PATIENT SAFETY WORKHSOP
WRONG SITE SURGERY EXAMPLE

From Event Report:

42-year-old male admitted for right arthroscopy on 12/23/04. Surgery performed on left knee. Patient informed.

After Investigation as part of RCA Process:

- **Mr. C., a 42-year-old former dancer and now choreographer, was admitted at 7 AM, for a 9:30 AM case, on Thursday, December 23, 2004 through day surgery for an arthroscopic repair of his right meniscus.**
- **His surgeon was a prominent and well-known orthopedic surgeon.**
- **His surgeon had followed him for several months and both now felt that a surgical repair was the best option.**
- **His admitting chart, including the History & Physical, laboratory work consisting of a CBC and the surgical consent form, were in day surgery.**
- **The nurse interviewed Mr. C. and noted that "the patient states he is here for a repair of his right knee."**
- **The anesthesiologist also saw Mr. C. and after assigning him an ASA Class I, documented that the surgery was to be a right knee repair.**
- **The surgeon saw Mr. C in the day-surgery admitting area at 7:15 AM, marked his right knee with a red "X" and then left to begin his first case at 7:30 AM.**
- **There were unexpected complications with the first case, in OR #1, and the surgeon finished at 10:45 AM.**
- **He had three more surgeries scheduled, including Mr. C's, and an 8 PM flight to Zurich to catch for his annual ski vacation in Davos.**
- **The staff knew of his plans and rushed to prepare the OR for the next case.**
- **Because it would take at least 30 minutes to prepare the surgeon's usual OR #1, the head nurse had the staff from OR #1 prepare the one next door, OR #3.**
- **She also assigned an extra scrub tech, who had joined the staff 1 month earlier, to help set up.**
- **Mr. C. was sent for and arrived in OR #3 at 10:55 AM with his chart.**
- **The anesthesiologist began and was involved with setting up and administering the regional block.**
- **The staff prepared the room for the arthroscopic repair, positioning the power source, laser, instruments, foot pedals and video.**

- **The orthopedic resident, on rotation from an affiliate hospital, seeing the red "X" on the right knee prepped and draped the left one while the surgeon was scrubbing.**

- **The new nurse thought that the "X" meant that was the knee to be operated on; however she was new to this hospital, was aware of the surgeon's reputation and didn't want to make any trouble.**

- **The surgeon entered the room, saw the exposed skin, positioned himself as was his usual custom and began the surgery.**

- **Incisions were made, instruments and camera inserted, and damaged tissue was seen on the monitor by the surgeon and resident.**

- **The surgery was completed without complications.**

- **The patient was transferred to the recovery room.**

- **In the recovery room, the patient's sister asked why his left knee was bandaged when it was the right one that had the problem.**

- **The surgeon was called.**

- **The surgeon responded and said that he would check the records.**

- **In between cases, the surgeon checked the patient's chart and confirmed that the surgery was to have taken place on the right knee.**

- **The surgeon spoke with the sister by telephone and later with the patient.**

- **The patient had surgery on the wrong knee.**

- **Even though the knee did exhibit some damage, it was not the surgery that he consented to and will now have to undergo another procedure.**

- **Surgery on the wrong side occurred once before in the past three years, on March 17th, 2004. That event involved a right hip replacement performed instead of the scheduled left hip replacement. The corrective action at that time was to develop and implement on September 1st, 2004 a *Time-Out* Policy and Procedure. During this *Time-Out*, all members of the team stop and double check and confirm, the patient's identity, medical record, procedure, which body part, which side, the consent form, and the accuracy of any imaging studies and X-rays in the OR.**