

Wrong site surgery, tissue sample extracted from the wrong site on the patient

1. The event:

A 47-year-old woman is called in to have a biopsy performed on a small lump in her breast. The handwritten referral slip dictates that the sample is to be extracted from the one o'clock position. The slip also states that the lump is very small. According to the patient record, a biopsy is performed at the seven o'clock position. The test result shows no signs of cancer. No further action is taken.

Six months later, the patient is admitted with a large lump in her breast. When reviewing the record, it becomes evident that the first sample was not taken from the one o'clock position, but from the seven o'clock position. This was probably the reason why the sample did not contain malignant cells, and the illness could not be diagnosed earlier.

2. Local action:

The event is reported to the local reporting system, and the following root causes are identified:

The original referral contains a handwritten note indicating that a lump was found at the one o'clock position, but the patient record indicates that the lump was found at the seven o'clock position. Patient records are typed from a draft copy, which has been handwritten by a junior doctor. The original draft no longer exists, but the error was probably caused by a transcription error in which the numbers 7 and 1 were confused. Also, at the time the lump was so small that it was unclear where the biopsy was to be performed. The analysis of the event uncovers the following causes:

1. The risk of making a transcription error increases if the site is marked using words and numbers, and not using indicators on a drawing.
2. The department did not have guidelines for the surgeon on how to mark the site in collaboration with the patient prior to surgery.

Consequently, the hospital implemented the following action plan:

1. Instead of using words or numbers to describe the site of a planned biopsy, the site is marked on a drawing.
2. A policy is implemented which requires that the surgeon in collaboration with the patient marks the site on the body where the procedure is to be performed (this rule is implemented for all types of procedures which entail a risk of wrong side/wrong site incidents).

The event and action plan are sent to a national reporting system.

3. National action:

Based on the above case - and relevant literature - a decision was made at the national level to implement a policy, which requires that the surgeon and patient discuss and mark off the

incision site. Furthermore, reviews of previously reported events show that other wrong site surgical procedures could have been avoided, had this method been used. Based on this, a national guideline is released, recommending that the surgeon and patient collaboratively mark off the incision site.