Eliminating Avoidable Disasters in the OR and Managing Them When They Occur

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Avoidable Disasters in the OR
Opportunity

- Critical incidents (“never-events” or sentinel events) in the operating room (OR) remain a serious threat to patient safety.
- The Veterans Health Administration (VHA) has a robust critical incident tracking notification (CITN) system.
- One model to minimize avoidable disasters

Avoidable Disasters in the OR
Definitions: Veterans Health Administration

- Critical Incidents
  - Wrong patient, side/site, implant or surgery
  - Retained item (e.g. sponge, instrument)
  - Death in operating room
  - Death by hemorrhage within 24 hours
  - OR fire or burn

Avoidable Disasters in the OR
Portland Veterans Affairs Health Care System

- World Health Organization OR Checklists
- High-risk patient protocol
- Medical event reporting and just culture
- Key signage in operating room

Avoidable Disaster in OR
WHO Operating Room Checklists

- Pre-op briefing (in operating room)
  ✓ Surgeon, Anesthesiologist, scrub tech and circulator
  ✓ Time out and fire safety check
  ✓ Mandatory 3 min dry of prep prior to draping
- Post-op debriefing (in operating room)
  ✓ Performed after final counts
Avoidable Disasters in the OR
High-risk Patient Protocol

- VASQIP or NSQIP mortality calculator
- If ≥ 5%, then these things MUST be completed:
  1. High-risk note must be completed (template)
  2. Peer-peer review of case
  3. Palliative care consultation
  4. Documentation as to decision making
  5. If surgery: two attending team; brief SICU
  6. Any stakeholder can stop-the-line

Avoidable Disasters in the OR
Medical Event Reporting and Just Culture

- Medical Event Reporting System (MERS): electronic entry platform to Risk Management
- Surgical MERS routed to Chief of Surgery and Operative Care Nursing Director for response
- All MERS require follow-up and review by Surgical Workgroup Committee (Chair: Chief of Surgery)

Avoidable Disasters in the OR
Key Signage in Operating Room

- Division Nursing Director response in system
- Surgical Workgroup response in system

Avoidable Disasters in the OR
Portland VA Critical Incidents

- 5-Year Trend of Operations and Critical Incidents
- Operation numbers included minor procedures
Avoidable Disasters in the OR
Management After Critical Incident
- Stakeholder debriefings
- Peer review process
- Root cause analysis
- Unit-based ethics conversation (UBEC)
- Network and central office reporting and audits

Avoidable Disaster in OR
Lessons Learned
- All stakeholders should participate in implementation of change
- Leadership must lead by example with consistent messaging
- Reward reporting, problem solving, emotional intelligence
- Piloting allows for “buy-in” prior to broad implementation