

Risk of operating on the wrong site: how to avoid a never event

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DESCRIPTION

A 23-year-old man was referred to our unit for surgery for a right-sided recurrent primary spontaneous pneumothorax. On the eve of his surgery, he was consented and marked for the procedure. On examination of the patient, a play symbol tattoo was noted on the left side of the patient's torso and pointing towards the patient's left side, with the potential to cause confusion of the site of surgery. A black arrow in indelible ink was drawn on the patient's right shoulder to indicate the correct site for surgery (figure 1).

The first item on the National Patient Safety Agency's (NPSA) list of never events is 'Wrong site surgery'. As preventative measures, the agency advocates the use of standardised patient wristbands and the WHO Surgical Safety Checklist.¹ Introduced by the WHO in 2008, the checklist was launched as a tool to help improve safety of surgery and save lives. The tool helps the care team ensure the correct patient undergoes the correct procedure and includes checkpoints for site of surgery and supportive imaging to be displayed in the operating theatre.

A checklist is only as good as the team that uses it, and to encourage coherent team work the NPSA published 'Five Steps to Safer Surgery' in 2010 outlining five communication steps to make surgery safer. These include the steps: briefing, sign-in, time-out, sign-out and debriefing.²

Despite these interventions, 84 wrong site surgery events were reported in National Health Service



Figure 1 Which is the correct surgical site? Photograph of male torso showing a surgical site marking on the patient's right shoulder and a play symbol tattoo, pointing towards the patient's left side, on the left side of the thorax.

Patient's perspective

'My parents always told me my tattoos would serve as a lesson one day, I don't think they pictured this. Glad I could provide a source of bemusement and hopefully education.'

Learning points

- ▶ Even the best preparations can be derailed by patient tattoos.
- ▶ The importance of clear communication with and examination of the patient combined with a review of radiographic imaging.
- ▶ The team brief is the first communication step to encourage teamwork and avoid mistakes.
- ▶ The tattoo on the opposite side of the surgical site should be highlighted here.

hospitals in England between April and September 2017.³

Although the patient's tattoo gave rise to quite a stir in the anaesthetic room and operating theatre, it reminded the entire team of the importance of correct site marking, the five perioperative communication steps and adhering to the WHO Surgical Safety checklist.

The patient recovered well from his right Video-assisted thoracoscopic surgery (VATS) bullectomy and pleurectomy and was discharged from hospital 2 days later.

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