Seguridad del paciente en el bloque quirúrgico

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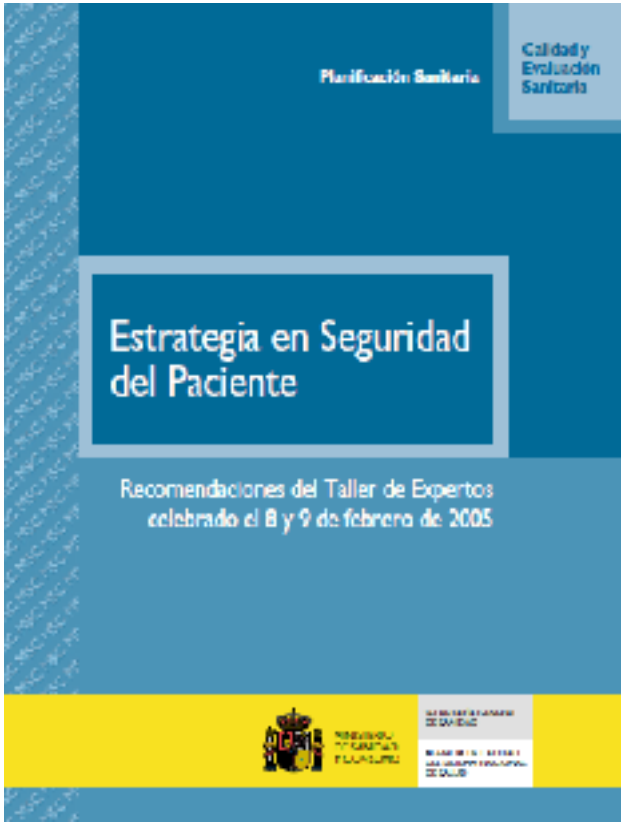
¿Seguridad?

safety patient 119
surgical safety patient 3515
surgical safety patient (2010) 277



LA SEGURIDAD CLÍNICA O SEGURIDAD DEL PACIENTE

Capítulo 11 Efectos adversos en cirugía

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de Xàtiva. . . . . .

SENSAR

Sistema Español de Notificación en Seguridad en Anestesia y Reanimación

www.seguridaddelpaciente.es

PATIENT SAFETY IN SURGERY

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

MAY 25, 2006

Making Patient Safety the Centerpiece of Medical Liability Reform

Hillary Rodham Clinton and Barack Obama

We have visited doctors and hospitals throughout the country and heard firsthand from those who face ever-escalating insurance costs. Indeed, in some specialties, high premiums are forcing physicians to give up performing certain high-risk procedures, leaving patients without access to a full range of medical services. But we have also talked with families who have experienced errors in their care, and it has become clear to us that if we are to find a fair and equitable solution to this complex problem, all parties — physicians, hospitals, insurers, and patients — must work together. Instead of focusing on the few areas of intense disagreement, such as the possibility of mandating caps on the financial damages awarded to patients, we believe that the discussion should center on a more fundamental issue: the need to improve patient safety.

We all know the statistic from the landmark 1999 Institute of Medicine (IOM) report that as many as 98,000 deaths in the United States each year result from medical errors.[1] But the IOM also found that more than 90 percent of these deaths are the result of faulty systems and procedures, not the negligence of physicians. Given this finding, we need to shift our response from placing blame on individual providers or health care organizations to developing systems for improving the quality of our patient-safety practices.[2]

To improve both patient safety and the medical liability climate, the tort system must achieve four goals: reduce the rates of preventable patient injuries, promote open communication between physicians and patients, ensure patients access to fair compensation for legitimate medical injuries, and reduce liability insurance premiums for health care providers. Addressing just one of these issues is not sufficient. Capping malpractice payments may ameliorate rising premium rates, but it would do nothing to prevent unsafe practices or ensure the provision of fair compensation to patients.[3]

Studies show that the most important factor in people's decisions to file lawsuits is not negligence, but ineffective communication between patients and providers.[4] Malpractice suits often result when an unexpected adverse outcome is

Seguridad del paciente
Relevancia

- Avance y mayor complejidad de tecnologías sanitarias (diagnóstico y terapéutica)
- Nuevos tratamientos farmacológicos
- Características de los pacientes (edad y comorbilidad)
- Nivel de formación de los pacientes
- Acceso a la información de los pacientes
- Participación del paciente en toma decisiones
- Reclamaciones y demandas

Seguridad del paciente

Concepto

- Conjunto de elementos estructurales, procesos e instrumentos que, basados en evidencia científica, contribuyen a minimizar el riesgo de sufrir un efecto adverso en el proceso de atención sanitaria, o a mitigar sus consecuencias si se produce.

Calidad asistencial

↓

Seguridad del paciente

↓

Áreas de riesgo (Bloque quirúrgico)

↓

Efectos adversos

Seguridad del paciente

↓

Práctica Clínica Segura

↓

Procedimientos diagnósticos y terapéuticos

- Efectivos y eficientes
- Bien indicados
- Ejecutados correctamente y sin errores

se hacen bien la **mayor parte** de las cosas
a la **mayor parte** de los pacientes
la **mayor parte** del tiempo

hacer bien **todas** las cosas
a **todos** los pacientes
todo el tiempo

Efectos adversos

Concepto

- Daño ocasionado al paciente no relacionado con la evolución natural de la enfermedad o con la esperada del tratamiento que puede condicionar la muerte, amenaza de muerte, incapacidad al alta, reingreso o prolongación de la estancia.

