ASHRM PATIENT SAFETY TIP SHEET

Preventing Wrong-Site Surgeries

AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

SITUATION:

Wrong-site surgery is a serious yet preventable adverse event. The estimated national incidence rate for wrong-site surgeries is as high as 40 per week, including wrong patient, wrong procedure, wrong site, and wrong side.[1]

BACKGROUND:

- The Joint Commission's Sentinel Event program has been a leader in the identification of wrong-site surgeries as a common event type. It held its first Wrong Site Surgery Summit in 2003 and launched the Universal Protocol in 2004.
- The Center for Transforming Healthcare collaborates with hospitals on identification of root causes of wrong-site surgeries and establishing processes to reduce risk.
- AORN's *Guidelines for Perioperative Practice* are published annually with up-to-date evidence-based practice recommendations.

ASSESSMENT:

Although wrong-site surgeries are rare, when they do occur, they tend to be the result of many contributing factors. Errors can be made at any point in the process, from scheduling to the operating room. Following are some top root causes of wrong-site surgery:

Scheduling Process

- Booking documents not verified
- Schedulers accepting verbal requests
- Use of unapproved abbreviations
- Documents missing at time of booking (e.g., consent, history and physical, surgical order)

Pre-Op/Holding

- Documents missing or incorrect
- Incorrect site marking
- Inconsistent use or absence of time out before regional blocks
- Rushing or absence of patient verification

Operating Room

- Discrepancy in site verification
- Handoff or communication issues
- Documentation/images not used to verify procedure or site
- Time out not performed appropriately

Organizational Culture

- Senior leadership not actively engaged
- Inconsistent organizational focus on patient safety
- Lack of speak-up culture
- Policy changes inconsistent with staff education

RECOMMENDATIONS

Perform a gap analysis (https://www.ashrm.org/safe-procedural-surgery-gap-analysis) in your perioperative settings to ensure evidence-based practices have been adopted for surgical and procedural safety to prevent harm. Risk mitigation strategies should then be developed based on the identified gaps in your organizational processes.

Resources: [1] Chassin MR, Loeb JM: High-reliability health care: getting there from here. Milbank Q. 2013;91(3):459-490. doi:10.1111/1468-0009.12023; [2] Joint Commission Center for Transforming Healthcare Safe Surgery Targeted Solutions Toolkit (https://www.centerfortransforminghealthcare.org/products-and-services/targeted-solutions-tool/safe-surgery-tst/?_ga=2.213333780.1610182919.1635368016-1646816274.1609373470); [3] Institute for Healthcare Improvement (IHI): Doing the "right" things to correct wrong-site surgeries (http://www.ihi.org/resources/Pages/Publications/DoingtheRightThingstoCorrectWrongSiteSurgery.aspx); [4] IHI: What Is an 'Always Event'? (http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Balik-WhatIsAnAlwaysEvent.aspx); [5] Agency for Healthcare Research and Quality (AHRQ) toolkits for safe surgery in hospitals (https://www.ahrq.gov/hai/tools/surgery/index.html) and ambulatory surgery centers (https://www.ahrq.gov/hai/tools/ambulatory-surgery/index.html); [6] AORN (Association of periOperative Registered Nurses): www.aorn.org; [7] Association of Surgical Technologists (AST): www.ast.org; [8] Association for the Advancement of Medical Instrumentation (AAMI): www.aami.org