Wrong-site errors as likely outside OR

Surprisingly, patients are just as susceptible to a wrong-site procedure outside the OR as they are in surgery, a new study finds.

Also surprising: Nonsurgical specialties contributed to patient injuries from wrong-site procedures as much as surgical specialties did.

The only death in the cases analyzed was from a patient treated by an internist who placed a chest tube in the wrong side.

“One of the main findings is that the time-out should be extended to settings where any type of invasive procedure is performed,” the lead author, Philip Stahel, MD, of the University of Colorado, Denver, told OR Manager. The time-out is a pause before the procedure to verify the correct patient and site.

Yet the findings also show lapses in the verification process: In 72% of wrong-site events, the time-out wasn’t performed.

The researchers evaluated all wrong-site and wrong-patient procedures reported by physicians to Colorado’s professional liability insurer from January 1, 2002, through June 30, 2008. The company’s policy provides incentives for early reporting.

They found 107 wrong-site and 25 wrong-patient incidents. Of these, 43 caused significant harm, with 5 involving the wrong patient and 38 the wrong site.

Examples were a prostatectomy on the wrong patient due to mislabeling of biopsy samples, a wrong-patient vitrectomy due to two patients with identical names, and a myringotomy rather than an adenoidectomy on a child after the wrong patient was brought to the OR.

For all of the events, the authors analyzed the records for root causes.

Wrong-patient root causes

Diagnostic errors were responsible in more than half (56%) of the wrong-patient incidents, such as mixups of patient records and biopsy samples.

For all of these, communication errors were a root cause, with breakdowns in both oral and written information transfers.

The authors said 60% of the oral communication failures might have been prevented by a readback by the caregiver team.

Wrong-site root causes

In wrong-site procedures, 85% were attributed to inadequate planning. Lack of a time-out accounted for 77 of the 78 systems issues that were identified.
Dr Stahel’s advice for surgical teams: “Increase efforts in communications.” Denver Health, where he is on staff, is testing the use of readbacks, similar to those used by airline pilots with air traffic control.

Increased vigilance is called for, even with the time-out. He recalls talking with a surgeon who had had a wrong-site surgery.

“The most shocking thing was when it occurred, there were 9 other people present, but no one raised a concern,” he says.

“I think people are growing numb. There is a need for vigilance at each step.”

Reference