Manitoba Health

Manitoba Health supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Surgery Performed on the Wrong Body Part

Summary: A patient was scheduled to have his/her trigger finger released on their right middle finger. The surgery was performed on the patient's right little (5th) finger. The patient was discharged home and upon removing the bandages he/she discovered that his/her incorrect finger had been operated on. The patient contacted the surgeon and had to undergo a second surgical procedure for the correct digit. The patient fully recovered from both surgical procedures. According to the "Never Events for Hospital Care in Canada", surgery on the wrong body part is considered a critical incident.

Keywords: Surgery, wrong body part.

This review is based on a single event.

Findings of the Review:

All completed documents except for the surgical consent form indicated surgery to be performed on the 5th finger of the right hand (incorrect finger).

Correct finger was not marked pre-operatively by patient and/or surgeon.

A partially completed pre-op check list increased the probability that the correct surgical digit was not identified.

Safety check list sign in did not have all team members present in the operating room (OR) during verbal confirmation by patient of correct surgical site.

Multiple communication break downs including incorrect documentation at various points in the surgical process led to an incorrect surgical procedure being performed.

Recommendation:

Educate that all surgical team members are to be present for the safety check list "briefing" when patient confirms surgical site (marked), procedure and consent.

*SUGGESTIONS TO ENHANCE PATIENT SAFETY

The information and suggestion that follow were brought forward during the Critical Incident review. These factors did not contribute to the critical incident; however, the suggestions are being shared as opportunities for system improvement. This information will not be included in the Manitoba Health Patient Safety Learning Advisory but will be shared with the respective Senior Leaders. These suggestions are not intended for follow up reporting to Manitoba Health.

Revise the OR Safety Check List including but not limited to the suggestions below:

Implement a monthly multi-disciplinary surgical team meeting at the site.

Implement optional quarterly regional surgical team meeting.