Wrong Site Surgery: The Disconnect In Prep

Amanda McGowan, editor

As surgical professionals, I am sure you are well-informed about Rhode Island Hospital, the facility in which surgeons recently performed the fifth wrong site surgery since 2007. For anyone following this story, one can't help but ask: How? How can this happen at all, but especially five times?

Ironically, just prior to the hospital's fifth offense in October, Diane Skorupski, RN, MS, CNOR, NE-BC and Director of PeriOperative Services at Rhode Island Hospital and Hasbro Children's Hospital, along with Jean Marie Rocha, MPH, RN and Vice President of Clinical Affairs for the Hospital Association of Rhode Island, gave a presentation at the Managing Today's OR Suite Conference in Las Vegas, NV, on "Life After Wrong Site Surgery."

The presenters discussed various explanations for why these events had occurred, especially at such an alarming rate, and what the hospital was doing to correct these problems in its system. They proposed possible underlying reasons why these wrong site surgeries were performed in the first place, such as an overconfident culture of surgery, system failures and inadequate communication between departments.

From the previous events, Skorupski and Rocha explained the "lessons learned" from these events, and what the hospital was doing to correct the problems in the hospital associated with these errors, including ensuring Universal Protocol is followed every procedure, not just time outs. Other efforts included changes in policy, including staff input in policy changes and educating all staff members on the value of a timeout, making sure these policies are not just tolerated, but enforced.

Additionally, the state of Rhode Island implemented a uniform surgical protocol in which all hospitals in the state would follow, including a surgical safety checklist to be performed in every operation. It seemed the hospital ridden with errors was on the mend.

Then, just a short time after these presenters spoke about what they had learned from the wrong site surgery events, it happened again.

How, amidst all the efforts to improve processes in the hospital, could this happen? Arguably, one major factor that may be overlooked is an apparent disconnect among the surgical team in the preparation process of the patient.

Obviously, it is important that processes be in place during a surgery to help prevent errors in the OR, such as time outs and ensuring surgeons value the time out process. According to Skorupski and Rocha, the majority of all wrong site surgeries are still due to errors related to Universal Protocol and not taking time outs seriously:

- 67 percent of all wrong site surgeries are due to one or more Universal Protocol steps not being done.
- In 40 percent of cases where wrong-site surgery occurred, a time out was not done or not completed.
- In 5 percent of cases, a site mark was done but not looked for by the surgeon.

However, it also should be considered how crucial it is for a surgical team to take the proper steps *before* entering the OR to prevent these events. In fact, the presenters discussed a number of other causes of wrong-site surgeries in which the cause is rooted in either missed steps or miscommunication before the surgical team and the patient even entered the OR:

- In 8 percent of wrong-site cases, an incorrect or ambiguous consent form was present.
- In 12 percent of cases, the test specimen or results were switched, mislabeled or incorrectly displayed.
- In 8 percent, a biopsy or other diagnostic test was misinterpreted.
- A technical error occurred in 5 percent of wrong-site surgeries.
- In 27 percent of cases, a required site mark was not done.

The patient prep process is more than gowning, draping and cleaning the surgical site. It should involve double checking patient information and tests, making the right surgical marks and communicating all this information to the surgeon and surgical team in the OR prior to surgery.

Today, Rhode Island Hospital is paying big fines for their errors, as well as investing in video cameras and implementing additional regulations for their surgeons and

surgical staff in order to hold them more accountable for their actions in the OR.

My question is, who or what holds the staff accountable during prep, before the team and patient enter the OR, and before that first incision is made?

This disconnect in the prep process is part of the problem with wrong-site surgeries, and it seems to be wrongfully overlooked. Part of the solution to preventing these errors is the preliminary process and until it is mastered, wrong site surgery will continue to be a problem in the OR.

What do you think need to happen to help prevent wrong-site surgery? E-mail me at amanda.mcgowan@advantagemedia.com [1]

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Amanda,
As an OR nurse (20+ years), I was employed at a hospital that had several cases of wrong
distraction of the circulator has been the major factor, and as you state, it was during the p
very aware of the right and left orientation of the patient. Standing at the patient's feet, the
I've observed several nurses that have exposed the right leg (should be the left) of the pati
situation when they approach from the foot of the OR table. Personally, I feel that a written
site (writing down the correct site on the erase board), allows everyone in the room to asse
correct site, and since the circulator doing the prep wrote it down on the board, it helps cer
correct site.

In my 20 + years, I have never prepped the wrong site. In one case (early in my career and
site on the erase board), I exposed the wrong leg for an arthroscopy case to place the tourn
anesthetist stated, "are you sure you want to use that leg?" It takes the entire surgical tear
site. That's why I like to write it on the erase board so all can see, and it helps me stay focu
-Al

Hello Amanda,
Wrong site should never occur. It happens when nurses lose focus of what they are really
either in a hurry to prep or they are distracted by other things going on in the room. Flirting
They are just not focused on the task at hand.
-Velma

Wow! What a disturbing, continued issue!

I am a Pre-Op/ PACU/Endo RN. I have worked in the OR as well and in Perioperative Servic
lot of change over the years.
In our institution, we go over the orders for the surgical procedure with the patient and h
words, what surgery they are having, including the site during the admit process. We chec
H & P. If there is any discrepancy, the physician is called to come talk to pt/family before t
area. Physicians are required to mark laterality, in the patient's Pre-Op room, after verifyin
surgical site. Pts are NOT taken to the OR until this is done. The circulating RN is part of th

communicates directly with the circulating RN. If any issue arises, the OR desk is notified.
surgical procedure when doing Pre-Op interview in the Pre-Op area. Additionally, we place
whenever laterality is involved.

Time out process is done with EVERY pt., regardless of whether laterality is present.
-Susan

This event had quite a few in the quality and safety field scratching their head. Do I read co
process...checking patient information and tests, making the right surgical marks and comm
to the surgeon...."

Where were the surgeon and the surgical team? Shouldn't they be the ones intimately invo
should they be getting this information second-hand?

One certainly hopes to learn from such incidents but as you have keenly pointed out, for th
between wrong site surgery. There will always be more to learn and your editorial keeps th
-Jean

Amanda,
Offer the patient a magic marker upon admission asking she/he to label the site. Who has
-Dennis

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