

**Department Of Health
Medical Quality Assurance Commission
Washington State**

Policy/Procedure

Title:	Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery	Number: MD2011-08
Contact:	Julie Kitten, Program Operations Manager	
Effective Date:	September 30, 2011	
Supersedes:		
Approved:	<i>Mimi Pattison, M.D.</i>	
	Mimi Pattison, MD, FAAHPM, Chair	

PURPOSE:

To improve patient safety in the state of Washington by taking an active role in preventing wrong site surgery.

BACKGROUND:

The Medical Quality Assurance Commission promotes patient safety and enhances the integrity of the medical profession through licensing, discipline, rule making and education. The Commission wishes to promote patient safety by actively assisting the medical profession in reducing wrong site surgery. In this policy, the term “wrong site surgery” includes wrong patient, wrong procedure, wrong site and wrong side surgeries.

The Commission recognizes a concerted national effort to prevent wrong site surgery. The Joint Commission has been at the forefront of this issue for a number of years. In 1998, the Joint Commission issued *Sentinel Event Alert* newsletter, “Lessons Learned: Wrong Site Surgery,” and issued a follow-up review in 2001.¹ In 2003, the Joint Commission convened a wrong site surgery summit that led to the development of the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery in 2004.² The Universal Protocol, which includes a pre-procedure verification, site marking and a

¹ Joint Commission Center for Transforming Healthcare, “The Wrong Site Surgery Project,” http://www.centerfortransforminghealthcare.org/UserFiles/file/CTH_Wrong_Site_Surgery_Project_6_24_11.pdf

²http://www.jointcommission.org/facts_about_the_universal_protocol/

time out, is required for accreditation of hospitals, ambulatory care and office-based surgery facilities.

The National Quality Forum identified 29 “serious reportable events,” the first three being wrong site, wrong procedure and wrong person surgery.³ Since February 2009, the Centers for Medicare and Medicaid Services has not paid for any costs associated with wrong-site surgery. Further, many providers are familiar with the work of Atul Gawande, MD, who has shown the checklists can drastically prevent medical errors including wrong site surgery.⁴

In the state of Washington, the legislature developed a system whereby healthcare facilities are required to report sentinel events, including wrong site surgery, to the Department of Health. The Department has implemented a quality improvement program designed to find the root cause of the event and ensure measures are taken to eliminate or reduce future medical errors.⁵

Despite the efforts of the Joint Commission, the National Quality Forum, the Washington State Department of Health, and many others, recent studies show that the incidence of wrong site surgery is not decreasing.⁶ Some estimates put the national rate as high as 40 incidents per week.⁷

Recognizing wrong site surgery as a critical patient safety issue, in 2009, the Joint Commission’s Center for Transforming Healthcare began collaborating with eight hospitals and ambulatory care centers to develop a project to address the problem. The hospitals and ambulatory surgical centers found a number of risk factors that contribute to the incidence of wrong site surgery, including scheduling and pre-op processes, ineffective communication and distractions in the operating room, and a time out without full participation of key operating room staff. The ongoing project measures the magnitude of the problem, pinpoints contributing causes, develops targeted solutions, and thoroughly tests the solutions in real life situations.

³ National Quality Forum, “Serious Reportable Events: Transparency, Accountability critical to reducing medical errors and harm.” http://www.qualityforum.org/Publications/2008/10/Serious_Reportable_Events.aspx. These events were initially called “never events,” on the theory that they should never occur. However, with the addition of other events, the term was changed to “serious reportable events.” <http://www.ama-assn.org/amednews/2011/06/27/prsa0627.htm>

⁴ A. Gawande, *the Checklist Manifesto: How to Get Things Right*, (Metropolitan Books 2009); E. Cooney, “Surgical Checklist Passes Rigorous Test,” *Boston Globe* (November 10, 2010) http://www.boston.com/news/health/blog/2010/11/surgical_checkl_1.html

⁵ Chapter 70.56 RCW.

⁶ “Surgical Errors Continue Despite Protocols, *New York Times*, October 15, 2010; “Never Say Never: Surgical Errors Remain a Concern,” *Elsevier Global Medical News*, October 18, 2010.

⁷ “TJC Center Takes on Wrong Site Surgery Prevention,” *Bulletin of the American College of Surgeons*, (2100) 96(9): 70-71.

