

Preventing Medical Errors: Wrong Site Surgery

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Patient safety and the prevention of medical errors have become the focus of most healthcare providers. Wrong site, wrong procedure, and wrong patient surgery are catastrophic, alarming and preventable medical errors that continue to occur despite increased efforts to eliminate these errors. Malpractice claims entailing wrong surgery are not limited to the surgical specialties. The reduction in surgical errors is a major patient safety goal for virtually all practitioners that can be met with fundamental risk management practices.

In September 2003, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) estimated receiving five to eight new reports of wrong surgery every month. Studies have shown that the majority of wrong-site surgeries occur in orthopedic or podiatric cases. The “American Academy of Orthopaedic Surgeons (AAOS) estimates that an orthopedic surgeon’s chance of performing a wrong site surgery during a 35-year career is one in four.”⁽¹⁾ The AAOS has taken the lead in efforts to eliminate wrong site surgery. At a national summit involving the AAOS, JCAHO, the American Medical Association, the American College of Physicians, the American College of Surgery, and the American Dental Association, a Universal Protocol was developed. The four components of the protocol include: a preoperative verification process; “Sign Your Site” – marking the operative site; “Time Out” – taking time for surgical team members to ensure all processes are completed and accurate prior to starting the procedure; and expected compliance with universal protocols regardless of the surgical setting. For example, the universal protocol would be applicable for an endoscopic procedure performed in a GI Lab, a cataract extraction in an ambulatory surgery facility, an arthroscopy in a private practice or a cardiac catheterization in a cardiac catheterization lab.

A review of surgical errors has identified that patients with unusual physical characteristics, those undergoing multiple procedures, those with multiple surgeons, or those with time pressures to initiate the surgical procedure are at greater risk for surgical error. Other factors that contribute to surgical errors include:

- Unusual equipment or set-up in the surgical suite;
- Staffing problems;
- Distractions;
- Lack of access to pertinent information;
- Failure to require adherence to verification processes;
- Failure to verify and mark the operative site;
- Failure to require a patient assessment; and
- Human factors, such as communication breakdowns, novice providers, and lack of teamwork.

Approaches to Surgical Error Reduction

In addition to implementing the Universal Protocol, other risk management approaches to reduce the incidence of surgical errors include:

- Involving the surgeon in obtaining informed consent;
- Reducing reliance on memory;
- Improving information access;

- Standardizing surgical processes;
- Improving employee training;
- Improving staffing and work environments;
- Improving communication;
- Improving teamwork;
- Incorporating error proofing in processes;
- Involving the patient and family members in the verification processes; and
- Maintaining or improving diligence in preparing for high-risk patients and procedures.

The reduction of surgical errors is a national patient safety goal. To eliminate the incidence of surgical errors, surgeons and surgical providers must examine their surgical processes and systems, identify flaws in those systems and processes, address the potential for wrong surgeries, and become actively involved in improving patient safety.

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