

Quarterly Update on Preventing Wrong-Site Surgery

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There were reports of 10 wrong-site surgeries during the second quarter of 2012, plus one report of belated awareness of wrong-site surgery in a prior quarter, discovered as a result of a lawsuit, resulting in a total of 491 since reporting began in July 2004. The reports this quarter matched the third-lowest number of reports in a quarter since statewide reporting began June 28, 2004 (see Figure). During this quarter, Pennsylvania operating rooms went—for the third time—for more than a month (32 days) without any reports of wrong-site surgery. During this past academic year (July 2011 through June 2012), there were 47 reports of wrong-site surgery, which is below the historical average of 63 and the lowest yearly total since data collection began in mid-2004. The two-year rolling average (51 per year) is also the lowest since reporting began. It is encouraging to see that implementation of the 21 principles to prevent wrong-site surgery is proving effective.

There were several instructive reports of near misses during the quarter.

The importance of proper scheduling:

This patient was scheduled for a total hip. There was miscommunication regarding the procedure to be performed, and the OR [operating room] instruments were incorrectly prepared. This was not realized until after the incision was made. The correct implant was able to be obtained in a timely manner.

The possibility of marking errors:

The surgeon marked the patient's surgical site in preoperative [holding] immediately after checking the history and physical and the operative consent and confirming with the patient. Then, the surgeon marked the incorrect side. The patient then called the nurse over to the bedside and stated, "He marked the wrong side."

The OR schedule stated a left-side hernia repair. All documentation and consent was for the right. The surgeon marked the left side in error. The RN [registered nurse] hand-off communication prevented error.

It is notable that the patient did not tell the surgeon he was making an error but told the nurse afterward. A good handoff caught the other error.

The importance of including images in the verification process:

A patient was scheduled for a right carotid endarterectomy. The surgeon had marked the operative site, and all notes on chart, surgical schedule, and operative consent stated right carotid endarterectomy. The surgeon changed the side of surgery to left side after reviewing x-rays. . . . MD had new consent signed to reflect change.

The possibility of errors with whiteboards:

[A patient] presented for a procedure on a foot. The greaseboard had the incorrect (left) side listed. Patient had surgery on the correct side.

The importance of the time-out for catching errors:

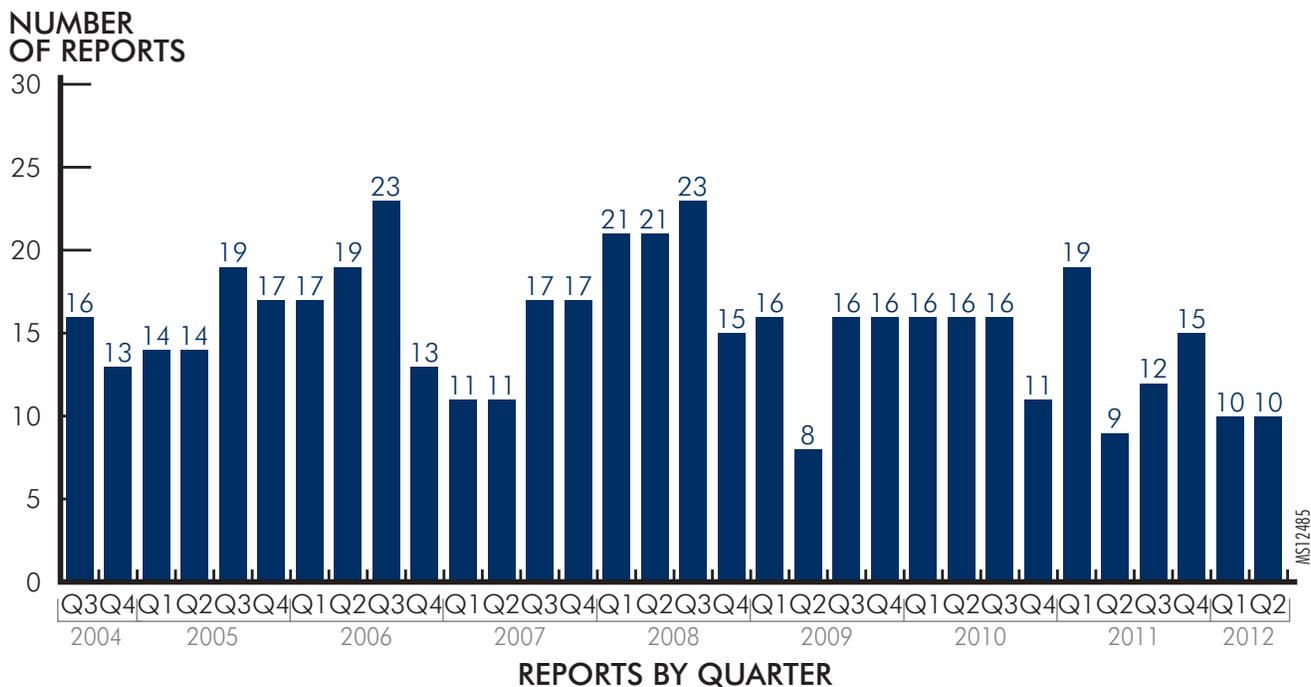
A patient was scheduled through surgeon's office for right vitrectomy. During the time-out procedure, the patient stated he was to have surgery on the left eye.

During the time-out process, the anesthesia provider/relief staff stated the wrong patient name for the intended procedure while looking at the anesthesia chart. The wrong name was discovered by the circulating nurse, and the time-out process and all activities stopped. It was determined the wrong patient was charted on from the beginning of the case by anesthesia provider. . . . The correct patient chart was opened by anesthesia, and we proceeded with the time-out, with all in agreement that we had the correct



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Figure. Pennsylvania Patient Safety Authority Wrong-Site Surgery Reports by Quarter



patient and procedure. . . . No harm to patient.

The possibility of errors from specimen labeling:

[A breast] specimen label was incorrectly labeled with the wrong side. It was also entered into the computer

incorrectly, with the left side [listed] when it was the right breast mastectomy. The error was corrected before taking the specimen [to pathology].

Comments on the Pennsylvania Patient Safety Authority’s Recommendations to Prevent Wrong-Site Surgery have been

received from medical professional societies in Pennsylvania and from Pennsylvania facilities that do surgery. Those comments, with analyses and responses, will be published in a forthcoming supplementary *Pennsylvania Patient Safety Advisory*.

PENNSYLVANIA PATIENT SAFETY ADVISORY

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