Community Health Network

Safety WINKS

What I Need to Know for Safety

The Story: A patient was admitted for a "Right Middle Finger Mass Resection" procedure. Another procedure "Release Right Trigger Finger" was performed. The correct procedure was also performed after the patient noticed the mass had not been removed. The consent was written and was signed "Right Middle Finger Mass Resection".

The site was marked on the right middle finger at the base of the finger. The timeout was performed and the consent was read per protocol immediately prior to the procedure: "Right Middle Finger Mass Resection". The scrub, but not the circulator heard the surgeon say "and trigger finger". The scrub DID NOT speak up; the surgeon DID NOT speak up. The circulator was not informed of the discrepancy with the procedures. Neither informed the circulator a trigger finger procedure was going to be performed and to obtain consent. The surgeon performed the trigger finger release.

The final timeout was performed and the consent was read: "Right Middle Finger Mass Resection".

Everyone in the room agreed with the timeout and the scrub tore down the table and sterile field. The scrub or the surgeon DID NOT state that a trigger finger had been performed and that the mass resection was not performed. As the physician talked with the patient still in the operating room, the patient stated "Aren't you going to remove this mass? I thought you were going to remove the mass on my finger". Patient was re-draped and sterile field set up and the mass was removed from the finger.

The root cause analysis found the following:

1. There was no "Speaking Up For Safety" during the first timeout. The surgeon or scrub spoke up when the surgeon stated he was adding a procedure to the surgical consent.
2. Surgical team did not direct their full attention to the person initiating the second time out. Surgeon was reading office notes. Circulator read consent from the desk not closer to the field.
3. The second time out did not occur immediately prior to initiation of the procedure, after the patient was prepped and draped. The second timeout was performed prior to prepping.
4. Did not occur prior to closure. Initiating the final time out prior to closure allows for one final review of documents and assurance that all members of the surgical team are in agreement to what surgical procedures were performed.
5. The procedure read ""Right Middle Finger Mass Resection" was not performed. All in the room agreed that this procedure had been performed. A "Trigger Finger Release" was performed.

Lessons Learned:

1. Everyone in the OR must stop what they are doing, turn and face the field, and focus their full attention on the timeout. IF anyone hears any discrepancy in what is read from the consent and the procedure to be performed or that was performed, it is that person's responsibility to **SPEAK UP.** All activities should stop until the discrepancy is resolved.

Speaking Up for the safety of your patients! We have tools for that!!

A review of the policy was done with all staff. Staff were all reminded to "Speak Up" and "Escalate Up" as needed. In the future, if there is a discrepancy the scrub will notify the circulator. This is an example of our Journey to Safety, **"Practice with a Questioning Attitude" Validate and verify.**

Use the ARCC tool!

Ask a question

Make a **R**equest

Voice a **C**oncern

Use **C**hain of command

Here is how it could have worked in this situation:

Ask a question: Are we sure this is the correct site?

Request: I request we check the order against the consent form before we continue.

Still concerned? Voice your concern:

Concern: I am concerned. The consent does not match the order.

Chain of Command: Finally when you still don't feel sure, feel free to get your manager involved.