➢inevitables

➢evitables

Estándares de atención

BRENAN (HMPS I). N Engl J Med 1991; 324:370-376

Efectos adversos

Concepto

Accidente

Suceso aleatorio imprevisto e inesperado que produce daño al paciente o pérdidas materiales o de cualquier tipo

Incidente

Suceso aleatorio imprevisto e inesperado que no produce daño al paciente ni pérdidas materiales o de cualquier tipo. También puede definirse como un suceso que en circunstancias distintas podría haber sido un accidente; o como un hecho que no descubierto o corregido a tiempo puede implicar problemas para el paciente

Aranaz JM. ENEAS 2005. Ministerio Sanidad

EFECTOS ADVERSOS EN EPISODIOS HOSPITALIZACIÓN	%
Thomas – USA	2,9
Gawande – USA	3
Brennan HMPS I – USA	3,7
Vincent – Reino Unido	10,8
Kable – Australia	21,9
Aranaz- España	8,4

- Metodología de registro
- Variabilidad en las definiciones
- Desacuerdos entre revisores

Efectos Adversos en Cirugía

Variabilidad de definiciones

- **Infección herida**
- **Fístula anastomótica**
- **Trombosis venosa profunda**
- **Mortalidad operatoria**

BRUCE J. The measurement and monitoring of surgical adverse events. Health Technol Asses 2001; 5:1-194

Efectos adversos: Relevancia

- Elevada incidencia (3-21%)
- Deficiencias en atención sanitaria (25-50%)
- Impacto físico y psicológico en el paciente (4-14% éxitus)
- Envejecimiento población (<65 años)
- Repercusión económica
- Indicador de calidad de atención sanitaria
- Factores de riesgo

Efectos adversos relacionados con una intervención quirúrgica

- Complicaciones de la herida quirúrgica
- Complicaciones de la técnica quirúrgica (hemorragia, dehiscencia anastomótica, infección de cavidad, yatrogenia intraoperatoria)
- Complicaciones sistémicas (infección respiratoria, infección urinaria, infección de vía central, infarto de miocardio, trombosis venosa profunda, tromboembolismo pulmonar, fracasos orgánicos)
- Fracaso quirúrgico (persistencia o recidiva de la enfermedad o de sus síntomas)
- Anestésicos
- Cuerpos extraños olvidados

Efectos adversos no quirúrgicos

- Reacciones adversas a medicamentos
- Diagnósticos equívocos o tardíos
- Complicaciones por procedimientos diagnósticos invasivos
- Complicaciones por procedimientos terapéuticos no invasivos
- Caídas
- Fracturas
- Accidentes postparto

Estudio Nacional de Efectos Adversos ligados a la Hospitalización (ENEAS)

Aranaz JM, Aibar C, Vitaller J, Ruiz P

Madrid, 11 de Mayo de 2006

ENEAS 2005

Estudio Nacional de Efectos Adversos ligados a la hospitalización

- Restrospectivo de cohortes

- Objetivo
  - Incidencia EA
  - Causas inmediatas EA
  - Definir EA evitables

- Impacto
  - mortalidad
  - incapacidad
  - Estancia

- 24 hospitales: todas altas en 7 días

PROYECTO IDEA

Identificación de Efectos Adversos

FORMULARIO RESUMEN DE LA HISTORIA CLÍNICA

Marque con una X en la casilla correspondiente, al lado de la respuesta adecuada.

	Si	No
1. Hospitalización previa durante el último año en paciente menor de 65 años, u hospitalización previa en los últimos 6 meses en paciente igual o mayor de 65 años.		
2. Tratamiento antineoplásico en los seis meses previos a la hospitalización		
3. Traumatismo, accidente o caída durante la hospitalización		
4. Reacción Medicamentosa Adversa (RAM) durante la hospitalización		
5. Fiebre mayor de 38,3º C el día antes del alta hospitalaria.		
6. Traslado de una unidad de hospitalización general a otra de cuidados especiales.		
7. Traslado a otro hospital de agudos.		
8. Segunda intervención quirúrgica durante este ingreso.		
9. Tras la realización de un procedimiento invasivo, se produjo una lesión en un órgano o sistema que precisara la indicación del tratamiento u operación quirúrgica		
10. Déficit neurológico nuevo en el momento del alta hospitalaria		
11. IAM (infarto agudo de miocardio), ACVA (accidente cerebro-vascular agudo) o TEP (tromboembolismo pulmonar) durante o después de un procedimiento invasivo.		

12. Parada cardiorrespiratoria o puntuación APGAR baja.	
13. Daño o complicación relacionado con aborto, amniocentesis, parto o preparto.	
14. Éxitus	
15. Intervención quirúrgica abierta no prevista, o ingreso (para intervención) después de una intervención ambulatoria programada, sea laparoscópica o abierta.	
16. Algún daño o complicación relacionado con cirugía ambulatoria o con un proce-dimiento invasivo que resultaran en ingreso o valoración en el servicio de urgencias.	
17. Algún otro Efecto Adverso (EA).	
18. Cartas o notas en la historia clínica (incluida la reclamación patrimonial), en relación con la asistencia que pudieran sugerir litigio	
19. Cualquier tipo de infección nosocomial	

SI ALGUNA RESPUESTA HA SIDO POSITIVA, COMPLETAR EL CUESTIONARIO MODULAR (MRF2) PARA LA REVISIÓN RETROSPECTIVA DE CASOS

Jesús Mª Aranaz Andrés. Dpto. Salud Pública. Universidad Miguel Hernández. Servicio de Medicina Preventiva. Hospital Universitari Sant Joan d'Alacant. Ctra. Alicante-Valencia s/n. 03550 San Juan de Alicante. Tfno.: 96 593 8663 y 593 8821 Fax: 96 593&652 E-mail: aranaz_jes@gva.es

