QUALITATIVE REVIEW OF WRONG-SITE SURGERIES: WHAT SIDE WILL MY SURGERY TAKE PLACE?

Lead Author: Anoosha Moturu, MD Candidate
Contributing Authors: Jessica Howe, Grace Tran
Category: Patient Safety

Background
Wrong site surgeries (WSS) are classified as "never events" and signify adverse events that are preventable. The prevalence of procedures in the wrong location is up to 50 WSS per week in the United States. Informed consent (IC) related contributing factors include communication breakdowns between staff and across units, lack of cross-checking documents, equipment-related issues, and lack of automation in document coordination. As part of a patient safety initiative, a qualitative analysis using patient safety event data was conducted to understand the scope of informed consent related factors impacting patient safety within a large healthcare system. Findings from this analysis supports the broader aims to reduce the risk of WSS through system-based interventions.

Objectives
1. Describe existing literature contributing to WSS focused on inconsistencies in the IC process. This lack of standardization contributes to wide variability in informed consent forms across healthcare.
2. Present findings from qualitative analysis of patient safety events from a large healthcare system in the Mid-Atlantic region to inform broader aims of patient safety initiative to reduce the risks for WSS.
3. Demonstrate the importance of system-based interventions that that reliably captures and verifies procedure information to reduce the risks for potential patient harm.

Methods
A qualitative review of IC and WSS-related factors was conducted using patient safety event (PSE) data within a large healthcare system in the mid-Atlantic region. From the database containing 132,683 PSEs from 2009 to 2017, a word-search query returned a total of 756 reports by including one or more of the following keyword terms: laterality, informed consent, and wrong-site surgery. Additional analysis included a manual review of the event narrative for each result, codes were identified and defined in a comprehensive codebook, inter-rater reliability established, and qualitative analysis conducted.

Results
Qualitative analysis of the PSE data indicated highest frequencies of the following codes: Absence of consent for treatment (25.7%), Incorrect or missing information recorded in the IC form (15.5%), and Ambiguity in laterality of the procedure on IC form/other medical documentation (12.5%). These contributing factors often lead to Late procedure start times (6.6%) and New consent document procurement (6.42%).

Discussion
These findings inform the need for system-based interventions to reduce risk. A targeted intervention focused on improving the design of IC forms and other medical documents could address some of these vulnerabilities. Developing a system-based approach to cross check procedure information increases the reliability of system safeguards to reduce the risk of potential patient harm.