

Wrong Site Surgery Rhode Island Hospital October 22, 2009

Step 1. Outline the Problem

What	Problem(s)	Surgery performed on wrong finger
When	Date	October 22, 2009
	Differences	Surgeries performed on same finger
Where	Physical Location	Rhode Island Hospital
	Work/Task Being Done	Surgery

Impact to the Goals

Safety - Patient	Unnecessary surgery	
Patient Services	Cameras installed in operating room	
Employee Impact	"Never" event	
Compliance	Fined by State Health Department	\$150,000
Organization		

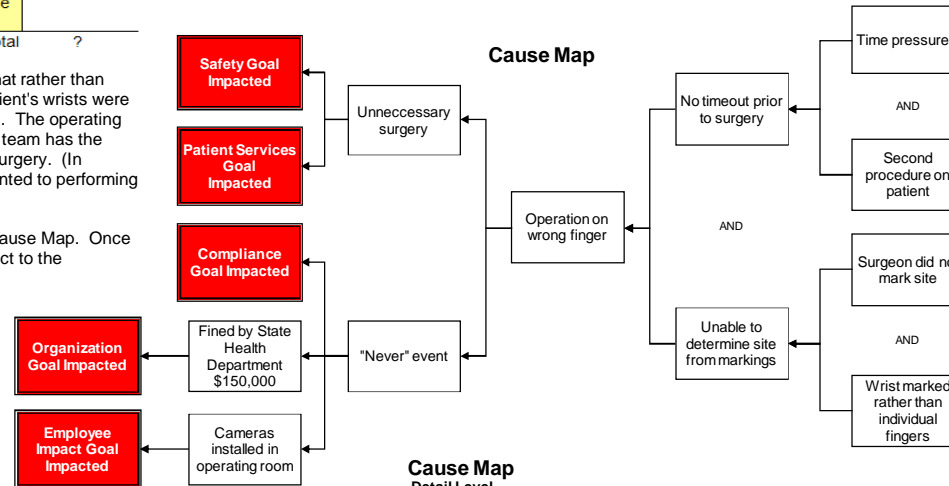
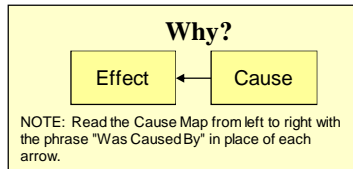
Frequency	This incident	5th wrong site surgery at hospital since 2007	Annual Total	?
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Although some of the details of the surgical error are unknown, it is known that rather than marking the individual fingers that were supposed to be operated on, the patient's wrists were marked. Additionally, it was not the operating surgeon who did the markings. The operating team also did not hold a "timeout", which is used to make sure the operating team has the right patient, right location and right surgery, before performing the second surgery. (In particularly disturbing news, after the error was noticed and the family consented to performing the operation on the correct finger, there was again no "timeout".)

As more details emerge during the investigation, they can be added to the Cause Map. Once the Cause Map is completed to a level of detail commensurate with the impact to the organization's goals, solutions can be found to mitigate the future risk.

Last month a patient at Rhode Island Hospital received surgery on his fingers. The surgery was supposed to be on two separate fingers (one on the right hand, one on the left), but due to a medical error, both surgeries were performed on the same finger. The family was then notified and the surgery was re-performed on the correct finger.

Although there was no risk of patient death due to this medical error, it is the 5th wrong site surgery to happen at this teaching hospital in two years. Rhode Island Hospital was previously fined \$50,000 for three prior wrong-site surgeries. The Rhode Island Health Department fined the hospital \$150,000 for the latest incident and is requiring the hospital to install cameras in its operating room. the future risk.



**Cause Map
Detail Level**

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