Utah Health Status Update:
Utah Correct Surgery Site Survey Results

Health care providers and professional organizations, patients and their families, and the Utah Department of Health (UDOH) share deep concern about prevention of harm to patients during medical care. To support patient safety improvement, a Utah Administrative Rule (Patient Safety Sentinel Event Reporting, R380-200) went into effect on October 15, 2001. This Rule requires that hospitals and ambulatory surgery facilities report sentinel events, or the most serious incidents of harm, that meet criteria specified in the Rule. Information in these sentinel event reports can increase understanding of how these events occurred and ways they can be prevented.

From October 15, 2001 to July 15, 2004, the Utah Department of Health (UDOH) received reports that identified 108 sentinel events in Utah's acute care hospitals and ambulatory surgery centers (see Figure 1). Of these 108 sentinel events, 19 were wrong site or wrong patient surgeries (see Figure 2). According to Richard Labasky, MD, President of the Utah Medical Association (UMA), these wrong site and wrong patient surgeries can be prevented.

A statewide initiative to improve correct surgery site practices has begun, including a review of surgery site marking practices. In this review, UDOH received information from 91% of acute care hospitals and 90% of ambulatory surgery centers. Variation was found in:

- Marking surgery sites
- Verification checklists
- Review of informed consent
- Review of imaging studies
- Time outs

Variation in surgery site marking includes:

- Who marks the surgery site (11 different staff roles)
- How the site is marked (12 different ways)
- Where the site is marked (9 different places)
- When the site is marked (7 different times)
- Devices used to mark the site (6 different devices)

Recognizing that a large number of physicians and healthcare staff work in more than one
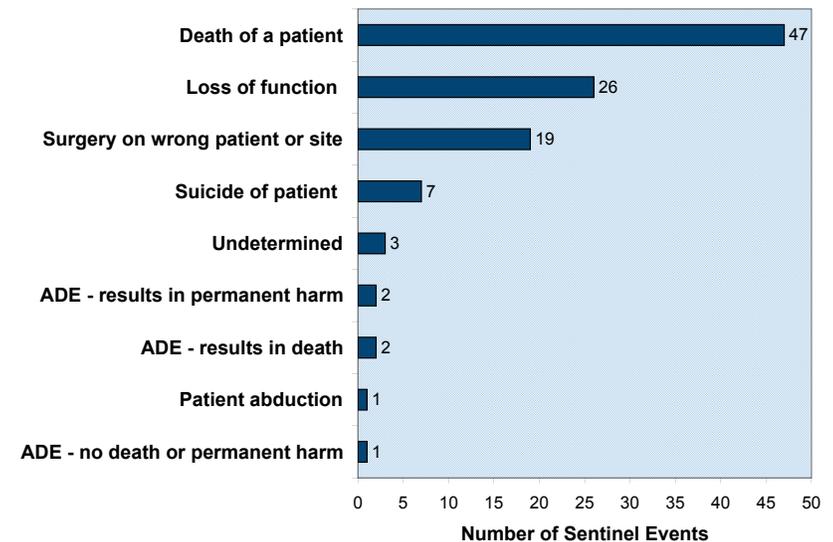
Sentinel Events by Year

Figure 1. Sentinel Events by Year of Event: Utah, October 15, 2001 to July 15, 2004.
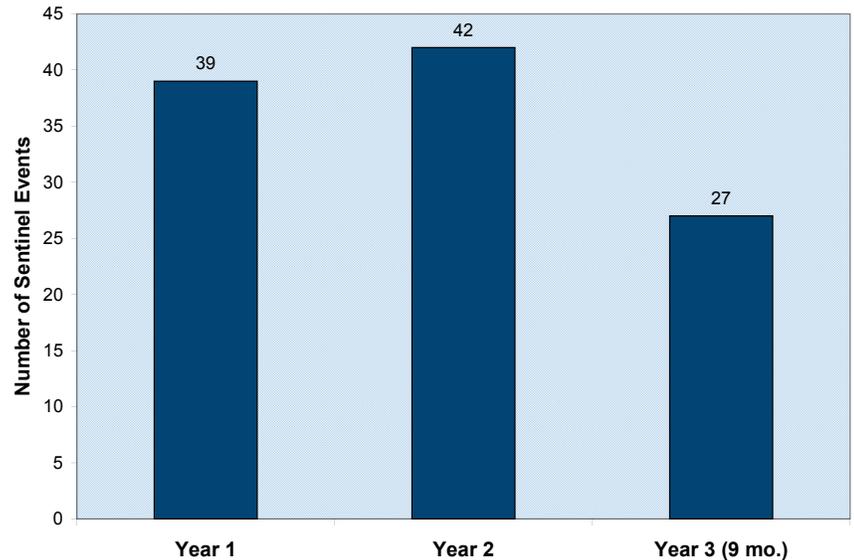
Sentinel Events by Type of Event

Figure 2. Sentinel Events by Type of Event: Utah, October 15, 2001 to July 15, 2004.

location, hospitals and surgery centers in Utah have agreed to adopt nationally supported guidelines developed by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) for an official time out program. According to Joseph Krella, CEO of the Utah Hospitals and Health Systems Association (UHA), "Utah is working to set a standard on how to mark a procedure site and who should be responsible

for marking it. But until those standards are in place, we can all agree to take a time out in the interest of patient safety." "Time out" means that before any surgery can begin, the entire team stops what they are doing and verifies that the correct surgery is being performed on the correct site on the correct patient.