ENEAS 2005

Estudio Nacional de Efectos Adversos ligados a la hospitalización

5624 pacientes

1755 (32%) cribado positivo

8.4 % EA

42.8% evitables

16% graves

10,5% EA quirúrgicos (36,5% evitables)

Aranaz JM. ENEAS 200. Ministerio Sanidad

Efectos adversos
Clasificación

- Inevitables - evitables
- Quirúrgicos - no quirúrgicos
- Menores - moderados - mayores - fatales

Efectos adversos

Ocultación → **Registro**

Culpabilización → **Raíz del problema**

Gestión de Riesgos en Unidades Clínicas

Concepto

- Actividades destinadas a identificar, evaluar y tratar el riesgo de que se produzca un efecto adverso (EA) durante el proceso de asistencia sanitaria.

- Analizan los defectos del sistema: organizativos o fallos del proceso

- Objetivos

  Evitar el EA: prevención

  Minimizar sus consecuencias negativas

Gestión de Riesgos en Unidades Clínicas

Fases

1. Identificación del riesgo
   - Fuentes de información
   - Técnicas de identificación de riesgos

2. Evaluación del riesgo (análisis causa-raíz y AMFE)
   - Frecuencia
   - Consecuencias
   - Coste

3. Tratamiento del riesgo: prevención

Gestión de Riesgos en Unidades Clínicas
Elementos básicos

- Apoyo del responsable de la unidad
- Estructura de apoyo del GdR
  - Personal facultativo
  - Personal enfermería
  - Unidad de Calidad Hospital: metodología

formación

- Sistema de información
- Metodología de análisis y mejora de la seguridad del paciente

Gestión de Riesgos en Unidades Clínicas

Fuentes de información

- CMBD
- Informes de alta
- Bases de datos específicas
- Reclamaciones SAIP
- Infecciones:
  - Comité infecciones
  - EPINE
  - PREVINE..

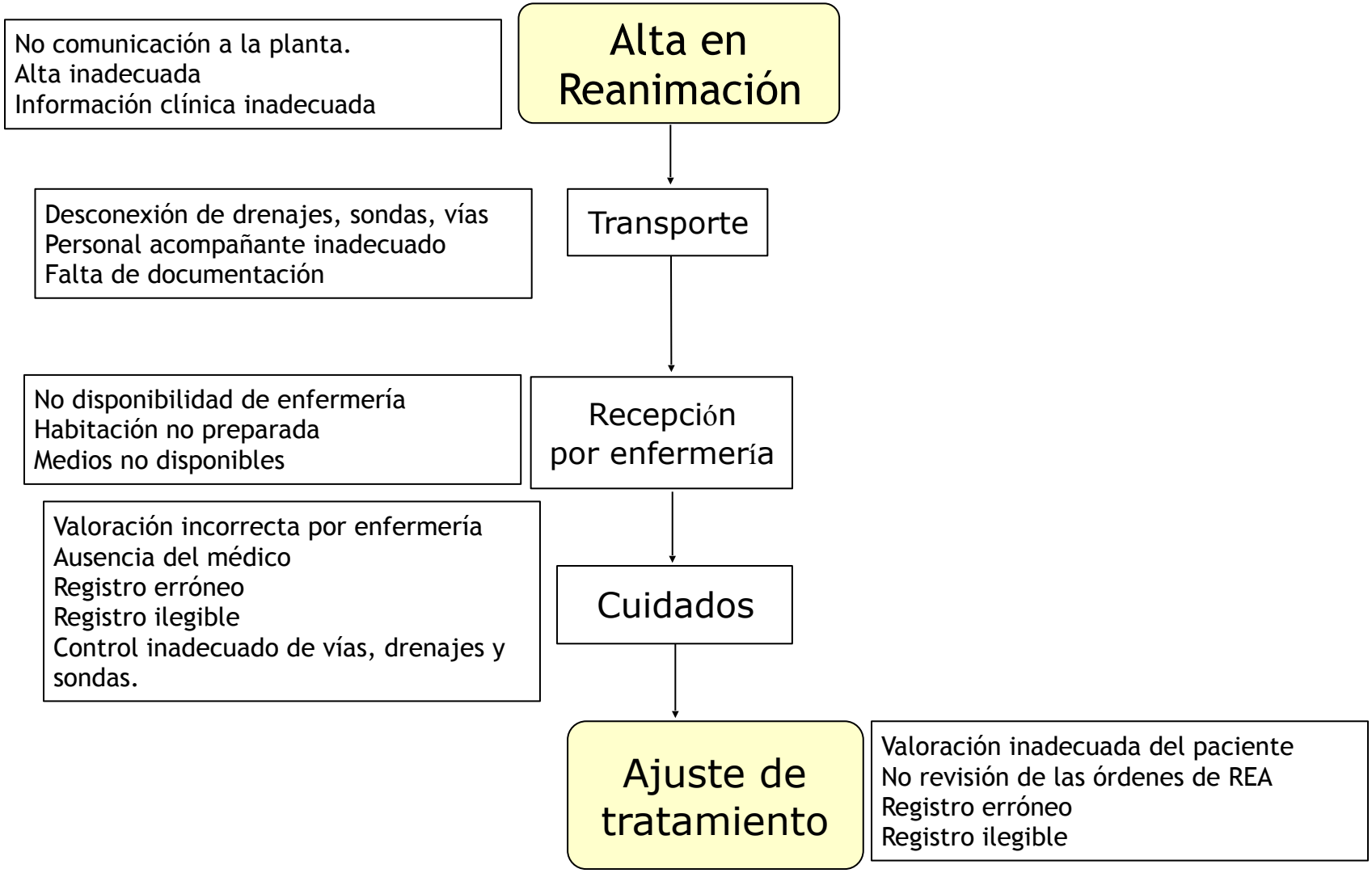
Gestión de Riesgos

AMFE (análisis modal de fallos y efectos)

