



PATIENT SAFETY & RISK SOLUTIONS

Reducing Surgical Treatment Risks in Otolaryngology

MedPro Group data show that allegations related to surgical treatment represent the largest malpractice claims category for otolaryngology/ENT providers (62 percent of all ENT claims). Surgical treatment allegations also account for more than half of total dollars paid for defense and indemnity costs in ENT claims.¹

Contributing factors noted in ENT surgical treatment claims include improper surgical technique, inadequate preoperative and postoperative patient management, and lack of intraoperative patient monitoring. The following list offers ENT providers strategies for managing surgical treatment risks.

1

Ensure your organization adheres to well-defined credentialing and privileging policies, including evaluation of each provider's surgical skills and competency with surgical equipment. Credentialing and privileging should occur at hire and periodically thereafter.

2

Participate in peer review activities to improve performance/quality, and enhance your surgical skills through continuing medical education.

3

Use clear, plain language when talking to patients about procedures, treatment plans, anticipated benefits, potential risks, and alternative therapies. Avoid complex terminology and medical jargon.

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Use a technique such as "teach back" (also called "repeat back") to gauge patient understanding of health and treatment information.



Adhere to a standardized informed consent process that includes common and significant risks that are relevant to the patient and the procedure. As part of this process, consider whether patients have realistic expectations of surgical outcomes.



Use interpreters and auxiliary aids to assist with patient communication and informed consent for patients who have limited English proficiency or disabilities.



Document the informed consent process, including discussion of risks, benefits, and alternative treatment options, as well as the provision of educational materials. Make sure any signed informed consent forms are included in patients' records.



Verify that each patient's health record contains thorough and appropriate information, such as history and physical, current medications, nonpharmalogical interventions, allergies, pain assessment outcomes, test results, consults/referrals, treatment goals, and preoperative screening results.



Verify that documentation for each patient supports the clinical rationale for the diagnosis and treatment decisions.



Conduct a thorough preoperative screening of patients for risk factors, including obstructive sleep apnea.

11

Ensure that all appropriate health information for each patient is available prior to commencement of a procedure.

12

Inventory and verify necessary equipment and supplies before each procedure begins.

13

Use standardized patient safety precautions during each procedure, such as timeout protocols and proper patient positioning.

14

Make sure patients are appropriately monitored during and following procedures (e.g., vital signs, airway, pain, etc.).

15

Maintain a consistent postoperative discharge assessment process, and carefully consider repeated patient complaints or concerns when making clinical decisions about patient care and diagnostic testing.



Complete a detailed operative report the day of each procedure. Ensure follow-up care is documented according to organization documentation timeframes.



Provide patients/caregivers with written and verbal instructions related to their treatment plans and follow-up care.



Document all instances of patient noncompliance as they occur, as well as any education provided to the patient or family/caregiver.

Endnote

¹ MedPro Group otolaryngology closed claims, 2007-2016.

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