Short Communication

Operation on a wrong person: Lets Make it "NEVER EVENT"

Dr Nirmal Lamichhane, nlamichhane @ hotmail.com

Surgical procedures are now very common, with estimates ranging from 4% of the general population having an operation per annum in economically-developing countries; which is 8% in economically-developed countries. Whilst these surgical procedures typically result in considerable improvements to health outcomes, it is increasingly appreciated that surgery is a high risk industry. Tools developed in the aviation industry are beginning to be used to minimize the risk of errors in surgery. One such tool is the World Health Organization's (WHO) surgery checklist.[1] The National Patient Safety Agency (NPSA) manages the largest database of patient safety incidents (PSIs) in the world, already having received over three million reports of episodes of care that could or did result in iatrogenic harm.[2] Though appears to be a peculiar scenario to hear, these scenarios are reported in the medical literature of as early as 1968.[3] There are reported evidences of wrong doings in the medical science from giving wrong medicines, operating on a wrong organ, wrong side of a patient and even operating on a wrong person. Seiden et al reported 2217 wrong side surgical operations, 3723 wrong treatments and wrong procedures in total of 5940 in 13 year period in USA.[4]

An operation was performed in a wrong person in BP Koirala Memorial Cancer Hospital in Bharatpur.[5] The scheduled operation was thyroidectomy but hysterectomy was performed. None of the persons involved in the particular surgery intentionally wanted this to happen but this happened. This is simply because the surgical safety checklist is not used in the hospital.

For such event not to happen, there are many identification processes, hand over mechanisms and tallying systems to confirm the patient and to confirm procedure to be performed. In third world countries, medical professionals are very much adamant to change and do not want to adopt the successful methods well practiced in other countries. After seeing this event to happen and media concern after it, these event has to be made as NEVER EVENTS. The perioperative health care team composed of nurses, physicians, anesthesia care providers, unlicensed assistive personnel, admission workers, clerks, and other ancillary staff members must make patient safety an uncompromising goal. Patients in our hospitals should feel very confident being operated in our care.

Surgical Pause:

Theatre:		Date:	
Name:		Age/sex:	
Diagnosis:			
Allergies:			
Special precautions:			
Instruments/ prosthesis correct: Yes No			

Correct patient	N/A	Yes	No
Correct Published procedure	N/A	Yes	No
Correct Consent	N/A	Yes	No
Operative site marked	N/A	Yes	No
Allergies	N/A	Yes	No
Notes and imaging present	N/A	Yes	No
Staffing adequate	N/A	Yes	No
Antibiotic prophylaxis	N/A	Yes	No
Blood transfusion arrangements	N/A	Yes	No
WERE ANY INTERVENTIONS REQUIRED? DESCRIBE BRIEFLY			

Nursing team Anaesthesiology team Surgical team

Many societies, countries, organizations have formulated many kind of checklists to minimize this mistake. WHO surgical checklist is the most commonly used method in this regard. I will recommend a system used in NHS highland hospitals, which in fact is the simplified version of WHO checklist. This system is practical and easy which needs to be done while patient in operating room. People from the team of surgery, anaesthesiology and

nursing have to participate and nursing team usually need to take a lead in this process.

In this process, the nurse takes the lead role and calls all other involved staffs to be beside patient on operating table and talk to patient confirming his identification and all other variables in the table below. At this point, wrist bands will be beneficial to confirm patient's identity and has to be worn in the ward before coming to operating room. Symmetrical sides of the body have to be marked with permanent markers for e.g. breasts, extremities, left and right side of body before entering into the operating room.[6] The sample table is given below which is ready to use in the hospital after some modifications.

REFERENCES:

1. http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf
2. Panesar SS, Noble DJ, Mirza SB, Patel B, Mann B, Emerton M, et al. Can the surgical checklist reduce the risk of wrong site surgery in orthopaedics? - can the checklist help? Supporting evidence from analysis of a national patient incident reporting system. J Orthop Surg Res. 2011 18;6:18. available form URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101645/?tool=pubmed
3. Fisher TL. Wrong patient: wrong part. Can Med Assoc J. 1968 9; 99(18):910-911.
4. Seiden SC, Barach P. Wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events: Are they preventable? Arch Surg. 2006;141(9):931-9.
5. Surya Prasad Kandel. Thyroid patient undergoes hysterectomy. Himalayan Times. 2011 Aug 12. Under URL: http://www.thehimalayantimes.com/fullNews.php?headline=Thyroid+patient+undergoes+hysterectomy!+&NewsID=299036
6. Knight N, Aucar J. Use of an anatomic marking form as an alternative to the universal protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. Am J Surg. 2010; 200(6):803-7.