

# Ensuring Intended Surgery and Procedures (EIS & P)

## Safety Factsheet

Analysis of 'procedures involving the wrong patient or body part' reported to the Queensland Health Patient Safety Centre during 2006/07

### 1. National data

According to the most recent published National Sentinel Events report, *procedures involving wrong patient or body part* is the highest category of reported sentinel event in Australia, followed by *retained instruments or other material after surgery* and *suicide of patient in an inpatient unit* (AIWH, 2007:12)<sup>1</sup>.

### 2. Queensland Health data

During 2006/07, there were 31 cases of *procedures involving the wrong patient or body part* reported to the Queensland Health Patient Safety Centre. During this same period, a total of 809,713 patients were admitted to Queensland public acute hospitals<sup>2</sup>.

Although relatively rare events, the consequences of *procedures involving wrong patient or body part* can be devastating for patients and clinicians involved, especially as they are **entirely preventable** events.

Table 1 provides a brief description of the 31 cases of *procedures involving the wrong patient or body part* reported to the Queensland Health Patient Safety Centre during 2006/07. As Table 1 shows, **incorrect cannulation, incorrect imaging/ diagnostic procedures, errors in blood collection and wrong tooth extractions** were the most frequently reported *procedures involving the wrong patient or body part* accounting for over half (N= 16, 52%) of all cases reported during 2006/07.

**Unplanned adenoidectomy and incorrect spinal surgery** were the next most frequently reported incidents of *procedure involving wrong patient or body part*, accounting for a further 13% of (N = 4) cases.

<sup>1</sup> Australian Institute of Health and Welfare & Australian Commission on Safety and Quality in Health Care, 2007. *Sentinel events in Australian public hospitals 2004-05*. Cat. No. HSE. 51 Canberra: AIWH.

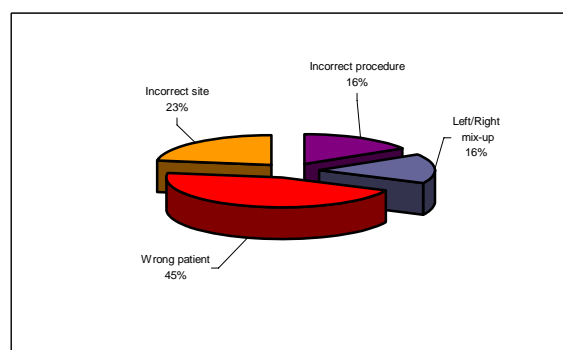
<sup>2</sup> This figure is still preliminary and subject to change as some data is still outstanding. Queensland Health, Health Information Centre.

**Table 1: Brief description of procedures involving wrong patient or body part reported during 2006/07 (N = 31)**

Brief description	N
Incorrect cannulation	5
Incorrect imaging/diagnostic procedure <sup>3</sup>	5
Error in blood collection	3
Wrong tooth extracted	3
Unplanned adenoidectomy	2
Spinal surgery at incorrect level	2
During hysterectomy right ovary removed in error	1
Gastroscopy instead of colonoscopy	1
Removal of left tonsil in error	1
Operation commenced on the left middle finger instead of left ring finger	1
Femoral nerve block on left side instead of right side	1
Regional block on the right arm instead of the left arm	1
Chest tube inserted into right lung instead of left lung	1
Wide re-excision of scar on left side of chest, instead of right	1
Ventriculoperitoneal shunt inserted on right side instead of left side	1
Ear mould impression applied to wrong patient	1
Botox injections administered into wrong body part	1
<b>TOTAL</b>	<b>31</b>

The 31 cases of *procedures involving the wrong patient or body part* were further classified into one of four categories: **wrong patient; incorrect procedure; left/right mix-up (incorrect side), and incorrect site** (Figure 1). As Figure 1 shows, of the 31 cases, almost half (N=14, 45%) involved the **wrong patient**. The remaining cases involved *incorrect site* (N=7, 23%), *incorrect procedure* (N=5, 16%) and *Left/Right mix-up* (N=5, 16%).

**Figure 1: Classification of procedures involving wrong patient or body part reported during 2006/07 (N = 31)**



<sup>3</sup> Four out of five cases involved an imaging procedure, one case involved diagnostic examination (rhinolaryngoscopy).

