5th Wrong-Site Surgery Puts Hospital In The Crosshairs

Health officials are investigating how a surgeon at Rhode Island Hospital mistakenly operated on the wrong part of a patient's hand, the hospital's fifth wrong-site surgery since 2007. Hospital President Timothy Babineau said in a letter that the mistake Thursday happened on a patient scheduled for surgery on two fingers. A joint on one finger underwent a procedure meant for another.

Babineau said the surgery was then performed on the correct finger and the patient was discharged. Hospital officials are investigating what went wrong, as is the state Department of Health.

Rhode Island Hospital was fined $50,000 after brain surgeons operated on the wrong side of patients' heads in three separate cases in 2007. On such incident involved a neurosurgeon who didn’t check the CT scans to verify which side of the head to work on, and instead relied on his memory.

In this instance the surgeon actually drilled into the wrong side of the patient’s head, realized his error, and immediately operated on the correct side. The patient died a few days later but the state medical examiner did not find a connection between the surgical error and the patient’s death. Following these incidents it was ruled that the hospital was not meeting the requirements of its license because of its “continued failure to provide adequate care to patients having neurosurgery.”

Ironically, Diane Skorupski, the facility’s director of PeriOperative Services, gave a presentation about the hospital’s past issues and the current program that it had put in place during the most recent *Managing Today’s OR Suite* event in Las Vegas last month. Skorupski was very forthcoming about the hospital’s past indiscretions, and promoted a partnership with the Hospital Association of Rhode Island. She reinforced the organization’s pro-active approach to addressing and preventing such events.

Although difficult, in looking past these recent events at Rhode Island Hospital, most in attendance took great value in Skorupski’s presentation, which included a number of key insights for establishing preventative protocols:

- Developing and implementing surgical safety checklists.
- Educating all personnel involved on the importance of paying attention to each and every item on the checklist in great detail.
- Uniform site marking procedures.
- Standardized procedural terms and definitions.
  It’s estimated that approximately 2,500 wrong site surgeries occur in the 7,500 U.S. hospitals each year, or about 1 out of every 3 locations will

experience a similar event.

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