THE COMMISSION'S ROLE

The Commission recognizes and supports the efforts of many entities that are trying to prevent wrong site surgery. In 2008, the Commission adopted a policy requiring an investigation of a complaint involving wrong-site, wrong-procedure and wrong-patient surgery. The Commission wishes to join this effort and play an active role in assisting the medical community to reduce or eliminate wrong site surgery.

The Commission recognizes that a team of health care providers share responsibility for the safety of a patient before, during and after surgery. The Commission supports the practice of each member of the team being empowered to speak out if the safety of the patient is at risk. The Commission also understands that wrong site surgery is usually the result of a series of lapses in the system, and that responsibility for the error cannot be placed on a single individual. However, the surgeon is the last person capable of preventing wrong site surgery and is in the best position to prevent it from happening. The Commission recognizes that in rare cases, the surgeon may be free of fault, and will review each case using its clinical expertise to determine the appropriate action.

The Commission can assist in the reduction or elimination of wrong site surgery in four ways. First, the Commission can take a consistent approach to these cases. By imposing a standard set of sanctions in every case, the Commission can help ensure that a physician does not repeat this mistake.

Second, the Commission can assist in educating the medical community about avoiding wrong site surgery. The Commission believes that it is particularly effective to require a physician who has had such an event to make presentations to educate his or her peers in the medical community or specialty regarding the incident and the steps necessary to eliminate wrong site surgery.

Third, the Commission can foster a culture of learning and transparency in the medical community. The Commission wants to participate in a project to reduce medical errors with the Washington State Hospital Association (WSHA) whereby the Commission will notify the WSHA of these events and other systems errors. The WSHA will use these reports to inform and educate every hospital in the state so that large segments of the medical community can learn how to prevent these incidents from occurring in their hospitals. The Commission also will collaborate with other appropriate entities to share information and help prevent wrong site surgery.

Fourth, the Commission will begin measuring outcomes from this new approach to wrong site surgery cases and will produce a report providing the results of this effort.

POLICY

The Commission will take a consistent approach to cases involving wrong site surgery. In the absence of exceptional circumstances, the Commission will impose sanctions designed to ensure the event will not re-occur. Physicians will be required to assist in educating the medical community about steps to prevent wrong site. The Commission also will include these events when it reports medical errors to the WSHA. The Commission will measure the incidence of wrong site surgery and produce a report.

PROCEDURE:

1. A panel of the Commission reviews a file concerning wrong site surgery.
2. The Commission panel votes to issue a Statement of Charges or offer Respondent a Stipulation to Informal Disposition, depending on the particular circumstances of the case, unless there are exceptional circumstances absolving the physician of fault.
3. The sanctions in the Order,⁸ will comply with the sanctions schedule set forth in WAC 246-16-810. Wrong site surgery will often fall into either tier B or C, depending on the level of harm to the patient. The sanctions will include the following:
 - A. A period of probation that is consistent with the applicable range of the sanction schedule.
 - B. A requirement that the Respondent work with the facility in which he or she performs surgery to develop a Commission-approved written protocol. The protocol will incorporate and be consistent with the guidelines for preventing wrong site surgery recommended by the Joint Commission, the American College of Surgeons or other appropriate national organizations.
 - C. The preparation of a typed paper on the topic of wrong site surgery, including how Respondent has implemented changes into his or her practice to prevent the event from re-occurring.
 - D. A requirement that the Respondent make a presentation on wrong site surgery to a peer group at the facility in which Respondent has privileges, or other appropriate group that will benefit from education on the issue.

⁸ For the purposes of this policy/procedure, the term "order" includes a Stipulation to Informal Disposition, a Stipulated Findings of Fact, Conclusions of Law and Agreed Order, and an order issued following a default or a waiver of hearing by Respondent, or a final order following a formal hearing.

E. A requirement that Respondent will report to the Commission wrong site surgery that occurs during the effective term of the Order.

F. Respondent will permit a representative of the Commission to conduct periodic practice reviews for the primary purpose of verifying that Respondent is following the surgical protocols approved by the Commission.

G. Payment of a cost recovery or fine to the Commission.

4. Commission staff prepares a report describing the event and submits it to the WSHA and other appropriate entities

5. The Commission continues to collect data on the incidence of wrong site surgery and measure outcomes.