Reducing the risk of wrong site, wrong procedure and wrong patient surgery is critical to patient safety and the reputation of any health care organization that performs these high risk procedures.

**What is the TST® for Safe Surgery?**

The TST® is a unique online application that guides health care organizations through a step-by-step process to accurately measure their organization’s performance, identify their barriers to excellent performance and direct them to proven solutions that are customized to address their particular barriers. The Safe Surgery TST® evaluates risks within an organization’s surgical system, including scheduling, pre-operative and operating room areas.

**Components of TST® for Safe Surgery:**

- Allows an organization to take a critical look at risks across its entire surgical care system, from the time a procedure is scheduled through the closing of the case.
- Identifies specific risk points in surgical booking, pre-op or pre-op holding, and the operating room that could potentially lead to a wrong site surgery event.
- Standardizes practices and promotes consistency in perioperative processes across multiple providers within the same organization.
- Promotes safe surgery practices that are critical to patient safety.

Although the reporting of wrong site surgery is not mandatory in most states, some estimates put the national incidence rate, which includes wrong patient, wrong procedure, wrong site and wrong side surgeries, as high as 40 per week.*

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To learn more about the TST® tools, contact us at 630.792.5800 or e-mail tst_support@eth.org
Why use the TST® for Safe Surgery?

While wrong site surgery events are rare, they can be life altering for the patients who sustain them. Wrong site surgery should never happen. When it does, the health care organization is vulnerable to additional risk and potential costs, and professional careers can be adversely affected.

Since the occurrence of wrong site surgery is rare, with most organizations going years without an occurrence, it could take a long time to monitor the incidence of wrong site surgery for a project. However, it is possible to monitor surgical cases for weaknesses that might result in a wrong site surgery, and that is exactly what the TST® for Safe Surgery does.

Through their project work, the original participating organizations were able to reduce the number of cases with risks by 46 percent in the scheduling area, by 63 percent in pre-op, and by 51 percent in the operating room. Many other hospitals and ambulatory surgery centers across the country collaborated with the Center to test the work of the original organizations that participated in the project and provide guidance on the development of the TST® for Safe Surgery. These organizations experienced gains similar to the original participating organizations.

Bringing targeted solutions to meet your organization’s unique needs

TST® modules are now available for improving hand hygiene, hand-off communications, preventing falls, and safe surgery

- Joint Commission accredited organizations can access the TST® and solutions free of charge on their secure Joint Commission Connect® extranet.
- Non-Joint Commission accredited organizations, contact us at 630.792.5800 or e-mail tst_support@cth.org

For more information about our Facilitated Oro 2.0 High Reliability Assessment or to discuss any of the Center’s high reliability training programs, please contact: David Grazman, Ph.D., M.P.P., Business Development Director, dgrazman@jointcommission.org  630.792.5471

To learn more about our high reliability initiatives for health care organizations, visit us at www.centerfortransforminghealthcare.org.