Child Health Patient Safety Organization®

SAFETY WATCH

Stay aware of these known risks to avoid preventable harm.

Procedural anchoring bias

Cognitive bias can occur at any phase of the procedural process. Anchoring is a type of cognitive bias in which a health care provider fixates on certain information while disregarding other pertinent details. For example, although elevated vital signs may be associated with postoperative pain, anchoring bias occurs when other causes are not considered or evaluated.

Causes

Causes of procedural anchoring bias may include:

- Accepting another provider's evaluation and expertise without independently validating and considering alternative diagnoses.
- Assuming a similar diagnosis or procedure from a previous experience will require the same treatment and follow the typical postoperative course.
- Providing or receiving communication or hand-off information that produces certain conclusions or preconceptions.

Harm

Cognitive bias "may result in surgical diagnostic error that leads to delayed surgical care, unnecessary procedures, intraoperative complications, and delayed recognition of postoperative complications." Biases can affect health care providers' medical decision-making and judgment and prevent them from seeking further assessment or guidance.

Harm Range

Significant harm to patients, including death.

Biases can affect health care providers' medical decision-making and judgment.

SAFETY WATCH

Procedural anchoring bias

Immediate Recommendations

- Develop or establish a process to promote/support the provider to complete a baseline assessment and assessments after any perceived changes in the patient's condition and develop a comprehensive differential diagnosis.
- Implement a post-procedural diagnostic timeout to avoid groupthink and inspire communication and collaboration among the multidisciplinary team.
- Promote patient and family involvement in the plan of care as crucial members of the health care team.
- Establish an escalation-of-care plan outlining who to involve in the decisions, who should be notified, the appropriate form of communication, and triggers and baseline parameters.
- Use a hand-off tool to provide all pertinent information in an objective, non-biased manner.

Resources

- Improving Communication in the Diagnostic Process Action Alert
- Diagnostic Safety Toolkit

References

- British Journal of Surgery, Cognitive Biases in Surgery: Systematic Review, Oxford Academic, 2023
- The Journal of Pediatrics, Cognitive Bias in an Infant with Constipation, ScienceDirect, 2024
- Surgical Clinics of North America, Cognitive Bias and Dissonance in Surgical Practice: A Narrative Review, NIH PubMed, 2023
- The HPI SEC & SSER Patient Safety Measurement System for Healthcare. Virginia Beach, VA: Healthcare Performance Improvement, LLC; 2009

Data for the Safety Watch is compiled from Child Health PSO safety analysis.

Find solutions

Members can find detailed prevention plans in Child Health PSO's Riskonnect Action Plan repository where children's hospitals share deidentified mitigation processes for various issues.

Join Child Health PSO

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Wrong-site frenulum procedural interventions

From 1997 to 2012, frenulum procedural interventions increased 866%. These procedures require difficult tissue marking in the oral cavity and high precision. In addition, safety events are more likely to occur when a patient undergoes multiple procedures in which one or several sites are difficult to mark. These factors, along with the significant rise in frenulum procedures, cause a high risk of wrong-site procedures.

Causes

Common causes include:

- Relying on memory of the correct surgical site instead of a verbal and visual reminder.
- Lacking vital components or team members in pre-operative time-outs, leading to insufficient communication and verification of the correct procedure or site.
- Using generic procedural names during the scheduling process and on consent forms, causing confusion in anatomical site and procedure.
- Completing more than one procedure during the surgery without additional verification and team consensus of procedural details.
- Unclear communication during the family procedure review in the pre-operative period.

Harm

Performing interventions on the wrong site has led to repeat visits to the operating room and prolonged anesthesia requirements. These safety events may cause increased operating room time, resources, and costs.

Harm Range

No detectable harm to moderate temporary harm.

From 1997 to 2012, frenulum procedural interventions increased

866%.

SAFETY WATCH

Wrong-site frenulum procedural interventions

Immediate Recommendations

- Encourage use of detailed procedural names in surgery scheduling practices.
- Ensure consent verbiage includes precise anatomic location of procedure and require use of electronic consents to confirm essential fields are completed.
- Standardize a clear and thorough verification process with the family pre-operatively on the day of surgery.
- Utilize diagrams or visual aids for difficult-to-mark sites.
- Implement a brief but robust and standardized time-out once the patient is correctly positioned for the operation. Include key stakeholders, review the consent and procedures, and communicate new or essential information, including any "add on" procedures. Initiate separate intraoperative timeouts before each additional procedure.

Resources

- Wrong-Site Surgeries/Procedures Safety Alert

References

- American Academy of Pediatric Dentistry, Policy on Management of the Frenulum in Pediatric Patients, 2022
- Up to Date, Ankyloglossia (Tongue-Tie) in Infants and Children, 2023
- The HPI SEC & SSER Patient Safety Measurement System for Healthcare. Virginia Beach, VA: Healthcare Performance Improvement, LLC; 2009

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Retained foreign objects or surgical items

Retained foreign objects (RFOs) or retained surgical items (RSIs) continues to be a significant procedural challenge among health care facilities. RFOs/RSIs are considered never events and are the most commonly reported sentinel events to the Joint Commission. These events occur most often in operating rooms, with guidewires and sponges being particularly frequent in pediatric cases.

Harm Range

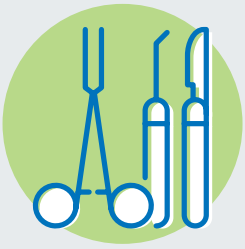
No harm to severe temporary harm.

Causes

Several contributing factors may include:

- Lack of a dependable process for removal of foreign objects and documentation of the procedure.
- Misinterpretation or undetected RFO/RSI on imaging.
- Inadequate communication among health care providers related to accurate counts, instrument utilization, and procedural variances.

RFOs/RSIs are the **most-reported** sentinel events to the Joint Commission.



Harm

Failure to identify and remove RFOs/RSIs may lead to infection or cause patients to undergo additional interventions, such as imaging, which causes further radiation. These "never events" put health care facilities at risk of litigation and increased healthcare costs and influence the reputation of the organization.

SAFETY WATCH

Retained foreign objects or surgical items

Immediate Recommendations

- Develop a clear and standardized approach to surgical counts that includes all instruments and soft items such as towels. Follow a protocol when a count discrepancy is noted.
- Standardize documentation of the surgical objects count and hardware removal using a uniform template in a consistent location in the electronic health record.
- Consider post-procedure imaging, especially in high-risk or emergent situations, while balancing the need to minimize radiation exposure. Evaluate whether obtaining a one-view versus two-view x-ray is appropriate for the circumstances. Remove all equipment from the imaging field to avoid difficulties in differentiating foreign objects from external devices.
- Foster accountability and direct, clear communication between health care providers perioperatively. With all team members present, articulate the final count, identify and report discrepancies, verbalize and create a visual reminder of new tools introduced into the body cavity, and communicate indications for imaging.

Resources

- Retained Foreign Objects or Surgical Items Action Alert
- AORN's Surgical Excellence Resource Center

References

- AORN Center of Excellence in Surgical Safety: Resource Center, 2024
- Schwartz, Zach, Understanding Retained Surgical Items (RSI): Importance, Prevention, and AORN Guidelines, AORN, 2024
- The Joint Commission Journal on Quality and Patient Safety, Unintentionally Retained Foreign Objects: A Descriptive Study of 308 Sentinel Events and Contributing Factors, ScienceDirect, 2019
- The HPI SEC & SSER Patient Safety Measurement System for Healthcare. Virginia Beach, VA: Healthcare Performance Improvement, LLC; 2009

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