Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.8, July 2007

Wrong site surgery (right/left)

Nine cases of wrong site surgery between right and left were reported. (information collection period, from October 1, 2004 to December 31, 2006; the infomation is partly included in "Medical Adverse Event Information to Be Shared"in the 8th Quarterly Report)

Most cases of wrong site surgery due to right-left confusion were caused by markings on the surgical site not properly carried out.

Marking	number of cases
Marked	2 cases
Not marked	6 cases
Unknown	1 case

◆ Among the two cases with marking, one case was a marking mix-up due to right-left confusion, and another case was marked on the dorsal hand for ophthalmologic surgery.

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Case 1

For bilateral osteoarthritis of the knees, surgery on left knee which had more severe symptoms was firstly scheduled. On the day before surgery, the patient was given an explanation of the surgery to be performed on the left knee, however, the knee was not marked as instructed in a manual. The following day, just after entering an operation room, the nurses, the anesthesiologist, and the surgeon confirmed with the patient that surgery was to be performed on the left knee, but did not confirm the marking at that time. Under general anesthesia, the surgeon did preoperative preparation on the right knee, contrary to the planned left knee, and the surgery began without anyone noticing the mistake. Thirty minutes after the surgery began, the mix-up between left and right was noticed.

Case 2

For vitrectomy of the left eye, the marking was made on the left dorsal hand to identify the side of surgery at a ward. After entering the operating room, the physician assisting in preoperative preparation, mistakenly carried out preoperative preparation, such as local anesthesia on the right eye which is the wrong side, and surgery was started as it was. Right after surgery began, the another physician who was watching a microscope image on a monitor noticed the mix-up between the left and the right eye for the surgery.

Preventive measures taken at the medical institutions in which the events occurred.

Create surgical site marking rules and thoroughly share it.

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of "Comprehensive Evaluation Panel" to prevent occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project. http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

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