UDOH, UHA, the Utah Medical Association (UMA), HealthInsight, the Association of peri-Operative Registered Nurses (AORN) and the Utah Organization of Nurse Leaders, as well as all Utah hospitals and ambulatory surgery centers, want to encourage patients to be part of the team to improve patient safety. Patients and their loved ones should feel comfortable asking questions about the surgery as well as how the surgery site will be marked and the facility's time out policy.

According to Krella, "Patient safety is a top priority for all health care organizations in Utah. In a very competitive health care market, this is one area where the competition ends and we have started working together to ensure what is best for the patient."

To learn more about sentinel events and related patient safety issues and activities, see Patient Safety Update, Vol. 1, No. 2 and Patient Safety Update, Vol. 2, No. 2 at http://www.health.utah.gov/psi/.

Sentinel Events by Patients' Age Group

Figure 3. Sentinel Events by Patients' Age Group: Utah, October 15, 2001 to July 15, 2004.
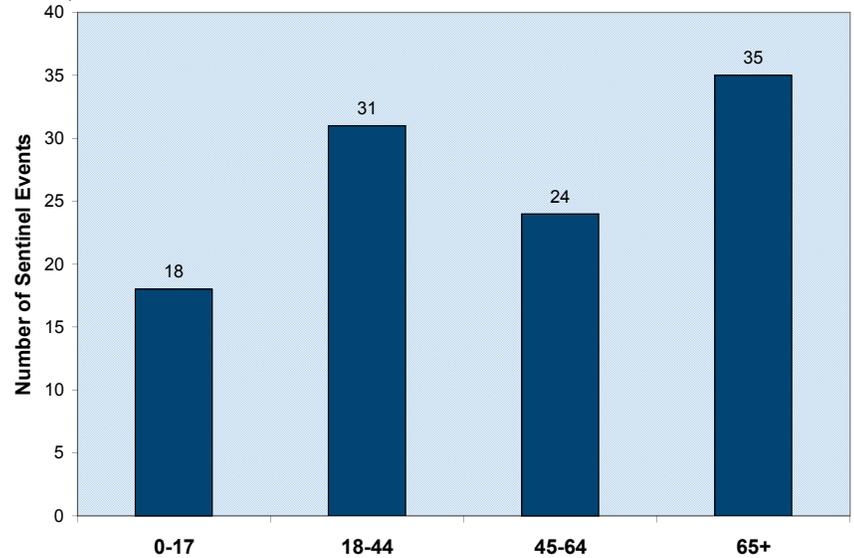

Figure 3 shows number of sentinel events by patients' age group. The largest number of sentinel events is among older patients (65 or more years of age, N=35), followed by younger adult patients (18 to 44 years of age, N=31, and 45 to 64 years of age, N=24). The lowest number of sentinel events is among pediatric patients (0 to 17 years of age, N=18).

Sentinel Events by Location in Hospital

Figure 4. Sentinel Events by Location in Hospital: Utah, October 15, 2001 to July 15, 2004.
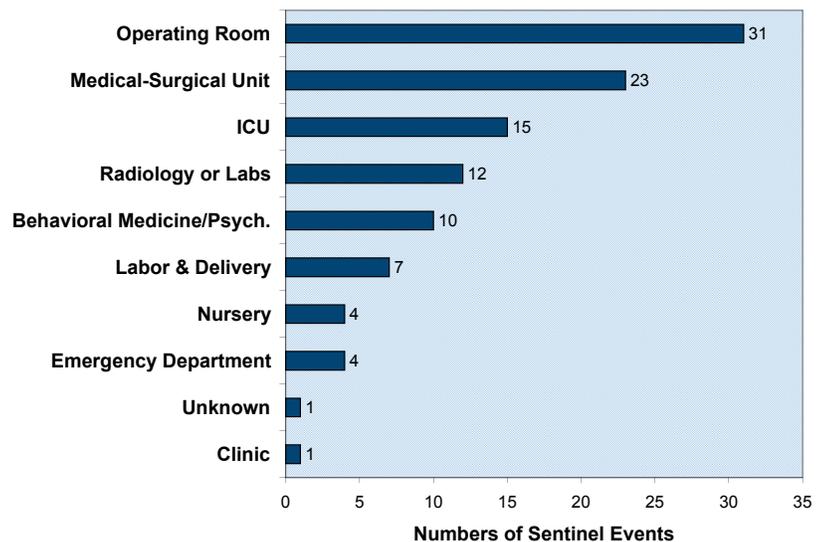

Figure 4 shows number of sentinel events by location in the hospital. The largest number of sentinel events occurred in the operating room (N=31), followed by the medical-surgical unit (N=23) and the ICU (N=15).