MedPro Group
a Berkshire Hathaway company

Checklist

Preventing Wrong-Site Surgery

Wrong-site surgery caused 7.9 percent of sentinel events voluntarily reported to The Joint Commission (TJC) from 2018 to 2021.[1] A closed claims analysis published by TJC showed that spine and intervertebral disc surgery, arthroscopy, and surgery on muscles/tendons were the most common types of procedures involved in wrong-site surgeries, and failure to follow policy/protocol and failure to review health records were the top contributing factors in those cases.[2]

Although infrequent, wrong-site surgeries can result in devastating outcomes that may jeopardize patients, families, healthcare providers, and healthcare facilities. These errors are not only legally and ethically indefensible, but also preventable. Healthcare organizations must have processes in place that combine standardized site-marking methods with collaborative processes to achieve a safer surgical environment.[3]

More specific considerations on these perioperative processes are included in this checklist,[4] which can serve as a helpful tool to assess organizational culture and commitment and determine whether any gaps exist in organizational processes, including those related to scheduling, consent, preoperative verification, site marking, and time-outs.

	Yes	No
Organizational Culture/Commitment		
Does your organization educate all providers and staff members and lead a campaign to prevent wrong-site surgeries throughout the facility (e.g., administrators participate in safety rounds or communicate progress on the organization's intranet)?	☐	☐
Does your organization reinforce the value of standardized processes?	☐	☐
Does your organization define the roles for healthcare providers and staff and hold them accountable for their roles in the risk reduction of wrong-site surgeries?	☐	☐

	Yes	No
Organizational Culture/Commitment (continued)		
Does your organization use a team approach when teaching how all new processes should be implemented and executed?	☐	☐
Does your organization provide ongoing education and just-in-time coaching?	☐	☐
Are providers and staff members encouraged and expected to speak up when they have a patient safety concern or when all team members do not participate in safety protocols?	☐	☐
Has your organization developed a measurement system for identifying inconsistencies in real time?	☐	☐
Does your organization share data with team members and allow them to ask questions and clarify information?	☐	☐
Scheduling/Consent		
Do providers and staff members confirm the presence and accuracy of all primary documents (including the original surgical or procedure orders, patient health records, and more) before the day of surgery?	☐	☐
Do providers and staff members verify that an exact description of the procedure (including site, level, side, and digit) is listed on the operating room (OR) schedule?	☐	☐
Does your organization only accept written (and not verbal) bookings for procedures?	☐	☐
Is an exact description of the procedure (including site, level, side, and digit) listed on the consent form?	☐	☐
• Does your organization use a standardized consent form?	☐	☐
• Do providers verify the consent was completed and that it includes the procedure name and all required signatures and dates?	☐	☐
• Does your organization educate physician offices about the requirement for consents to be clear, correct, and legible, as well as contain no cross-outs or unapproved abbreviations?	☐	☐

	Yes	No
Scheduling/Consent (continued)		
• Are all consents that do not meet the established criteria returned to physician offices for correction?	☐	☐
Does your organization use one or more surgical safety checklists (e.g., the World Health Organization Surgical Safety Checklist)?	☐	☐
• Are checklists customized to particular types of surgery?	☐	☐
• Has your organization considered enlarging surgical safety checklists (i.e., to poster size) so every provider in the OR can watch the circulating nurse check off essential steps?	☐	☐
Preoperative Verification		
Is a preoperative briefing performed upon arrival in the OR with patient involvement (if possible) to verify the patient's identity, procedure, site and side, as well as other critical information including the OR schedule, consent, history and physical, and patient's understanding of the procedure?	☐	☐
Does your organization use a standardized preoperative verification checklist?	☐	☐
Do at least two providers independently perform verification and documentation?	☐	☐
Does the facility require accurate primary documents to be received 48 hours before surgery?	☐	☐
• If inconsistencies are found, does the OR staff flag the OR schedule to alert staff and treat the case as high risk?	☐	☐
Site Marking		
Does the facility have a protocol requiring surgeons to use a single-use surgical-site marker with a consistent mark type (e.g., surgeons' initials) placed as close as anatomically possible to the incision site?	☐	☐
• Does the facility's protocol comply with The Joint Commission Universal Protocol?	☐	☐
• Does the facility involve the patient in marking the surgical site?	☐	☐

	Yes	No
Site Marking (continued)		
• Does the facility maintain a large supply of one-time-use indelible markers in the preoperative and holding areas and the OR?	☐	☐
• Does the facility test selected pens for satisfactory results with prep solutions?	☐	☐
Does site marking occur before administration of sedation and/or anesthesia?	☐	☐
Is the mark visible when the patient is positioned, prepped, and draped?	☐	☐
Time-Outs		
Do staff members perform a standardized and role-based time-out process?	☐	☐
• Is each team member assigned an active role?	☐	☐
• Are all documents verified during time-out, including the patient's name, procedure, site, and side?	☐	☐
• Is the time-out conducted before regional or local anesthesia is administered?	☐	☐
• Are all members of the team engaged, all work stopped, and verbal acknowledgment given to complete the time-out?	☐	☐
• Is the final time-out performed after the patient is positioned, prepped, and draped?	☐	☐
• Does the surgeon encourage the surgical team to speak up if any concerns exist?	☐	☐
Do staff members verify the patient, side, and site for all regional blocks using a standardized time-out process?	☐	☐
Other Considerations		
If the same provider performs multiple procedures, is the OR staff required to stop between each case to ensure that the procedure, site, and laterality of each procedure is being performed accurately and according to the signed surgical consent?	☐	☐
Is all patient information removed from the OR before the next patient arrives?	☐	☐

Resource

For more information, see MedPro's *Risk Resources: Wrong-Site Surgery*.

Endnotes

[1] The Joint Commission. (2023, April 25). *Closed claims data analysis identifies wrong-site surgery risk factors*. Retrieved from www.jointcommission.org/resources/news-and-multimedia/news/2023/04/closed-claims-data-analysis-identifies-wrong-site-surgery-risk-factors/

[2] Ibid.

[3] Pennsylvania Patient Safety Authority. (2007). Doing the "right" things to correct wrong-site surgery. *PA-PSRS Patient Safety Advisory, 4*(2), 29,32-45. Retrieved from https://patientsafety.pa.gov/ADVISORIES/Pages/200706_29b.aspx

[4] This checklist is largely adapted from the following resources: Health Research & Educational Trust and Joint Commission Center for Transforming Healthcare. (2014, August). *Reducing the risks of wrong-site surgery: Safety practices from The Joint Commission Center for Transforming Healthcare project.* Chicago, IL: Health Research & Educational Trust. Retrieved from https://www.aha.org/ahahret-guides/2014-08-29-reducing-risks-wrong-site-surgery-safety-practices-joint-commission; Pennsylvania Patient Safety Authority, Doing the "right" things to correct wrong-site surgery.