Improve Patient Safety ... Check

Sometimes, we need to take a step back and make sure we are doing our jobs correctly. For me, an error is usually just a matter of a word. For you, it can be your patient's life.

This past week, I spent time thinking about mistakes in the workplace and how to prevent them. Regardless of profession, it is safe to say that no one wants to make mistakes at their job. As an editor, I do everything I can to avoid a typo or misspelling, the wrong headline or photo, etc.

Sometimes, though, deadlines get tight and I find myself rushing to finish an article or product page and it makes me nervous. When I do not have time to slow down and double-triple (even quadruple) check my work, I worry there will be something wrong I didn't notice in the document.

When I compare this with the profession of a surgeon, OR supervisor or OR nurse, though, making a mistake in your professions has an entirely different level of consequences. When I make a mistake, while I undoubtedly will do anything to avoid it, the error can usually somehow be fixed. If there is a typo in this column, for example, I should be able to go back into the page after the content is posted to the web and fix the typo. If the mistake is published in the print magazine, I can try to correct the problem by re-running the product or content that was wrong.

When a surgical professional makes a mistake, it's usually not as reversible. Surgical errors have been a common theme in these *Surgical E-Focus* e-newsletters as of late, from never events to surgical fires, and it's because they carry such a large weight in the OR, and oftentimes, they are preventable.

A surgical error can be devastating (or in worst cases fatal) to the patient, can have extreme financial implications for hospitals as a whole, and can negatively impact the careers of the surgical professionals involved.

Recently, a surgeon told me that he does not want to do anything in a surgery that will slow him down. Most surgeons want to get in and out of the OR as efficiently as

possible, while still maintaining the highest level of safety. A study [1] released year shows, however, that if a surgical staff takes the time to conduct a Surgical Safety Checklist [2], as provided by the World Health Organization (WHO) [3], errors leading to death in a surgical patient are reduced.

According to the study, the rate of death of surgical patients was 1.5 percent before the checklist was introduced, and declined to 0.8 percent after. Inpatient complications decreased from 11 percent to 7 percent after the checklist was introduced.

Not only can implementing this checklist reduce deaths in surgical patients, it can help decrease the risk of infection, retained surgical sponges, wrong site surgery, etc. just by improving the communication in the OR. Watch a video on how to properly conduct the WHO Surgical Safety Checklist. [4]

The time we have to do our jobs gets tight for all use, from magazine editors to surgeons. Sometimes, though, we need to learn to take a step back, slow down and check that we are performing them at the highest level —even if it means taking a little more time than we want. In the end, it will be worth it. For me, it’s usually just a matter of a word. For you, it can be your patient’s life.

What's your take? E-mail amanda.mcgowan@advantagemedia.com [5]

Source URL (retrieved on *07/28/2014 - 7:15pm*):
http://www.surgicalproductsmag.com/product-releases/2009/06/improve-patient-safety-check?qt-recent_content=0

Links:
[1] http://content.nejm.org/cgi/content/full/NEJMsa0810119
[2] http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf
[3] http://www.who.int/en/
[4] http://www.surgicalproductsmag.com/scripts/ShowPR~PUBCODE~0S0~ACCT~0000100~ISSUE~0906~RELTYPE~PF~PRODCODE~5480~PRODLETT~AR.asp
[5] mailto:amanda.mcgowan@advantagemedia.com