- Selección de un proceso
- Grupo de trabajo
- Diagrama (de flujo) del proceso

- Modalidades de fallo en cada paso del proceso
- Tabla de análisis de riesgos: riesgo-índice de priorización IPR
- Tabla de acciones de mejora: fallos y acciones de mejora

Ejemplo.- Traslado de un paciente desde Reanimación hasta la planta de Cirugía

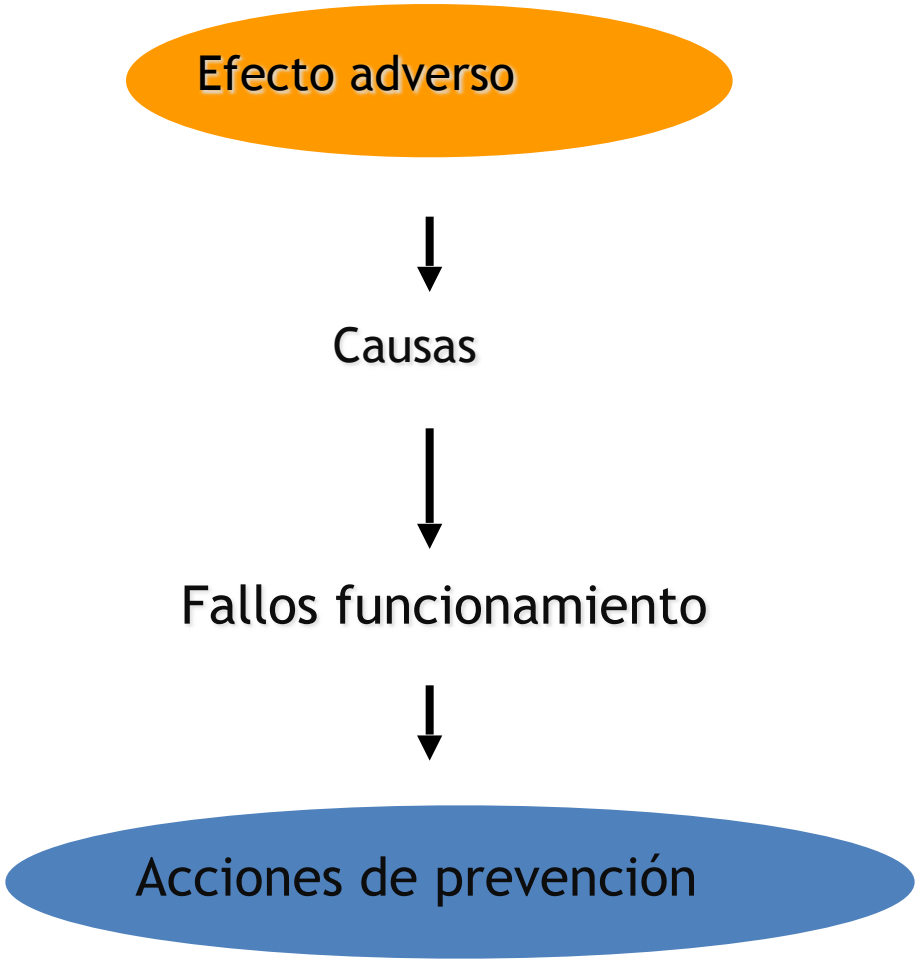


Ejemplo

TABLA DE ANÁLISIS DE RIESGOS								
PROCESO: Traslado desde REA a planta			FECHA: 17/11/2005			PG Nº 2		
MIEMBROS EQUIPO:	PUNTUACION	I. Gravedad	I. Aparición	I. Detección				
		Catastrófico 9-10 Mayor 5-8 Moderado 3-4 Menor 1-2	Frecuente 9-10 Ocasional 7-8 Infrecuente 5-6 Remoto 1-4	Baja 9-10 Moderada 7-8 Ocasional 5-6 Alta 1-4				
PASOS DEL PROCESO	POSIBLES FALLOS	POSIBLES CAUSAS	POSIBLES EFECTOS	PUNTUACIÓN				
				IG	IA	ID	IPR	
AJUSTE DE TRATAMIENTO	**•Valoración inadecuada del paciente** **•** **•No revisión de las órdenes de REA** **•** **•** **•** **.** **.** **.** **3.Registro erróneo o incompleto**	-Sobrecarga asistencial -Falta de experiencia -Sobrecarga asistencial -Falta de experiencia -Delegación de funciones por parte de los médicos -Exceso de confianza -Desconocimiento de la existencia del registro en uso -Sobrecarga asistencial	-Diagnóstico equivocado -Empeoramiento -Muerte -Diagnóstico y tratamiento equivocados -Prescripción de pruebas inadecuadas -No prescripción de pruebas necesarias -Empeoramiento -Muerte Tratamiento incorrecto -Prescripción de pruebas inadecuadas -No prescripción de pruebas necesarias -Cuidados inadecuados				

