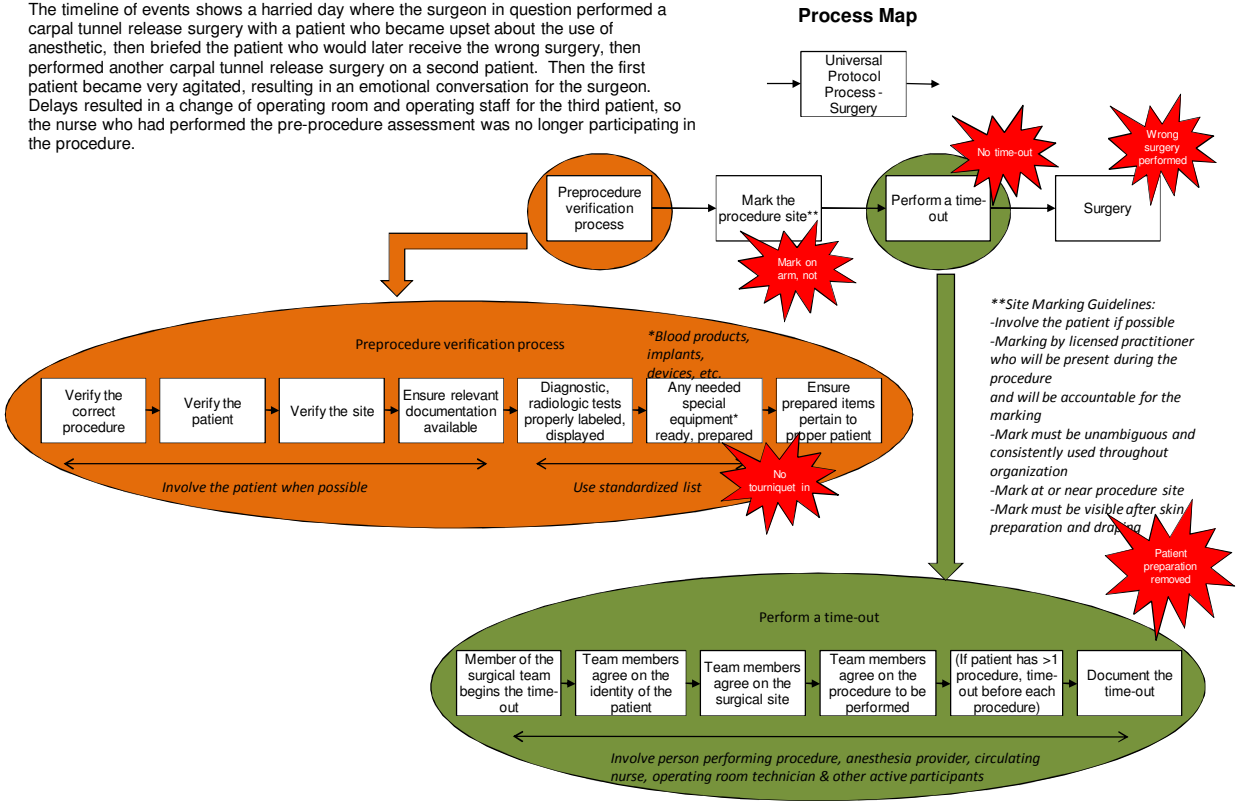
Wrong Surgery Performed on Patient

Timeline

Date/Time	Description
3 months prior to surgery	Patient seen in the orthopedic clinic of the hospital
	Diagnosis of idiopathic trigger finger (stenosing tenosynovitis)
	Local injection of dexamethasone
10 days prior to surgery	Patient report, examination show no improvement in the joint symptoms
	Risks, benefits, limitations, and alternatives of operative and nonoperative treatment were discussed
	Patient elects to proceed with surgery
Day of surgery	Patient admitted to day-surgery unit
	Operating physician performs carpal tunnel release surgery on a different patient
1 hour prior	Operating physician was asked to translate during her preoperative preparation
	Correct arm marked at the wrist by the nurse (planned incision site on the hand was not marked per protocol)
	Operating physician performs carpal tunnel release surgery on a second, different patient
	Decision made to move patient to different operating room
	Operating physician has emotional encounter with first patient, who is upset
	Operating physician enters (new) operating room
	Operating physician notices there is no tourniquet
	Circulating nurse leaves the room to get a tourniquet
	Patient's arm washed with soap, alcohol, and povidone–iodine
	Operating physician spoke with the patient in Spanish
	Operating physician begins performing carpal tunnel release procedure on patient
	Nursing staff change
~15 min after surgery	Operating physician dictates report of surgery
	Operating physician releases wrong procedure has been performed
	Operating physician informs staff of wrong procedure
	Operating physician informs patient of the wrong procedure
	Operating physician apologizes to patient, tells patient correct procedure can be performed
	Patient agrees to have correct surgery performed
	Staff assembled for operation
	Safety report filed
	Operating physician notifies hospital's risk manager of the error and rectification
	Trigger-finger release procedure performed without complication
	Patient recovery
	Patient discharged (same day)

The timeline of events shows a harried day where the surgeon in question performed a carpal tunnel release surgery with a patient who became upset about the use of anesthetic, then briefed the patient who would later receive the wrong surgery, then performed another carpal tunnel release surgery on a second patient. Then the first patient became very agitated, resulting in an emotional conversation for the surgeon. Delays resulted in a change of operating room and operating staff for the third patient, so the nurse who had performed the pre-procedure assessment was no longer participating in the procedure.

Process Map



The procedure was further delayed when the circulating nurse had to leave to find a tourniquet, since there wasn't one in the operating room. The surgeon spoke to the patient in Spanish (she did not speak English), which the nurse took as the time-out, so a real surgical time-out did not occur. As per hospital protocol, the patient's arm, but not the specific surgical site, was marked, but it washed off while her arm was being prepped for surgery.

It's easy to see how this sets the scene for mistakes. Unfortunately, these kind of things happen, and so it is important that there are procedures in place to minimize errors. The procedures shown here are the universal protocol. Additionally, the parts of the process that were not performed, or were performed improperly, are noted in red.

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