Examining A Case Of Wrong Surgery Performed On A 6-Year-Old

Patient Safety Blog

A California hospital has been fined $50,000 – its fifth administrative penalty from the State since 2009 – for performing the wrong procedure on a 6-year-old boy. The boy was supposed to receive a tongue lesion resection, but instead a tongue tie release was performed.

We can examine the issues that resulted in this incident within a Cause Map, or visual root cause analysis. The first step in any analysis is to define what you are analyzing. We begin with impacts to the organization's goals. In this case, we look at the impacted goals from the respect of the hospital. First, the patient safety goal was impacted due to an increased risk of bleeding, infection, and complications from anesthesia. The compliance goal is impacted because performing the wrong surgical procedure on a patient is a "Never Event" (events that should never happen). The organizational goal is impacted because of the $50,000 fine levied by the State of California. The patient services goal is impacted because the wrong procedure was performed and the labor goal was impacted due to the additional procedure that was required to be performed.

The second step of our analysis is to develop the cause-and-effect relationships that describe how the incident occurred. We can develop these relationships by beginning with the Impacted Goals and asking "why" questions. For example, the patient safety goal was impacted because of the additional risk to the patient. The patient received additional risk because of the performance of an additional procedure. An additional procedure was necessary because the wrong procedure was initially performed.

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