Gestión de Riesgos

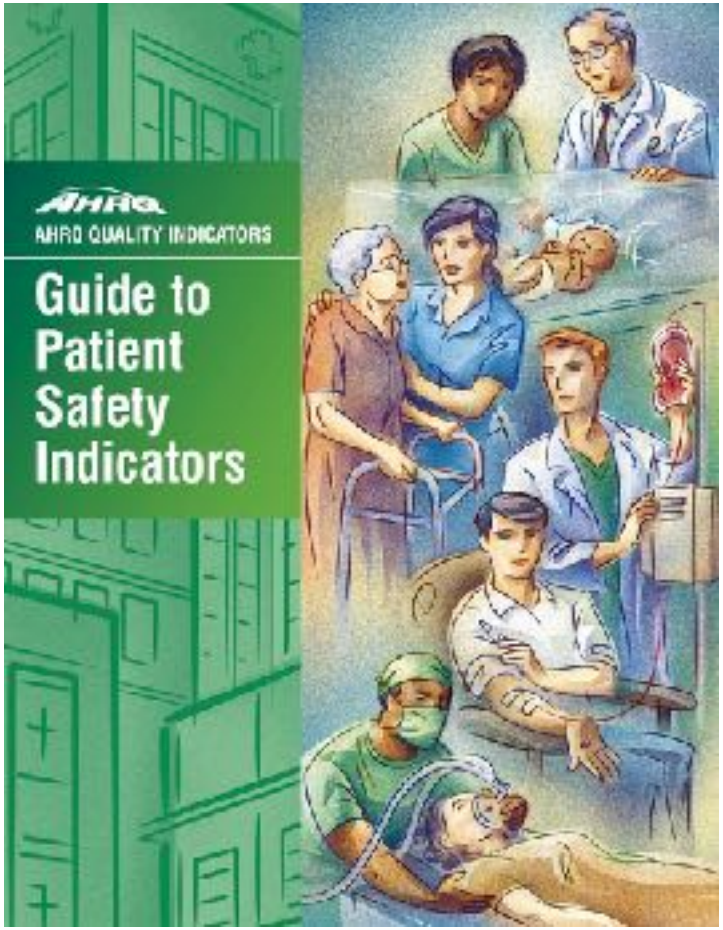
Análisis de causas raíz



Gestión de Riesgos

Análisis de causas raíz: metodología

- Identificación del EA
- Selección del equipo
- Recogida información
  - Lugar y momento
  - Unidades involucradas
  - Fases del proceso
  - Elementos estructurales y personal
- Mapa de los hechos
- Factores y causas desencadenantes
- Análisis de causas raíz
- Acciones de mejora



AHRQ Quality Indicators
Guide to Patient Safety Indicators

Department of Health and Human Services
Agency for Healthcare Research and Quality
http://www.qualityindicators.ahrq.gov
March 2003
Version 3.1 (March 12, 2007)

PSI (patient safety indicators)

Complications of anesthesia (PSI 1)

Death in low mortality DRGs (PSI 2)

Decubitus ulcer (PSI 3)

Death among surgical inpatients with serious treatable complications (PSI 4)

Foreign body left in during procedure (PSI 5)

Iatrogenic pneumothorax (PSI 6)

Selected infections due to medical care (PSI 7)

Postoperative hip fracture (PSI 8)

Postoperative hemorrhage or hematoma (PSI 9)

Postoperative physiologic and metabolic derangements (PSI 10)

Postoperative respiratory failure (PSI 11)

Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)

Postoperative sepsis (PSI 13)

Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 14)

Accidental puncture and laceration (PSI 15)

Transfusion reaction (PSI 16)

Birth trauma -- injury to neonate (PSI 17)

Obstetric trauma -- vaginal delivery with instrument (PSI 18)

Obstetric trauma -- vaginal delivery without instrument (PSI 19)

Obstetric trauma -- cesarean delivery (PSI 20)

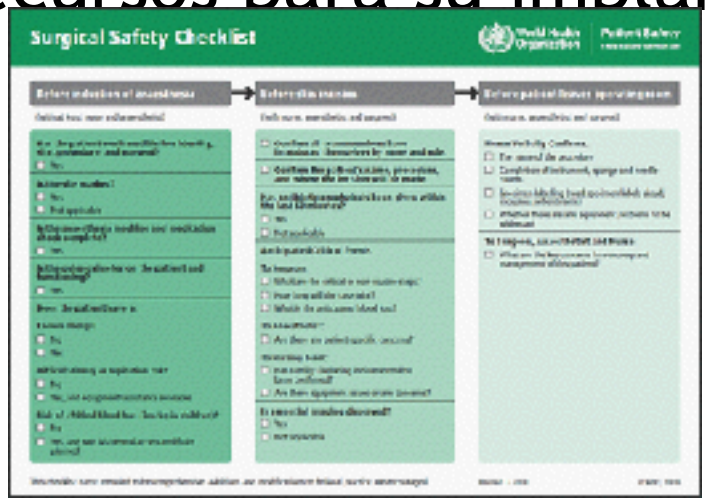
Gestión de Riesgos en el bloque quirúrgico

Prevención: checklist

- Área de alto riesgo EA
- Aplicación de industria aeronáutica
- Estrategia de verificación de todo el proceso de atención del paciente desde su entrada hasta su salida del área de quirófanos
- Confirmación verbal por parte de todo el equipo quirúrgico (enfermería, anestesia y cirujanos) de una serie de items relacionados con
  - ➢ identidad del paciente
  - ➢ el procedimiento quirúrgico
  - ➢ lugar y lado a intervenir
  - ➢ alergias medicamentosas
  - ➢ profilaxis antibiótica y TEP
  - ➢ medicación anestésica
  - ➢ aparataje y prótesis
  - ➢ reserva de sangre
  - ➢ esterilidad del material
  - ➢ identidad de especímenes
  - ➢ contaje de material

Ventajas checklist

- Adaptable al entorno local
- Basado en evidencia científica
- Evaluado en diferentes centros de todo el mundo
- Promueve prácticas seguras
- Mínimos recursos para su implantación



SPECIAL ARTICLE

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H., William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D., Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D., Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D., Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A., Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D., and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*

ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care would reduce complications and deaths associated with surgery.

