Patient Safety Learning Advisory

Patient Safety Event:

Surgery Performed on the Wrong Body Site.

Why was this a Critical Incident?

Surgery on the wrong body site resulted in the need for another surgery for the patients.

What happened in the incident?

Multiple process and communication breakdowns led to an incorrect surgical procedure being performed.

What is the Health Care System learning?

Wrong site surgery is considered a “never event” in Canada. "Never events" are patient safety incidents that result in serious patient harm or death that are preventable using organizational checks and balances

Marking the surgical site and team confirmation of the surgery did not occur as per the surgical safety checklist.

All team members were not present during verbal confirmation by the patient of the correct surgery and surgical site.

A standardized protocol for marking the surgical site near to or at the exact incision site was not in place.

Incorrect documentation included the incorrect body site identified for surgery.

The leaders for the phases of the surgical safety checklist were not identified, the phases were not kept separate and an intentional pause and focus for conducting each phase did not occur allowing distractions.

What are the recommendations?

Educate that all surgical team members must be present for the checklist “briefing” when patient confirms and marks surgical site, procedure and provides consent.

Revise surgical safety checklist to include site marking process and phase leader identification, as per World Health Organization’s Surgical Safety Checklist.

Provide staff education on the importance of the checklist and site marking process.

Conduct audits to evaluate completion of surgical safety checklist. Share audit results with surgical team to improve use of checklist and identify any opportunities for improvement.

Keywords: surgery, wrong site, surgical safety checklist, surgical site

Glossary: Surgical Safety Checklist- The surgical safety checklist is designed to assist surgical teams to reduce the number of preventable surgical complications by communicating important information at three critical stages, or phases, during the surgical procedure.

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.