The implementation of the surgical pause in selected Private Healthcare Institutions in Gauteng

Presenter
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Disclosure

• Authors
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  – Nieuwoudt, S.M.

• Sponsorship
  – Hospital Manager of Unitas Hospital (Mr R Jordaan)

• Learning Objectives
  – The importance of Surgical Pause (Time out)
  – Possibilities to improve it
Introduction

• What is Surgical Pause?

• Who is responsible?

• How is it done?
  – Step back
  – Focus on patient & procedure
  – Verbalize
  – Advocate

Background & Rationale

- 1910 - Dr Ernest Codman
  - 1st noted surgical errors
  - Over 5 years: 36.5% (123 errors from 337 patients)
  - Started research & made recommendations
- 1978 - California Code of Regulations
- 1998 - Joint Commission Center of Transforming Healthcare
- 2001 - 1st newsletter published
- 2003 - The first Wrong Site Surgery Summit
- 2004 - The first Universal Protocol was launched

Background & Rationale

- 2012 - Patient Safety Network
  - Errors still occur
  - Lack of Implementation
  - Omission of some steps
  - Poor communication
  - Lack of time
Background & Rationale

• Consequences of inadequate implementation:
  – Reputational damage - hospital and staff
  – Psychological damage - incorrect side, site, wrong patient or procedure performed
  – Litigation
  – Financial for patient and hospital

Research Problem

• Surgical pause insufficiently implemented

Research Purpose

• Ensure patient safety
• Implement participative action plan
• Evaluate participative action plan
Research Questions

• Was the surgical pause implemented effectively?
• Why was the surgical pause not implemented correctly?

Research Objectives

• Step 1 - Assess the implementations
• Step 2 - Assess the reasons for non-compliance
• Step 3 - Formulate a participative action plan
• Step 4 - Implement participative action plan
• Step 5 - Evaluate compliance of surgical pause
Research Method & Design

- Action research
  - Quantitative approach
  - Qualitative approach

Population & Sampling

- Surgical teams
  - Surgeon
  - Scrub nurse & floor nurse
  - Anaesthesiologist
- Non-probability convenience sampling

Stringer, 2008
Data Collection Procedure

- Step 1
  - Checklists

- Step 2
  - Questionnaires

- Step 3
  - Participative action plan formulation

- Step 4
  - Implementation Participative action plan

- Step 5
  - Evaluation with checklist

Stringer, 2008
Data Analysis

• Step 1:
  – 37 surgical teams were observed on the implementation of surgical pause
## Checklist

<table>
<thead>
<tr>
<th>Verbal Briefing of surgical pause</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Presence of correct patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(any member of the surgical team verbally confirm patient’s name)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Confirm patient ID band</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(compare computerized admission sheet with patient’s ID bands)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Identification of correct site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(any member of the surgical team verbally confirm site of surgery)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Identification of correct side</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(correct side operation is performed on; left or right)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Procedure to be performed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(any member of the surgical team verbally confirm procedure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Availability of correct implants and/or loan instrumentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(confirm on theatre list what is needed and make sure it is in theatre before patient is pushed in)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Components of WHO checklist and AORN checklist
Data Analysis

• Step 2:
  – 33 participants filled in the questionnaire
  – All 33 participants were part of the 37 surgical teams that were observed.
Exploration of surgical pause application in selected Private Healthcare Institutions in Gauteng

Research Statement:
This research questionnaire is distributed to the surgical team members that understand the difficulties of implementation of surgical pause and how to improve compliance to surgical pause, so that patient safety is improved.

This questionnaire consists of 2 questions:

1) According to your opinion, what are the reasons why surgical pause is not implemented?

2) According to your opinion, what can be done to enhance the compliance of surgical pause?
Data Analysis

• **Question 1: Why is surgical pause not implemented?**
  - Time and workload 57% (n=19)
  - Habit and forget 33% (n=11)
  - Lack of knowledge 24% (n=8)
  - Intimidation by surgeons 18% (n=6)
Data Analysis

• **Question 2: What can be done to improve compliance?**
  – Reminder 36% (n=12)
  – Discipline 33% (n=11)
  – In-service Training 30% (n=10)
  – Become Habit 27% (n=9)
Data Analysis

• Step 3:
  – Participative action plan was formulated

• Step 4:
  – Implemented by means of in-service training.
  – Reminders was put-up in all theatres, tearooms, scrub-rooms and on the BP handles of all surgical sets.
  – Reminders in theatres can be moved around to keep personnel’s attention.
  – Poster in doctors’ tea room.
Reminders in Theatres and Tearooms
Surgical Pause

Who should be present?
The surgeon, anaesthetist, scrub nurse and floor nurse.
Surgical pause is conducted before knife is applied to skin to ensure the correct patient undergoes the correct procedure, the correct site and side with all the relevant equipment and devices available. The surgical team involved in the intended procedure should be present and do surgical pause prior to the commencement of surgery. It should be done using interactive communication to vital information. While surgical pause is done, other activities are suspended, as far as possible, without compromising patient safety (Mohammed, 2011; Stover, n.d.).

