



Medical-legal risks associated with wrong site, wrong procedure, wrong patient surgery

Wrong site, wrong procedure, and wrong patient surgeries are patient safety incidents that are largely avoidable if healthcare providers use the available preventative measures. These rare events are often complex and involve multiple healthcare professionals, highlighting the importance of effective team communication and fail-safe systems.

THE STATISTICS AND WHAT THEY MEAN FOR CMPA MEMBERS



The most common surgical sites involved were :



→ FACTORS CONTRIBUTING TO WRONG-SITE, WRONG PROCEDURE, WRONG PATIENT SURGERY

- consent forms listing the wrong procedure or site
- consent forms not on file
- mix-up of patients by healthcare providers
- inexact site descriptions in notes
- not updating pertinent information pre-operatively, e.g. operating room schedule
- incorrectly positioning or preparing the patient
- not communicating discrepancies with respect to procedure or site in the documentation
- time pressures
- distractions
- not following safety protocols including:
 - adequately confirming the patient’s identity pre-operatively
 - reviewing or adequately reviewing the consent documentation
 - reviewing or adequately reviewing pre-operative diagnostic images
 - marking or adequately marking the site
 - performing surgical safety protocols, e.g. time outs

Continued

ACTION FOR SAFER MEDICAL CARE

Medical-legal risks associated with wrong site, wrong procedure, wrong patient surgery

→ ISSUES TO CONSIDER

CASE 1

Surgery on wrong leg

In the emergency department, an orthopaedic surgeon assesses an elderly patient who has fallen at home. The surgeon diagnoses a fracture of the left distal femur. The surgeon explains the planned fixation including potential complications and risks. He also obtains the patient's history and consent for the procedure.

Nurses position the patient on her left side for surgery on the right leg according to the patient's X-ray images, which are marked "R." After the orthopedic surgeon arrives for surgery, the team conducts a "time out" to verify patient identifiers. The surgeon double-checks the displayed X-ray image to verify the side he will be operating on. After completing the incision, the surgeon realizes that there is no fracture and that he is operating on the wrong leg. The incision is closed and the patient repositioned for surgery on the other leg.

Following surgery, the surgeon discloses the patient safety incident to the patient and family. The patient recovers well, but launches a legal action. A settlement is subsequently paid, shared by the CMPA, on behalf of the surgeon, and the hospital for inadequate surgical safety procedures.

→ RISK REDUCTION REMINDERS

Despite improvements such as protocols and safety checklists, instances of wrong surgery continue. The following points can assist physicians in avoiding these events:

- Verify the patient's identity, the planned procedure, and the operative site with the patient, if feasible.
- Review the medical record and all relevant diagnostic imaging before the surgery.
- Confirm that there are no discrepancies in the documentation about the procedure or site.
- Ensure that roles and responsibilities for communication are clear between all members of the healthcare team.

→ LEARN MORE BY ACCESSING THESE RESOURCES

CMPA articles

- *Surgical safety checklists: A team approach to patient safety*
- *A is for alias—Getting the right care to the right patient*

CMPA Good Practices Guide

- *Reducing risk in surgery*

CASE 2

Wrong finger surgery

A plastic surgeon performs an extensor tenolysis procedure on the fourth digit of a young patient who had had previous surgical reduction of a poorly healing complex fracture. As the surgeon is turning over the patient's hand to perform flexor tenolysis, he is interrupted by a colleague with a question about another patient.

When the plastic surgeon turns his attention back to the patient, he begins to make an incision into the tendon sheaths of the patient's third finger. The plastic surgeon quickly realizes the error, closes the incision, and completes surgery on the correct finger.

The patient launches a legal action. The CMPA pays a settlement of behalf of the surgeon.

- Support effective team communication by encouraging team members to speak up if they have concerns, listening to those concerns, considering different points of view, openly sharing information, and communicating clearly and respectfully.
- Be aware of and follow protocols for surgical safety including checklists and other fail-safe systems.¹
- If a protocol requires marking of the surgical site, confirm this step with the patient and the team.
- When possible, avoid distractions. If distracted, refocus on the checklist when returning to the patient.

¹ The CMPA defines a fail-safe system as protocols, procedures, or systems in hospitals, offices, and clinics designed to prevent or mitigate errors. An example is a process to follow up on the results of lab tests and diagnostic imaging studies so abnormal findings are flagged and reliably acted on. Another example is the use of checklists in surgery.

Tel: 613-725-2000, 1-800-267-6522 www.cmpa-acpm.ca