METHODS

Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ifakara, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization's Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3733 consecutively enrolled patients 16 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 3955 consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including death, during hospitalization within the first 30 days after the operation.

RESULTS

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

From the Harvard School of Public Health (A.B.H., T.G.W., W.R.B., S.R.L.), Massachusetts General Hospital (A.B.H.), and Brigham and Women's Hospital (S.R.L., A.A.G.) — all in Boston, University of California, Irvine, Sacramento (T.G.W.); Prince Hamzah Hospital, Ministry of Health, Amman, Jordan (A.-H.S.B.); University of Washington, Seattle (E.P.D.); College of Medicine, University of the Philippines, Manila (T.H.); St. Stephen's Hospital, New Delhi, India (S.J.); St. Francis Designated District Hospital, Ifakara, Tanzania (P.L.K.); National Institute of Health, University of the Philippines, Manila (M.C.M.L.); University of Auckland and Auckland City Hospital, Auckland, New Zealand (A.F.M.); Imperial College Healthcare National Health Service Trust, London (K.M.); and University Health Network, University of Toronto, Toronto (M.K.R., K.T.). Address reprint requests to Dr. Gawande at the Department of Surgery, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115, or at safesurgery@hsph.harvard.edu.

*Members of the Safe Surgery Saves Lives Study Group are listed in the Appendix.

This article (10.1056/NEJMsa0810119) was published at NEJM.org on January 14, 2009.

N Engl J Med 2009;360:491-499.

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Gestión de Riesgos en el bloque quirúrgico

Prevención: checklist

- Multicéntrico 8 hospitales economías diversas
- Procedimientos quirúrgicos (no cirugía cardíaca)
- 3955 pacientes checklist vs 3733 pacientes control
- Checklist: 19 items
  - Antes inducción anestésica
  - Antes de incisión
  - Antes de salida del quirófano
- Objetivos: mortalidad y morbilidad / implementación de 6 medidas

	Control	Checklist	
Infección sitio	6.2	3.4	P<0.001
Reintervención	2.4	1.8	0.047
Mortalidad	1.5	0.8	0.003
Complicaciones	11	7	P<0.001

Haynes AB. N Engl J Med 2009; 491-9

Checklist

- Puede prevenir > 90% de los errores y EA causados en el área quirúrgicas
- Reduce los problemas o errores de comunicación del personal del área quirúrgica
- Facilita la relación del personal del área quirúrgica, reduciendo la tensión ambiental
- Buena aceptación por el personal del área quirúrgica

De Vries. Qual Saf health Care 2009; 18: 121-6

Lingard. Qual Saf Health Care 2004; 13:330-4

Nilsson. Acta Anaesthesiol Scand 2009

Lingard. Arch Surg 2008; 143:12-17

National Patient Safety Agency. WHO Surgical Safety Checklist

Achieving the National Quality Forum's "Never Events"

Prevention of Wrong Site, Wrong Procedure, and Wrong Patient Operations

Robert K. Michaels, MD, MPH, Martin A. Makary, MD, MPH,† Yasser Dahab, MD,* Frank J. Frassica, MD,‡ Eugenie Heitmiller, MD,* Lisa C. Rowen, RN, DNSc,§ Richard Crotreau, MD,¶ Henry Brem, MD,‖ and Peter J. Pronovost, MD, PhD†*

Objective: Review the evidence regarding methods to prevent wrong site operations and present a framework that healthcare organizations can use to evaluate whether they have reduced the probability of wrong site, wrong procedure, and wrong patient operations.

Summary Background Data: Operations involving the wrong site, patient, and procedure continue despite national efforts by regulators and professional organizations. Little is known about effective policies to reduce these "never events," and healthcare professional's knowledge or appropriate use of these policies to mitigate events.

Methods: A literature review of the evidence was performed

use to start evaluating whether they have reduced adverse events in operations.

(*Ann Surg* 2007;245: 526–532)

Despite a recent surge in patient safety awareness, preventable harm to surgical patients remains a problem. Wrong site, wrong procedure, and wrong person surgical procedures can be catastrophic to patients, healthcare profes-

EDITORIAL • ÉDITORIAL

Garth L. Warnock, MD
Coeditor, *Canadian Journal of Surgery*

Of surgeons and safety checklists

Nearly 2 years has elapsed since the landmark study and report by the Safe Surgery Saves Lives Study Group about reduction of morbidity and mortality in a global population through the use of a surgical safety checklist.[1] In Canada, recommendations to adopt the checklist have been endorsed by the Canadian Patient Safety Institute, several national specialty societies and provincial councils on patient safety and quality. Implementation of a checklist is now an accreditation standard for Canadian hospitals. By now, sufficient time has elapsed for wide implementation. A quick tour of hospital operating rooms (ORs) throughout the country confirms that posters identifying a multiphase checklist have been adopted into the culture of the OR.

