducing exposure to litigation and loss.

About the Author

Diane Doherty, M.S., CPHRM services as Senior Vice President, Chubb Healthcare and is based in New York City. Ms. Doherty joined Chubb's predecessor company ACE in 2001. She is responsible for providing a broad range of risk consulting services to clients that are designed and customized to help meet continually evolving healthcare industry challenges. Ms. Doherty has more than 25 years of healthcare risk management experience. Her areas of specialization include clinical risk management, hospital administration, long term care, patient safety, and claims management. She is an active member of ASHRM and several regional ASHRM chapters, including GHSHRM, SCAHRM, GASHRM, and CASHRM. Ms. Doherty holds a Bachelor of Science degree from the College of Mount Saint Vincent and Master of Science degree in Healthcare Administration from Iona College.

Footnotes

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