Who should initiate it?
Any member of the surgical team can initiate surgical pause!!!!!
According to Stover (n.d.), surgical pause is a verbal confirmation of surgical patient’s details, by any team member of the surgical team before every procedure. The surgical team, consisting of a surgeon, anaesthesiologist, scrub nurse and floor nurse, cease all work and give full attention to the patient information.

Is it important?
Yes it is, it can reduce wrong site surgery!!!!
Surgical pause in an operating theatre is critical to ensure patient safety. According to Norton, et al (2014) there is a lot of proof available in America that the utilization of a surgical checklist, including surgical pause, improve patient safety.

According to East and Snycers (2011) incorrect surgeries are a very unnecessary complication.

Please Help Theatre Improve surgical pause complians!!!!!!!!!!
Data Analysis

• **Step 5: Evaluation**

  – 17 surgical teams were evaluated after the participative action plan was implemented
  – The checklist used in step 1 was used in step 5
  – 2 weeks after the participative action plan was implemented
<table>
<thead>
<tr>
<th>Category</th>
<th>Correctly Done</th>
<th>Incorrectly Done</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of Correct Patient</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Confirm Patient ID Band</td>
<td>71%</td>
<td>29%</td>
<td>0%</td>
</tr>
<tr>
<td>ID of Correct site</td>
<td>94%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>ID of correct Side</td>
<td>93%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Correct Procedure to be Performed</td>
<td>88%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Availability of Correct Implants</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## Data Analysis

<table>
<thead>
<tr>
<th></th>
<th>Step 1</th>
<th>Step 5 Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of correct patient</td>
<td>51%</td>
<td>100%</td>
</tr>
<tr>
<td>Confirm patient ID</td>
<td>35%</td>
<td>71%</td>
</tr>
<tr>
<td>ID of correct side</td>
<td>49%</td>
<td>94%</td>
</tr>
<tr>
<td>ID of correct site</td>
<td>45%</td>
<td>93%</td>
</tr>
<tr>
<td>Correct procedure confirmed</td>
<td>36%</td>
<td>88%</td>
</tr>
<tr>
<td>Correct implants available</td>
<td>62%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Data Analysis

• These results showed a significant increase in the implementation of surgical pause after the implementation of the participative action plan.

• But only a 100% will be satisfactory due to the legal and ethical importance of the surgical pause and that it creates a safe environment for the patient.
Limitations of Study

- Intended 3 selected private healthcare institutions to only 1 selected private healthcare institution, due to researchers withdrawing.
- Anaesthetic nurses too busy with own work during procedures and some did not understand what was expected of them.
- Time limitation for the study.
- Time collecting the questionnaires.
- Perception of risk of victimization.
Implications for the Profession

- Habit must be formed from an early stage
- All theatre staff must be aware of the Surgical Pause Policy in the profession
- All staff must be aware of the Litigation that can follow if not implemented
- Physical & Psychological harm to patients
Recommendations

• Future Research

  – Multiple healthcare institutions = larger sample
  – Longer period for research to be conducted
    = larger sample
  – Correlation between surgical pause and wrong site, wrong side & wrong patient surgeries.
Recommendations

- Nursing practice
  - In-service training
  - Reminders
  - Evaluation
  = Increase compliance
Recommendations

• Nursing education
  – Include in basic training
  – Increase awareness
  – Litigation & negligence
  – Include ethical part of surgical pause
Re-Evaluation

• Re-evaluation was done on 17 surgical teams, to see if the research was sustainable or not
  – 8 months after research was completed
• To see if interventions were needed to uphold the compliance of surgical pause or not
Presence of Correct Patient: 82%
Confirm Patient ID Band: 82%
ID of Correct site: 76%
ID of correct Side: 80%
Correct Procedure to be Performed: 76%
Availability of Correct Implants: 69%

Correctly done: Green
Incorrectly done: Red
N/A: Blue

Netcare Education: For Carers of the Future
## Comparison of Data Analysis

<table>
<thead>
<tr>
<th></th>
<th>Step 1</th>
<th>Step 5 Evaluation</th>
<th>Re-Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of correct patient</td>
<td>51%</td>
<td>100%</td>
<td>82%</td>
</tr>
<tr>
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<td>69%</td>
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</tbody>
</table>
Final Conclusions

- Surgical pause is an important part of the daily routine
  - Ensure patient safety

- Good habits must exist

- Surgical pause can prevent wrong side, wrong site, wrong patient and wrong procedure surgery
Thank You

• Mrs H Aspeling & Dr J de Kock
• Mrs A van der Wal
• Private Healthcare Institution
• Participants
• Classmates
• Family, friends and our support teams
• Thank you for all the support, hours on end. Much appreciated
• Hospital Manager for sponsoring the congress
• Mrs G Herselman and team
THANK YOU FOR YOUR TIME