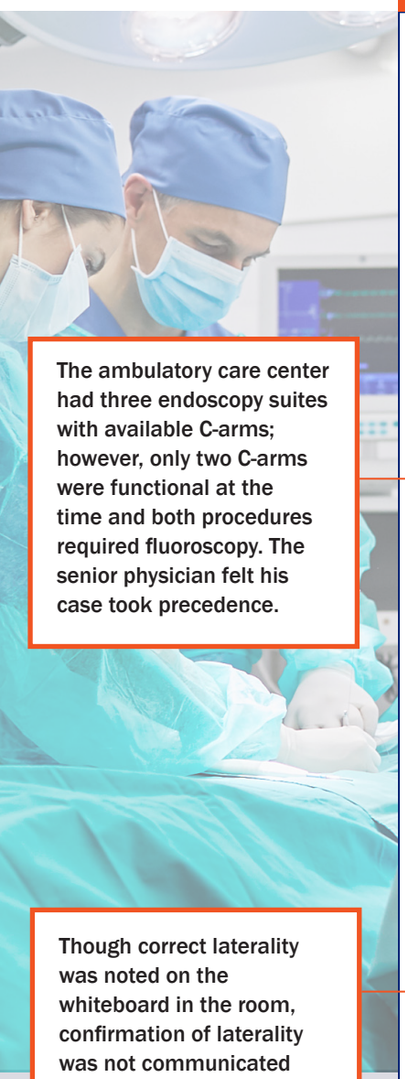
The Joint Commission

Case Example #2
Patient undergoes additional procedure after wrong lung biopsy

CASE EXAMPLE



A patient was scheduled for a transbronchial biopsy of the right upper lung to obtain specimens for determining if a lung mass was malignant. The patient was consented for the bronchoscopy procedure (using fluoroscopy).

The consent only spoke to the procedure and did not include laterality.

The appointment was scheduled to be the first case of the morning; however, despite a full caseload that day, the case was delayed approximately one hour due to another physician's need to use the endoscopy suite — bumping the procedure.

The more senior physician had a history of bumping cases.

The ambulatory care center had three endoscopy suites with available C-arms; however, only two C-arms were functional at the time and both procedures required fluoroscopy. The senior physician felt his case took precedence.

Pre-op verification was completed by the nurse. When the endoscopy suite became available, other cases were beginning to delay significantly, and the team felt a sense of urgency to turn over the room quickly. The circulating nurse set up the C-arm and laterality of images, as the diagnostic radiology technician (DRT) was in the next room assisting with the completion of another procedure. The images portrayed left side laterality, in error.

Only one DRT was available for three OR suites. This was a known concern expressed to leadership in the past. Staff had grown accustomed to sharing tasks when the DRT was unavailable.

Though correct laterality was noted on the whiteboard in the room, confirmation of laterality was not communicated during the time-out process as the consent was the document used to guide the time-out. There was no standardized process for what documents were used or how visual aids (such as the whiteboard and images) were incorporated to verify laterality, nor were there clear expectations as to who was expected to participate during the time-out process.

After the room was prepped, the pulmonologist entered the room and a time-out was performed.

The pulmonologist had just completed a left-sided needle biopsy on another patient prior to this procedure.

The pulmonologist inserted the scope entering the left lung, obtaining biopsy specimens. The DRT entered the suite at this time to provide additional assistance with fluoroscopy. When the pulmonologist communicated completion of the left lung specimen collection, the DRT noted the discrepancy with the whiteboard, yet assumed it was the correct site as the images aligned with the pulmonologist's communicated location and no one else appeared concerned.

Each team member was focused on his/her specific task.

During the post-procedure debrief within the OR, it was discovered that the wrong lung had been entered. The patient was reprepped and the correct specimens were obtained.

