Current Preliminary Associations between Elements of a Prevention Program for Wrong-Site Surgery and Success in Trapping Wrong-Site Errors before Harm Occurred

ELEMENT	NEAR MISSES	WRONG-SITE SURGERIES	SIGNIFICANCE (P LESS THAN)
Surgeon reconciled discrepancies in documents	31 of 36	6 of 18	0.001
Time out done after draping*	44 of 50	14 of 27	0.001
Someone raised a concern	38 of 48	6 of 24	0.001
Surgeon responded to the concern raised	31 of 33	10 of 19	0.001
Surgeon did a preoperative verification	44 of 47	18 of 27	0.01
Identification involved wristband and chart	47 of 47	22 of 26	0.01
Surgeon's records available in the operating room (OR)*	40 of 41	22 of 27	0.05
Diagnostic images available in the OR*	28 of 29	10 of 13	0.05
Diagnostic tests reviewed by surgeon before incision*	24 of 24	10 of 12	0.05
Patient identification verified during preoperative briefing with surgeon*	26 of 26	10 of 12	0.05
Procedure verified during preoperative briefing with surgeon*	26 of 26	10 of 12	0.05
Antibiotics verified during preoperative briefing with surgeon*	19 of 20	6 of 9	0.05
Mark visible during time out	37 of 43	13 of 21	0.05
Information verified against patient's response*,†	40 of 49	25 of 25	0.05

* One of eight additional elements of a prevention program for wrong-site surgery not present in results presented in March 2008.

† According to the submitted results, the patient verified information in the documents in every wrong-site surgery event, but not in every near miss. It is possible that near-miss reports were intended to convey that the patients' responses did not agree with the written information.

For more information, visit http://www.psa.state.pa.us.

These results accompany the following:
Quarterly update on the preventing wrong-site surgery project.
Pa Patient Saf Advis
2008 Jun;5(2):69-71.