Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.128, July 2017

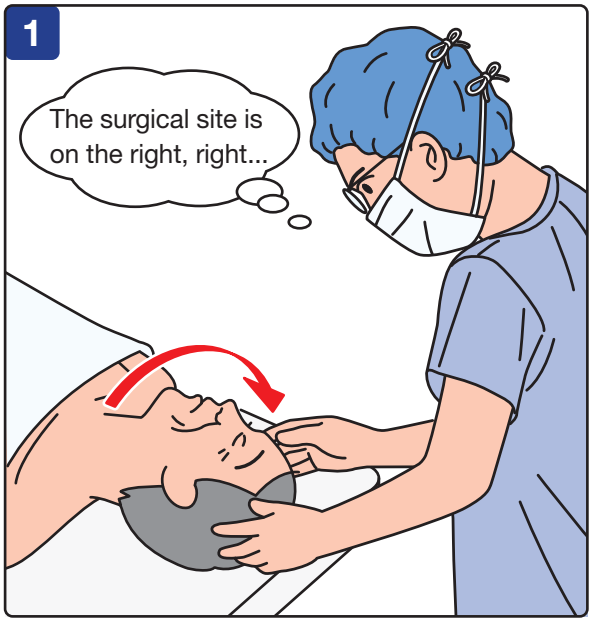
Wrong Site Surgery (Right/Left)
—Neurosurgical Procedures—

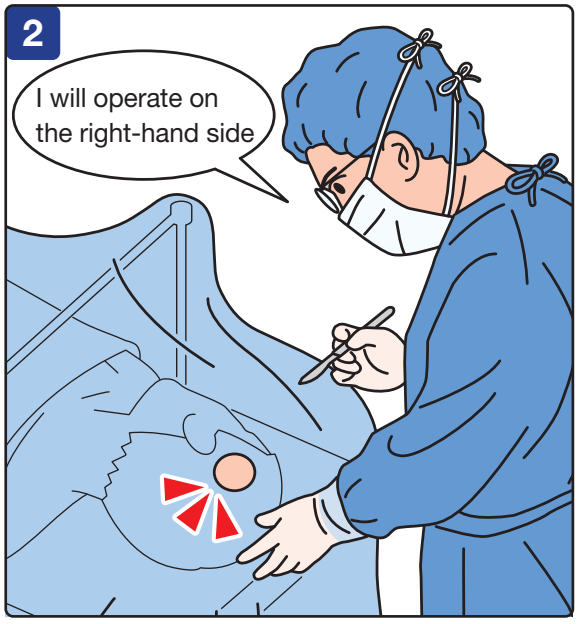
Information about the wrong site surgery (right/left) was provided in Medical Safety Information No.8 (July 2007) and No.50 (January 2011). Since then, 26 similar cases have been reported. Of these, 11 occurred during neurosurgical procedures (information collection period: from December 1, 2010 to May 31, 2017). The information is compiled based on “Recurrence of Events and Occurrence of Similar Events” (p.163) in the 48th Quarterly Report.

Eleven cases of wrong site surgery (right/left) in neurosurgical procedures have been reported.

- **In all 11 events, the image was checked, but the surgical site was not checked before positioning was carried out.**
- **In four cases, the surgical site called out by the physician immediately before making the skin incision was not cross-checked against the site of the skin incision.**

Image of case 1





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Case 1

After the patient entered the operating room, the surgeon looked at the image with the assisting physician and the circulating nurse, and confirmed that the surgical site was the right-hand side. The scrub nurse did not know on which side the operation was to be performed. Failing to notice that the patient's face was facing right and that the operative field was therefore facing downward, the surgeon shaved the left-hand side of the head, on the opposite side from the operative field, and administered local anesthesia. The surgeon disinfected and draped the area, and then, immediately before making the skin incision, read out to the other staff the name of the patient and their disease, the surgical procedure, and the side on which the surgery was to be performed (right-hand side). However, nobody confirmed that the operative field was the right-hand side. While making the incision into the dura mater after making the incision into the skin and cutting through the bone, the assisting physician noticed that there was no hematoma and realized that there had been a mix-up between left and right.

Case 2

The patient required emergency surgery due to a right chronic subdural hematoma and the physician ordered surgery on the right-hand side on the surgical handover form. After the patient entered the operating room, the physician used the image to confirm that the surgical site was the right-hand side, but did not mark the area. While Nurse A laid out the surgical instruments and Nurse B measured the patient's vital signs, the physician shaved the left-hand side of the head, on the opposite side from the operative field. After disinfecting and draping the area, the physician said aloud, "I will operate on a right chronic subdural hematoma." Nurse A heard the physician's words, but the drapes were already in place, so Nurse A was unable to confirm that the operative field was the right-hand side. After the physician made a burr hole in the left-hand side and then made the incision into the dura mater, they noticed that there was no hematoma and realized that there had been a mix-up between left and right.

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

- **In neurosurgical procedures, the findings on the image will be cross-checked against the surgical site by multiple medical staff, including physicians and nurses, immediately before carrying out positioning and other preparations for surgery.**
- **When checking the surgical site immediately before making the skin incision, the surgical site called out by the physician will be cross-checked against both the site where the physician plans to make the skin incision and the surgery application form.**

* 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 the "Comprehensive Evaluation Panel" to prevent the 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 cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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