Wrong Site, Wrong Procedure, Wrong Patient Errors (WSPEs)

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BACKGROUND

Wrong site, wrong procedure, wrong patient errors (WSPEs) have been an area of focus for regulatory and accrediting agencies, as well as for healthcare organizations, for a number of years. Beginning in 2007, The Centers for Medicare and Medicaid Services (CMS) stopped paying for any additional costs related to medical errors. In 2009, CMS ruled that hospitals would not be reimbursed for any costs tied to WSPE’s. These were also deemed to be “never events” by the National Quality Forum (NQF), as it was believed such occurrences should never happen and that these events reflected significant underlying patient safety issues. In addition, The Joint Commission specified that WSPEs were “sentinel events” for the same reasons. Typically, these errors have been under-reported, making it difficult to identify any one action to reduce WSPEs. Also, one study by the Veterans Affairs found that half of these errors in their facilities occurred outside of the operating room. Previous efforts to reduce WSPEs have primarily been focused on trying to standardize perioperative processes to include all procedures being performed throughout healthcare organizations. The Joint Commission statistics reflect that 12.8% (120/934) of all sentinel events reported to them in 2015 were WSPEs. In 2016, they were 14.7% (121/824) of sentinel events reported, and 11.8% (95/805) in 2017. Needless to say, there is more work to be done to improve in this area of practice. A culture of patient safety is essential to reducing these kinds of medical errors in every setting where procedures are performed.

Root cause analyses completed after WSPEs have found that they are preventable medical errors. Communication issues have been identified by The Joint Commission as the most consistent factor in these types of sentinel events. Standardizing policies and protocols for preparing patients before procedures, to the extent possible, can help prevent many of these potential errors. It is important that related policies and protocols are clearly delineated and that all staff and providers involved in performing procedures throughout the facility are educated before working independently.

A planned pause, often called a “time out,” immediately prior to performing the procedure, serves as the final safety check before any procedure gets underway.

Unfortunately, even with the integration of The Joint Commission’s standardized “Universal Protocol” in the procedure area, certain errors can still occur before the patient arrives in the procedure/operating room, especially when personnel are under time pressures and rush to perform the procedure.


The Joint Commission developed a Universal Protocol, which has been widely adopted by professional organizations, such as the Association of periOperative Registered Nurses (AORN). This protocol and accompanying guidelines are based upon evidence-based practice. The Universal Protocol includes:

- **Pre-procedure verification**—frequency to be defined by the organization
  - All needed equipment and documents are available before the procedure starts (i.e., history and physical, consent forms, pre-anesthesia assessment, labels for specimens or test results, implants to be used, blood to be given, etc.)
  - Items are matched to the patient’s identity and are labeled correctly with the proper patient identifiers
  - The team members review the patient’s identity and expectations regarding the procedure to be performed, site, etc.
  - Points during which these areas are reviewed should be specified and may include:
    - When scheduled
    - During preadmission
    - Upon admission
    - In the preoperative/pre-procedure area
    - After any changes in personnel involved in the procedure

- **Specifically, to prevent mistakes in surgery/procedures**, in addition to using two patient identifiers, The Joint Commission’s 2018 Hospital National Patient Safety Goals (NPSG) relating to their Universal Protocol (UP.01.01.01, UP.01.02.01, and UP.01.03.01) require:
  - Making certain that the correct surgery is performed on the correct patient and at the correct location on the body
  - Marking the correct place on the patient’s body where the surgery is to be performed, by a licensed independent provider who knows the patient and will be participating in the procedure
  - Pausing (taking a “time out”) before starting the procedure, as the final check to be certain that a mistake is not going to be made
  - Any discrepancies must be resolved before proceeding with the procedure

The AORN Position Statement, *Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events*, supports implementing evidence-based risk prevention strategies to reduce the chance of errors, to include:

- **Standardized processes and practices**, in collaboration with regulatory and accrediting agencies
- A multidisciplinary group consisting of all members of the surgical team, including perioperative nurses, surgeons, and anesthesia providers, as well as quality, risk management, and other health care personnel develops policies and procedures to prevent WSPEs
- Clear delineation of the roles and responsibilities of physicians and all other licensed independent providers involved in providing perioperative/pre-procedural marking and verifying the correct site
- Implementation and monitoring of standardized policies and protocols developed
- Completion of a preoperative/pre-procedure checklist by the surgical team members, including pre-procedure patient verification, marking of the site, completion of “time out” procedures, and other important care considerations
- While a comprehensive approach is required, perioperative registered nurses serve as patient advocates and communicate with the entire surgical team and other nursing staff to assure that all parts of the standardized process have been completed satisfactorily prior to the procedure

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STRATEGIES FOR SUCCESS

The following strategies may be helpful in achieving standardization and consistency in practice across organizations to reduce the risk of WSPEs:

• Full compliance with The Joint Commission’s “Universal Protocol”\(^5\)
  
  **NOTE:** The “2018 Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery” may be found on pages 13–16 in the 2018 Hospital NPSG\(^5\)

• Consider the use of the “AORN Comprehensive Surgical Checklist”\(^6\) that can be adapted to the specific organization

• Assure education of all healthcare personnel and providers who will be involved in procedures throughout the organization prior to working independently and whenever changes are made to the policies or protocol

• Implement and enforce consistent practice of all related policies and procedures related to all patient safety practices, including the Universal Protocol requirements

• Monitor and evaluate staff and provider performance and act promptly to address any inconsistencies identified through performance improvement/peer review processes

• Provide periodic summary reports of organizational performance and any sentinel events related to WSPEs to the Performance Improvement Committee, leadership, and the Board.

**NOTE:** Additional practical implementation measures may be found in the AORN Journal’s article, “Back to Basics: The Universal Protocol”.\(^7\)

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When patients agree to a procedure, they expect to receive competent, proper care so they will have the correct procedure performed on the agreed upon body part. If this does not occur, and a WSPE results, this may be perceived as a violation of the patient’s trust and this can adversely impact the organization’s reputation in the community. It may also prompt a significant claim and/or the organization absorbing or covering additional expenses resulting from the WSPE. In some cases, there may also be licensure considerations for staff, providers, and/or the facility related to accountability and possible corrective active.

Assuring the consistent use of best practices to avoid WSPEs may help minimize financial losses and affirm community trust. Key performance elements include redundancy, teamwork, a culture of patient safety, and extreme vigilance by each member of perioperative/pre-procedure teams.
REFERENCES:


“2018 Hospital National Patient Safety Goals” (Chapter), The Joint Commission, Oakbrook, IL, January 1, 2018 https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2018.pdf


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