Wrong-Site, Wrong-Patient Surgery: "Never Event" That Still Occur

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"Wrong-site operation, though infrequently reported, is a preventable incident.[1] This results in embarrassment for the surgical team, but more importantly leads to adverse events that cause morbidity and mortality. Social media and newspapers in contemporary times are quick to pick such incidents and report them widely.[2] Ordinary people thus are truly concerned and their trust on healthcare providers is thus tarnished. It is important that such incidents should be taken seriously and a transparent probe initiated to find out the root-cause of the event. The causes may be different in different healthcare settings. A facts based investigation report may help in devising future polices in this context.

The issue is important as it gets further complicated because the consequence of wrong-site surgery is not limited to the patient who is operated but can involve another patient with whom it was confused. This is called wrong-patient surgery.[3] The affected patient in this situation is subjected to a surgical procedure that was not indicated. Such incidents are more often reported in an ambulatory surgery setup. In a study, orthopedic and podiatric specialties combined, topped the list. These incidents are described as "never event". However, they continue to occur. NHS England describes never event as those incidents, of serious nature, that are preventable. For this reason, safety protocols are developed and made available at national level to all the relevant stakeholders and are expected to be implemented.[4]

World Health Organization (WHO) Surgical Safety Checklist is one of such measures to address the safety of the patients who are scheduled for the operations. It has three components that includes sign-in, to be conducted before the induction of anesthesia, time-out before making a skin incision and finally the sign-out to be performed either immediately after skin closure or before the patient is moved out of the operation theatre.[5] However, it is reported that compliance is lacking.[6] Many shortcomings are identified in various studies that reflect breach in the protocols. An important factor identified is a lack of communication between the operating surgeons and his team, including nursing and paramedical staff.[6]

In United Sates, The Joint Commission defined such incidents as patient safety event. This may lead to temporary or permanent harm and at times results in a mortality. The commonly reported consequences include need of an additional surgery as the primary condition was not addressed, undue pain inflicted to the individual, late recovery, delayed mobility, unnecessary scarring, at times loss of an organ and permanent disability. The Joint Commission therefore suggested implementation of the Universal Protocol for Preventing Wrong-Site, Wrong-Procedure, and Wrong-Person Surgery in 2003. The three important basic steps include pre-procedure verification process, marking the surgical site and a time-out. Other factors that are identified as a cause of adverse events include incomplete and incorrect medical records, lack of documentation, technical issues like markings ink used, the similar names, age and gender of the patients to name a few. Sometimes surgeons themselves fail to appreciate the radiological findings of the disease and on which side of the patient they stand. These appear minor failures of the judgement on the part of the operating surgical team but has dire consequences.[6]

In order to ensure correct-site surgery many surgical societies and patient safety organizations have developed guidelines.[8] However, it is important to involve patients during elective surgical procedures. In the reception area of the operation theater (preoperative check-in room) the patient may be seen

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by the surgical team together with the anesthesiologists. In case of pediatric patients, a good communication with the parents may help in ensuring correct identification of the patient, the disease they suffer from and the surgical procedure to be performed with exact marking of the surgical site rather than relying only on the nursing and paramedical staff.

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