A key question persists as to whether adoption has fully penetrated the practice of OR teams and whether it has yielded a positive impact on patient safety at the local level. Not infrequently, surgeons report that the checklist is merely an administrative exercise to meet accreditation standards. An with checklists in the context of a growing mandate to provide a patient-centred approach to safety and quality improvement. This mandate has specified a number of strategies for clinical services. The first is outcomes monitoring. From a process/compliance perspective, checklist compliance may be monitored. More importantly, end-result monitoring is forthcoming to track such events as surgical site infections, postoperative pneumonia and thromboembolism. An example of this is the American College of Surgeons' National Surgical Quality Improvement Project (NSQIP), which has in recent years been adopted in 2 British Columbia hospitals and soon will roll out to other sites throughout that province. An important aspect of NSQIP is the ability to adjust the data according to patient risks. A second major strategy is that of ongoing surveillance. Typically, case series audits have fulfilled this role, and some have been suitable for publication in this journal. However, novel safety reporting systems are focusing on structural data collection and risk adjustment such as the

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ORIGINAL ARTICLE

Evaluation of a Preoperative Checklist and Team Briefing Among Surgeons, Nurses, and Anesthesiologists to Reduce Failures in Communication

Lorelei Lingard, PhD; Glenn Regehr, PhD; Beverley Orser, MD, PhD; Richard Reznick, MD, MEd; G. Ross Baker, PhD; Diane Doran, RN, PhD; Sherry Espin, RN, PhD; John Bohnen, MD; Sarah Whyte, MA

Objective: To assess whether structured team briefings improve operating room communication.

Design, Setting, and Participants: This 13-month prospective study used a preintervention/postintervention design. All staff and trainees in the division of general surgery at a Canadian academic tertiary care hospital were invited to participate. Participants included 11 general surgeons, 24 surgical trainees, 41 operating room nurses, 28 anesthesiologists, and 24 anesthesia trainees.

Intervention: Surgeons, nurses, and anesthesiologists gathered before 302 patient procedures for a short team briefing structured by a checklist.

Main Outcome Measure: The primary outcome measure was the number of communication failures (late, inaccurate, unresolved, or exclusive communication) per procedure. Communication failures and their consequences were documented by 1 of 4 trained observers using a validated observational scale. Secondary outcomes were the number of checklist briefings that demonstrated "utility" (an effect on the knowledge or actions of the team) and participants' perceptions of the briefing experience.

Results: One hundred seventy-two procedures were observed (86 preintervention, 86 postintervention). The mean (SD) number of communication failures per procedure declined from 3.95 (3.20) before the intervention to 1.31 (1.53) after the intervention ($P<.001$). Thirty-four percent of briefings demonstrated utility, including identification of problems, resolution of critical knowledge gaps, decision-making, and follow-up actions.

Conclusions: Interprofessional checklist briefings reduced the number of communication failures and promoted proactive and collaborative team communication.

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POOR COMMUNICATION IS THE single most frequent cause of

ing of clinical goals,[10] teamwork,[11] and communication.[13] However, these studies have

Information Transfer and Communication in Surgery

A Systematic Review

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Objectives: We conducted a systematic review of published literature to gain a better understanding of interprofessional information transfer and communication (ITC) in hospital setting in the field of surgical and anesthetic care.

Background: Communication breakdowns are a common cause of surgical errors and adverse events.

Data Sources: Medline, Embase, PsycINFO, Cochrane Database of Systematic Reviews, and hand search of articles bibliography.

Study Selection: Of the 4027 citations identified through the initial electronic search and screened for possible inclusion, 110 articles were retained following title and abstract reviews. Of these, 38 were accepted for this review.

Data Extraction: Data were extracted from the studies about objectives, clinical domain, methodology including study design, sample population, tools for assessing communication, results, and limitations.

Results: Information transfer failures are common in surgical care and are distributed across the continuum of care. They not only lead to errors in care provision but also lead to patient harm. Most of the articles have focused on ITC process in different phases especially in operating room. None of the studies have looked at whole of the surgical care process. No standard tool has been developed to capture the ITC process in different teams and to evaluate the effect of various communication interventions. Uses of standardized communication through checklist, proformas, and technology innovations have improved the ITC process, with an effect on clinical and patient outcomes.

Conclusions: ITC deficits adversely affect patient care. There is a need for standard measures to evaluate this process. Effective and standardized communication among healthcare professionals during the perioperative process facilitates surgical safety.

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37% of errors in critical care units were associated with verbal exchanges between nurses and physicians. In a retrospective study, Wilson et al[3] discovered that communication errors were the leading cause of adverse events and were associated with twice as many deaths as clinical inadequacy. Studies in various fields,[4,5] including emergency medicine and general practice have further confirmed that communication breakdown is one of the leading system factor for adverse incidents and errors.

Recent systems approaches to patient safety in surgery[6–8] have placed a premium on information transfer and communication (ITC). Effective communication is not only a component of the systems approach but is integral to the success of all other factors. Moreover, the evolution of surgical care toward a team-based approach creates an urgent need to improve interprofessional ITC. Although a number of research reports, including observation studies[6] and retrospective case record reviews[4,7] have identified communication failures as one of the leading causes of adverse events, incidents or errors, little is known about the specifics of surgeon ITC. Despite the fact that communication is a key factor affecting patient safety, there is little research into what type of communication actually occurs between healthcare professionals. The tools used for assessing the communication and information transfer have been variable and various interventions used to improve ITCs have been implemented without thorough understanding of the process.

