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VA study: Communication is main cause of surgical errors

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Surgical never-events have attracted lots of national attention recently, particularly the case of a Rhode Island hospital which saw five wrong-side or wrong-part surgeries [1] over the past two years alone.

Now, researchers at the Veterans' Administration have taken an in-house look at such problems, concluding, as have others, that poor communication is the principal reason for surgical errors.

In 2003, the VA's National Center for Patient Safety put out a directive that all surgeries should follow standard safety protocols, including a "time out" in which medical staff stop and make sure they're operating on the correct patient, the correct body part and the correct side of the patient.

To see how that played out, the NCPS reviewed 342 surgical problems which nonetheless took place at 130 VA hospitals from 2001 through the middle of 2006.

Upon review, VA researchers found that adverse events occurred once in every 18,000 procedures. Among the data they reviewed were 212 adverse events, where wrong procedures were performed, the procedure was performed in the wrong patient, or at the wrong site. Researchers also found 130 "close calls," in which clinical staffers corrected a problem before a procedure took place.

VA research concluded that in 21 percent of errors, the root of the problem was poor communication between surgical team members. In some of these cases, the "time-out" procedure would not have been enough to address the problems involved.

To find out more about this study:

- read this *HealthDay News* piece [2]

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