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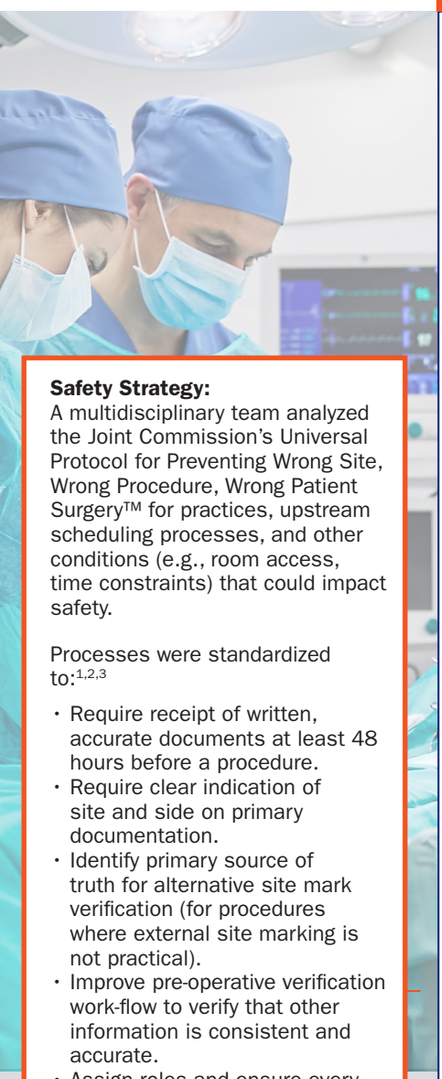
SAFETY STRATEGIES



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Safety Strategy:
A multidisciplinary team analyzed the Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Patient Surgery™ for practices, upstream scheduling processes, and other conditions (e.g., room access, time constraints) that could impact safety.

Processes were standardized to:[1,2,3]

- Require receipt of written, accurate documents at least 48 hours before a procedure.
- Require clear indication of site and side on primary documentation.
- Identify primary source of truth for alternative site mark verification (for procedures where external site marking is not practical).
- Improve pre-operative verification work-flow to verify that other information is consistent and accurate.
- Assign roles and ensure every team member participates in the time-out process and is empowered to speak up.

Medical leadership also took steps to ensure attending physician engagement in the pre-operative briefing and final verification process.

Safety Strategy: A team training program was implemented to build effective teamwork systems. Tools regarding maintaining situational awareness, recognizing hazards and speaking up when hazards are identified were incorporated.[4]

Safety Strategy: Leadership discussed the organization's code of conduct during daily safety huddles, educating staff that intimidating and disrespectful behaviors disrupt a culture of safety, and staff will be held accountable for professional behavior.[4]

Safety Strategy: Leadership hired additional staff to increase coverage for concurrent procedures, and staffing became a topic in daily safety huddles. Additionally, to counter potential drift into unsafe practices by discouraged staff, leadership created a structure and process for providing feedback to reported concerns to ensure that care team members continue to report and make suggestions. Feedback is shared during daily safety huddles and through a visual management system to demonstrate progress.[4]

Safety Strategy: The organization implemented systems-based strategies to mitigate the risk of a cognitive bias (an unconscious flaw in judgment) from impacting patient safety. Such strategies included:[5]

- Ensuring adequate time to assess information and verify assumptions.
- Conducting pre-briefs to discuss the plan in advance and ensure all information is in agreement.
- Providing team training to enhance situation monitoring and facilitate speaking up.
- Promoting conditions for effective decision-making and communication (reduction of noise and distractions).

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RESOURCES

1. Joint Commission Center for Transforming Healthcare: Safe Surgery Targeted Solutions Tool®
2. Becker's Clinical Leadership & Infection Control: 5 Time-Out Tips for Safe Surgery, July 8, 2013
3. The Joint Commission: Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Patient Surgery™ and Speak Up: The Universal Protocol poster
4. The Joint Commission. Sentinel Event Alert #57, "The essential role of leadership in developing a safety culture," March 1, 2017
5. The Joint Commission: Quick Safety, Issue 28, "Cognitive biases in health care," Oct. 25, 2016

The Joint Commission: Quick Safety, Issue 34, "Daily safety briefings — a hallmark of high reliability," June 2017

Joint Commission Center for Transforming Healthcare: Facts about the Safe Surgery Project, November 2016