Reducing perioperative harm
Case study template

Case studies are an important learning tool for health practitioners. They provide information that may enhance patient care in general and improve professional practice by nurses and doctors.

Case studies provide the facts and an account of an event that has happened.

The Commission is looking for District Health Boards and providers to share their experiences.

A suggested case study template follows on the next two pages.

OVERVIEW

Through the Reducing Perioperative Harm programme, the Commission aims to improve the quality and safety of health care services provided to patients undergoing surgery in hospital. It focuses on preventing adverse events which can harm patients.

BACKGROUND

Harm associated with operations, also known as perioperative harm, is a significant patient safety issue in New Zealand. It can lead to preventable deaths, ongoing health effects, longer hospital stays and extra costs for the health system. Over 300,000 publicly funded operations are performed in New Zealand each year, and in most cases excellent care is provided. However, sixty-six serious adverse events were reported to the Commission in 2012/13 as having occurred during the perioperative stages of a patient’s care. These included incidents where the wrong site had been operated on, the wrong procedure had taken place and items such as swabs had not been removed. This number does not include many other events resulting in less serious or minimal harm, or no harm. Moreover, indicative data from ACC indicates that 205 claims between July 2005 and June 2011, were accepted for retained equipment or wrong-site surgery.

Harm associated with operations can be reduced by the following interventions:

- effective use of all three parts of the surgical safety checklist
- the use of briefings and debriefings
- effective teamwork and communication
- all patients having a risk assessment for blood clots and then appropriate treatments.
# Template for Perioperative Harm Case Studies

Please use the template below to provide us with information about how the interventions described above, when used in practice, have had positive effects in the operating theatre and may potentially reduce perioperative harm.

## Background

Briefly provide some context – e.g. size of hospital / ward, typical surgical case mix – whatever is relevant to the case study.

Then summarise the situation / challenge / problem – what was the issue that you were trying to resolve?

## Interventions in practice

Who/what/where/when were the interventions used?

How were the interventions used in practice?

## Outcome/Results

A quick summary of results

Quantitative and/or qualitative data

## Lessons learnt / Top tips

Was there one action/question/method that was the most important?

If you were explaining the overall benefits of this intervention to someone else, what would be your top tip to them to help them realise its full potential?
Evaluation
Reactions of those involved

What was the general perception of method used?

Corresponding benefits or usefulness (to both patients and staff)

Next steps
What are your planned next steps?

Contact info
Name
Occupation
DHB / Provider
Contact phone number
Email address

Are you happy for your contact details to be published so that readers of this case study can contact you directly? Yes / No

Once completed please email to communications@hqsc.govt.nz