Beth Israel Deaconess Medical Center

In June of 2008 Kenneth Sands MD. Sr Vice President of Health Care Quality sent an e-mail to all BIDMC employees that read in part:

"This week at BIDMC, a patient was harmed when something happened that never should happen: a procedure was performed on the wrong body part. With the support of all our chiefs of service, we are sharing this information with the whole organization because there are lessons here for all of us.
While respecting the confidentiality of both the patient and caregivers, here are the key facts: it was an elective procedure, involving an excellent team of providers. It was a hectic day, as many are. Just before hand, the physician was distracted by thoughts of how best to approach the case, and the team was busily addressing last minute details. In the midst of all this, two things happened: first, no one noticed that the wrong side was being prepared for the procedure. Second, the procedure began without performing a "time out," that last minute check where the whole team confirms "right patient, right procedure, right side." The procedure went ahead. The error was not detected until after the procedure was completed. When it was, our patient safety division was notified immediately, and they in turn took all appropriate steps including investigation, reporting, and corrective action. The physician discussed the error with the patient at the first opportunity, and made a full apology.

What a horrifying story. What important lessons. We learned that when teams are busy and distracted, it makes it easier to overlook something. We learned that key safety steps, like "the time out", need to occur every single time, since even one failure can be serious. We learned that serious events rarely relate to the performance of any single person. We learned that we have vulnerabilities that we were not even aware of, and that there are surely others out there."

This event shook the medical center and the perioperative community to it's core. How could this happen at BIDMC?

Immediately following this e-mail a multidisciplinary team was mobilized to address the culture of safety at the point of care in Perioperative Services. This "Safety Culture Task Force" (SCTF) included a small group of representatives from nursing, surgeons, anesthesiologists and technologists who deliver care in the operating rooms. They were charged to utilize general principles of patient safety improvement such as building in redundancies and cross checks, standardizing and simplifying with an emphasis on teamwork and enhanced communication.

Meeting weekly the group embarked on a journey to reinvigorate safety checks in the pre-operative period and to restore "reverence" to the final time out. While this sounds easy, anyone who has implemented a large scale change realizes quickly that this work on complex systems is very challenging. Over the course of the first few meetings the

task force set a time line that included short and long term goals. Within a week there were changes implemented in the operating room that included:

- Establishing that the operating surgeon was responsible for the final time-out
- Agreeing that no blades will be mounted for incision until the final time out is completed
- Agreeing that ALL Members of the team stop and participate using scripted responses
- Visualing the site marking must be ALL team members
- Adressing ALL concerns before procedure begins
- Readressing side, site, instruments and antibiotic administration for each additional procedure

The SCTF recommended that every quarter there should be a combined safety grand rounds meeting for all of the 300+ members of the perioperative community with the first one scheduled for 7/30/08. The SCTF force recognized that the traditional academic model resulted in siloed education. In our case, every Wednesday morning we start the operating room schedule an hour late so that the members of surgery, anesthesia and nurses/techs in perioperative services can meet. For years, they have met in 3 different venues. At this meeting the work of the SCTF was presented. The first combined safety grand rounds was focused on a presentation of the new enhanced safety processes implemented in the immediate period following the wrong site procedure. There was a robust discussion of the processes and their impact on perioperative work flow. This meeting was viewed by most attendees as a rousing success. What a novel idea…that the perioperative community would all hear the same information at the same time about work that was designed and implemented by their peers.

Over the next 2 months, the SCTF developed a set of training videos with members of the perioperative community serving as “actors”. Entitled
“Universal Protocol: The Good, the Bad and the Ugly” these videos told the story of 3 scenarios of sign in and time out in the operating room. These were presented to the community at the 11/12 combined quarterly Safety Grand Rounds.

By June of 2009, almost a year to the date of the event and after multiple pilots and revisions the entire surgical safety checklist was implemented within our electronic perioperative management system. Today, as a result of their work all of the current sign in, time out and sign out processes have been adopted and are incorporated into the electronic perioperative information management system. The work of the SCTF has become a model for other institutions to follow.

Over the past 2 years the SCTF has continued to meet and has made many practice changes. This includes the development of a robust tracking and auditing system to ensure sustainability of practice changes.

The SCTF has continued to support the quarterly combined safety grand rounds with a focus on patient safety topics. At our most recent 9/1/10 rounds we hosted Sue Scott RN,

MSN from the University of Missouri to talk about the peer support model that they have implemented. Our SCTF will be instrumental in assisting with this work. The plan for this year is to develop and implement a peer support service for perioperative services. The current SCTF work if focused on the development of another set of training videos that are focused on examples of conflict in the operating room. The intent is to demonstrate best practices for conflict resolution. We intend to preview these at the combined March Safety Grand Round.

IN 2008 the e-mail to all employees from Dr Sands concluded:

"The strength of an organization is measured not by counting the number of successes, but by its response to failure. We have made an institutional commitment to eliminating harm, and that requires sharing information about cases such as this so that we all have a chance to learn from it. We still have more to learn, and changes that need to be made, and so will be providing more information in the future. "

The response of the perioperative community at BIDMC through the SCTF exemplifies the spirit of MITSS. The SCTF has worked tirelessly toward the goal of improving patient safety in the operating room . The lessons learned there have been extended to other areas of the medical center. I am so proud of them and hope that you will consider them as deserving of this most prestigious recognition.