



## WRONG SITE SURGERY – CONTINUING PROBLEMS

The American Academy of Orthopaedic Surgeons (AAOS) originally published a report on wrong site surgery in September 1997, with a revision dated February 1998. The AAOS recognized the importance of addressing this problem and called for national involvement to reduce and hopefully eliminate these events.

The Joint Commission followed with the Sentinel Event Program and National Patient Safety Goals to address the problem. Universal protocol was implemented in order to prevent wrong site, wrong procedure, wrong person surgery. All accredited organizations are required to use a preoperative verification process and surgical site marking process. Since inception of the Joint Commission's Sentinel Event program, there has been a total of 867 cases reported as of September 30, 2009.<sup>1</sup>

The Joint Commission issued two National Patient Safety Goals on January 1, 2003 to target wrong site surgery:

Goal 1 – To improve the accuracy of patient identification by using two patient identifiers **and** a “time-out” procedure before invasive procedures.<sup>2</sup>

Goal 4 – To eliminate wrong-site, wrong-patient, and wrong-procedure surgery using a preoperative verification process to confirm documents and to implement a process to mark the surgical site and involve the patient/family.<sup>2</sup>

Both goals remain on the 2010 list of National Patient Safety Goals. Wrong site surgery most commonly occurs in orthopedic, general surgery, urological and neurosurgical procedures. By using root cause analysis, the Joint Commission found the top causes of wrong site surgery to be communication failure (70%), procedural noncompliance (64%) and leadership (46%).<sup>3</sup>

According to the Physician Insurers Association of America (PIAA), wrong-site, wrong-patient surgery remains on the top 10 most prevalent medical misadventure. The average indemnity payout in wrong site misadventure is \$84,508.

### **Where are we today?**

Even with specialty society and national organizational protocols, wrong site surgery continues.

### **So what is the problem?**

Protocols are effective only when the people using them implement and follow them correctly.

There are several methods for eliminating wrong site surgery. Some of these methods include:

1. The surgeon, in consultation with the patient and their family, should mark the site with permanent marker in the pre-operative area.
2. During spine surgery, intraoperative x-ray should be marked the exact level to prevent surgery done on the wrong vertebral level.
3. Nursing staff in the pre-procedure area should do a verification of the right patient, procedure and correct marking of surgical site before the patient leaves the area.
4. In the operating room the surgical team should perform a “time-out” to confirm patient identity, correct procedure, site and include a double check of the patient’s record and x-rays.

All surgical teams should adhere to universal protocol standards on all cases. Team members involved in the care of the patient should not be afraid to communicate with other members and raise any questions or concerns that need resolving before proceeding with the case.

*Let’s dig a little deeper and imagine the following scenarios which result from ‘minor’ communication differences:*

- Physician legibility on orders and consent form not ideal. Is the surgery for “CTS” carpal tunnel syndrome or cubital tunnel syndrome? Carpal tunnel release was done when the planned procedure was cubital tunnel release, even though it was the correct arm.
- What do you call those fingers and the thumb? Is it the thumb and first, second, third and fourth finger? Or, is it the thumb, second finger, third finger, fourth finger and fifth finger? If you took a poll of the staff in your operating room, you would probably identify a potential risk right away because even different medical professionals often use different terminology. According to the coding guidelines and medical dictionary references digits of the hand are referred to as:
  - First finger = Thumb
  - Second finger = Index finger
  - Third finger = Middle finger
  - Fourth finger = Ring finger
  - Fifth finger = Little finger

Consider adding these suggestions to your facility protocol:

- Have all staff clarify which digit by noting the name of the finger (thumb, index, middle, ring, or little) along with the 'number' of the finger. Everyone understands thumb, index, middle, ring, or little while first, second, third, fourth and fifth can be confusing.
- Patients should not be moved from the pre-operative area until the physician has arrived and checked-in with the patient as evidenced by the surgeons initials on or adjacent to the operative site. Errors occur when surgeons are rushed and patients are prepped prior to arrival of the surgeon.

1. Joint Commission. Sentinel event statistics as of September 30, 2009. Available at: <http://www.jointcommission.org/SentinelEvents/Statistics>.
2. Joint Commission on Accreditation of Healthcare Organizations. 2003 JCAHO National Patient Safety Goals. Available at: <http://www.jcrinc.com/26813/newsletters/3746/>.
3. Joint Commission. Root causes of wrong site surgery. Available at <http://www.jointcomission.org>.

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