Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.50, January 2011

Wrong site surgery (right/left) (1st Follow-up Report)

Information regarding wrong site surgery (right/left) was released as Medical Safety Information No. 8 (July 2007). After that, 21 similar cases were reported, so the information is provided here again. (Information collection period: from January 1, 2007 to November 30, 2010)

The cases of wrong site surgery between right and left, have been reported again. The following are among such cases.

1) Marking of the surgical site was not properly carried out.

2) Marking was carried out but the surgical site was not confirmed immediately before making skin incision.

Marking	Number of cases
Marked	5 cases
Not marked	8 cases
Unknown	8 cases

Confirmation of the surgical site immediately before making skin incision

Confirmed 0 case

Not confirmed 5 cases

◆ Among the five cases with marking, two cases were a marking mix-up due to right-left confusion, and one case where the marking came off, and two cases where the marking was not clearly seen due to being covered by cloth, etc.

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Case

On the day before surgery for an inguinal hernia on the left side inguinal region, the surgical site was confirmed by the physician, the patient and family, and marked on the dorsum of foot with a permanent marker. On the day of surgery, the primary physician confirmed the patient's surgery site, etc., and signed the checklist in the operation room. The anesthesiologist and the operation room nurse then confirmed the surgical site of the patient, etc., together, and signed the checklist. After initiating anesthesia, the primary physician confirmed the marking on the left dorsum of foot, which was the side for the surgery. But upon examination of the inguinal region, he/she noticed a swelling on the right inguinal region. The primary physician performed skin disinfection, saying "the surgical site, left," located the right inguinal region as the surgical field. The marking was not confirmed immediately before making skin incision.

Preventive measures taken at the medical institution in which the event occurred.

- **Maintain a manual of preoperative marking and Time-Out.**
- **Carry out a Time-Out by the physicians and nurses handling the surgery.**

Complementary comment by the Comprehensive Evaluation Panel

Time-Out during surgery means 1) immediately before making skin incision 2) by all team members, 3) stops all the procedures for a moment, and 4) verbally confirms the patient, site, operative procedure, etc., 5) according to the checklist.

* 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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