To address these limitations, and to synthesize the existing research on communication in surgery, we performed a systematic review of the literature. The specific objectives that this review seeks to achieve are as follows:

- To characterize the quality and quantity of interprofessional com-

Prevention of Surgical Malpractice Claims by a Surgical Safety Checklist

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Objective: To assess what proportion of surgical malpractice claims might be prevented by the use of a surgical safety checklist.

Background: Surgical disciplines are overrepresented in the distribution of adverse events. The recently described multidisciplinary SURgical PAtient Safety System (SURPASS) checklist covers the entire surgical pathway from admission to discharge and is being validated in various ways. Malpractice claims constitute an important source of information on adverse events. In this study, surgical malpractice claims were evaluated in detail to assess the proportion and nature of claims that might have been prevented if the SURPASS checklist had been used.

Methods: A retrospective claim record review was performed using the database of the largest Dutch insurance company for medical liability. All accepted or settled closed surgical malpractice claims filed as a consequence of an incident that occurred between January 1, 2004 and December 31, 2005 were included. Data on the type and outcome of the incident and contributing factors were extracted. All contributing factors were compared to the SURPASS checklist to assess which incidents the checklist might have prevented.

Results: We included 294 claims. Failure in diagnosis and perioperative damage were the most common types of incident; cognitive contributing factors were present in two-thirds of claims. Of a total of 412 contributing factors, 29% might have been intercepted by the SURPASS checklist. The checklist might have prevented 40% of deaths and 29% of incidents leading to permanent damage.

Conclusion: Nearly one-third of all contributing factors in accepted surgical malpractice claims of patients that had undergone surgery might have been intercepted by using a comprehensive surgical safety checklist. A considerable amount of damage, both physical and financial, is likely to be prevented by using the SURPASS checklist.

(*Ann Surg* 2011;0:00–00)

shown that the majority of surgical errors occur outside of the operating room.[7,11,12] This perception formed the basis for the SURgical PAtient Safety System (SURPASS) checklist, the development of which was initiated as early as 2004. SURPASS was developed based on literature and real-time observation data, and subsequently validated in surgical practice.[7] SURPASS is a surgical safety checklist that covers the entire surgical pathway from admission to discharge. It aims to improve surgical patient safety by providing a frame for the surgical pathway and promoting interdisciplinary communication. The checklist is split up into the different stages of the pathway (preoperative ward, operating room, recovery or intensive care unit, postoperative ward, and discharge) and is multidisciplinary: ward doctor, nurse, surgeon, anaesthesiologist, and operating assistant are all responsible for completion of parts of the checklist (Table 1).

The external validation of SURPASS is being performed in various ways: by observation techniques, by real-time registration of intercepted incidents, and by studying the effect of the checklist on patient outcomes in a multicenter setting[11]. Malpractice claims constitute an interesting supplement to the above-mentioned methods. Although not every malpractice claim is the consequence of an adverse event, they provide a broad catchment point for information on medical errors and adverse events, represent large groups of patients and focus on adverse events that led to serious outcomes.[12,14,15]

In the present study, surgical malpractice claims were evaluated in detail to assess the proportion and nature of claims that might have been prevented if the SURPASS checklist had been used.

METHODS

Record Selection

A retrospective record review was performed using the

PAPER

Surgical Case Listing Accuracy

Failure Analysis at a High-Volume Academic Medical Center

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Hypothesis: Describe the incidence, type, and detection method of surgical listing errors and implement a system to reduce errors.

Design: All errors/discrepancies between the surgical listing and the performed procedure reported to an institutional event line during 2008 were analyzed.

Setting: Academic tertiary medical center.

Main Outcome Measures: Error characteristics and detection mode were documented. An error causal tree analysis was developed and used to modify the standard listing process to reduce errors.

Results: During 2008, 759 listing errors were reported of 55 197 surgical procedures for an error rate of 1.38%. No wrong-site surgeries occurred. The errors were missing laterality (501; 66%), incorrect side (108; 14%), incorrect listing besides laterality (86; 11%), and other (64; 9%). Identification/correction of the listing error occurred in the following areas: nursing review the evening prior to surgery (517; 68%), preoperative admission unit (132; 17%), operating room (98; 12%), recovery room (6; 0.8%), and other (6; 0.8%). Using a causal tree analysis, error-proofing strategies applied in an electronic standardized case listing system significantly reduced the error rate from 1.50% to 0.54% ($P<.05$) and 2.06% to 0.49% ($P<.05$) in gynecologic and colorectal surgery, respectively.

Conclusions: Surgical listings errors occur with a low constant rate across specialties. The majorities of errors were related to laterality and were detected prior to surgery. An electronic listing system using standardized case descriptions with required laterality significantly reduced the error frequency.

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...últimamente viene fallando…ayer dejó de funcionar

….la semana pasada se utilizó el último.....y si no lo han repuesto…

….le han pintado el lado derecho…pero en la historia consta el contrario..

…¿le ha pasado el antibiótico de la profilaxis?…

…la culpa es del jefe que ya lo sabe..

…no quedan…

Conclusiones

- Garantizar la seguridad del paciente constituye uno de los objetivos de todo sistema sanitario.
- El bloque quirúrgico es un área de alto riesgo de efectos adversos.
- Un número importante de EA en el bloque quirúrgico pueden prevenirse mediante checklist.
- La gestión de riesgos es una herramienta útil para garantizar la seguridad del paciente.

“...uno de los objetivos de los sistemas sanitarios para este siglo es garantizar la seguridad del paciente mediante la prevención de efectos adversos....”

R. Smith (Editor BMJ) 2004