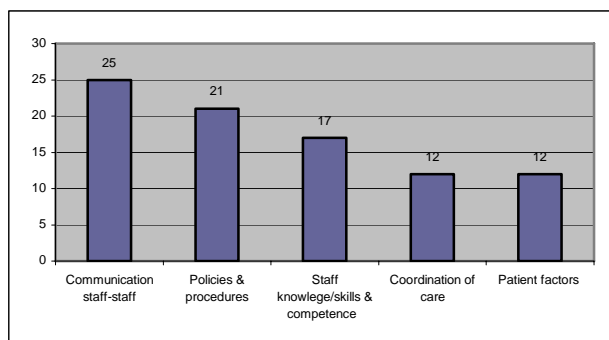
The available information<sup>4</sup>, including Root Cause Analysis Reports and Reportable Incident Briefs, for the 31 cases of *procedures involving the wrong patient or body part* were examined for **contributory factors** using the approved framework for such analysis.<sup>5</sup>

Contributing factors are those factors which are directly relevant to the incident. Multiple contributing factors can be identified per event<sup>6</sup>.

Figure 2 shows the ‘top five’ contributory factors. **Staff to staff communication**, followed by **lack of or failure to follow policies and procedures** were the most significant factors contributing to the 31 reported cases of *procedures involving the wrong patient or body part*.

**Staff knowledge/skills/competence** followed by **coordination of care** and **patient factors** (eg. being a child, elderly, cognitively impaired or very sick) were also important contributory factors.

**Figure 2: Summary of contributory factors (N = 31 cases)**



### 3. Compliance with 4 safety steps

The 31 cases were examined for implementation of the Ensuring Intended Surgery (EIS) four step protocol (Policy No. 26961).

Although EIS implementation efforts across Queensland Health have to-date focused on surgical procedures in the operating theatre, the **four safety steps** of (1) Informed Consent (2) Marking the site (3)

<sup>4</sup> Due to the recency of the case data, the information available for analysis was variable and included Root Cause Analysis Reports (14/31), Reportable Incident Briefs (31/31), and a research template (9/31).

<sup>5</sup> Queensland Health, 2007. *Patient Safety: From Learning to Action: First Queensland Health Report on Clinical Incidents and Sentinel Events* pp. 27-28.

<sup>6</sup> Due to the varied content and depth of the available information, no assurance can be given that the assignment of contributing factors was undertaken in a standardised manner. The underlying purpose of assigning contributory factors is not the production of statistics but the identification of a focus for remedial action to prevent recurrence.

Identifying the Patient and (4) a Final Check are also applicable to other procedural areas such as radiology, chemotherapy, pathology, interventional cardiology etc.

**Table 2: Documented compliance with 4 safety steps (N = 31 cases)<sup>7</sup>**

Informed Consent	Mark site	Patient ID	Final check
4/31 (13%)	2/31 (6%)	12/31 (39%)	1/31 (3%)

The results in Table 2 indicate that there was an under application of the four safety steps in these cases. Of particular note, the safety steps of ‘marking of the site’ and ‘final check’ were infrequently undertaken in these cases.

### 4. Where can I obtain further information?

A full report, analysing the 31 cases presented in this Safety Factsheet, is available on request from the Patient Safety Centre: [rose\\_bovey@health.qld.gov.au](mailto:rose_bovey@health.qld.gov.au)

For information about the Ensuring Intended Surgery Policy (No: 26961) and four step protocol visit: <http://www.health.qld.gov.au/patientsafety/eis/documents/26961.pdf>

For additional EIS information and information on the Queensland Health Incident Management Policy (No. 23360) visit the Patient Safety Centre Website: <http://www.health.qld.gov.au/patientsafety>



### Extension of EIS protocol to procedural areas

Funding (2007/08) has been set aside to further implement the four step EIS protocol in procedural areas outside the operating theatre (eg. Oral Health, Radiology). Initiatives will be announced shortly.

### October 2007, EIS Observational Audit

Another state-wide EIS Observational Audit is planned during the month of October 2007. The Audit will again focus on the ‘final check’ including marking the site. Details are available on the Patient Safety Centre Website: <http://www.health.qld.gov.au/patientsafety/eis/webpages/eisaudit.asp>

<sup>7</sup> Due to the varied content and depth of available information, the level of reported compliance with EIS for the 31 cases may alter slightly once all the information becomes available.