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Patient Safety Tip of the Week

September 10, 2024

Scheduling and Informed Consent Contribute to Wrong-Site Surgery

We've discussed how surgical scheduling and informed consent can contribute to wrong-site surgery in many columns (see, for example, our Patient Safety Tips of the Week for October 30, 2012 "Surgical Scheduling Errors" and September 10, 2013 "Informed Consent and Wrong-Site Surgery").

Now Taylor et al. (Taylor 2024) have taken a deep dive into the Pennsylvania Patient Safety Reporting System (PA-PSRS) database to see how these two processes contribute to wrong-site surgery.

Over a four-year period from January 2019 through December 2022, the authors found 1,166 event reports that described a consent and/or schedule error. 86% of the reports were from hospitals and 14% were from ambulatory surgery facilities (ASF's). Among the 1,166 reports, 56% described a schedule error, 34% had a consent error, and 10% involved both error types. Scheduling errors were slightly more frequent at hospitals than ASF's (58% vs. 49%). At hospitals wrong-side schedule errors (42%) were reported twice as often as the wrong-side consent errors (21%). But at ASF's, the percentage of wrong-side schedule errors (25%) and wrong-side consent errors (23%) were similar.

In the sample of reports, the frequency of error subtypes were: wrong side (69%), wrong procedure (24%), wrong site (4%), and wrong patient (3%). The analysis also revealed similarities and differences in the distribution of error types and subtypes across hospitals and ASF's.

Wrong-side errors were reported 14 percentage points more at hospitals than at ASFs, but wrong procedure errors were 18 percentage points higher at ASFs than at hospitals (40% vs. 22%).

The article has a nice table listing risk factors for errors in informed consent or scheduling or both. Examples include things like the consent being obtained by someone other than the attending provider or a patient (or representative) consenting to erroneous information. Some examples of scheduling errors involved the scheduler not confirming information from primary documents, receiving only a verbal order, booking multiple cases, or being insufficiently knowledgeable about clinical issues. In the past, we've stressed that last item. All too often, a non-clinical person in a physician's office rather than the physician is the person calling in to the hospital or ASF to schedule a case. The table also notes that paper or electronic forms that allow open text may be problematic and that disparities often occur when both electronic and paper forms are used. The table also includes examples related to handwriting, abbreviations, and communication.

The Taylor article provides a table listing 33 strategies to mitigate the risk of consent of scheduling errors. You'll need to go to the article itself for all 33, but we'll mention a few key strategies:

- Consent should always be obtained by the attending provider.
- All primary source records should be easily available to staff while consent is obtained.
- The patient (or representative) should use "sayback" or "readback" during consent.
- Standardized forms should be used and electronic ones can avoid handwriting errors.
- Scheduling should be done by someone knowledgeable about the procedure and other relevant clinical content.
- Orders for a procedure should be in written form (and when a verbal order must be given, it should be done with "readback" and "hearback".
- In the patient records, the provider should provide sufficient details about the indication, recommended procedure, site, and side.
- Only approved abbreviations (or none at all) should be allowed.

Many of both the risks and the mitigation strategies in the Taylor paper were previously detailed in our Patient Safety Tips of the Week for October 30, 2012 "Surgical Scheduling Errors" and September 10, 2013 "Informed Consent and Wrong-Site Surgery". The Taylor study is an important contribution to our understanding of factors contributing to wrong-side surgery. Wrong-site surgery continues to occur despite all our patient safety efforts. It's clear that errors in both the informed consent and scheduling procedures contribute to wrong-site surgery. It's time that all parties involved give the same undivided attention to these procedures as we give to the surgical timeout.

Some of our prior columns related to wrong-site surgery:

September 23, 2008 "Checklists and Wrong Site Surgery"
June 5, 2007 "Patient Safety in Ambulatory Surgery"
July 2007 "Pennsylvania PSA: Preventing Wrong-Site Surgery"

March 11, 2008	"Lessons from Ophthalmology"
July 1, 2008	"WHO's New Surgical Safety Checklist"
January 20, 2009	"The WHO Surgical Safety Checklist Delivers the Outcomes"
September 14, 2010	"Wrong-Site Craniotomy: Lessons Learned"
November 25, 2008	"Wrong-Site Neurosurgery"
January 19, 2010	"Timeouts and Safe Surgery"
June 8, 2010	"Surgical Safety Checklist for Cataract Surgery"
December 6, 2010	"More Tips to Prevent Wrong-Site Surgery"
June 6, 2011	"Timeouts Outside the OR"
August 2011	"New Wrong-Site Surgery Resources"
December 2011	"Novel Technique to Prevent Wrong Level Spine Surgery"
October 30, 2012	"Surgical Scheduling Errors"
January 2013	"How Frequent are Surgical Never Events?"
January 1, 2013	"Don't Throw Away Those View Boxes Yet"
August 27, 2013	"Lessons on Wrong-Site Surgery"
September 10, 2013	"Informed Consent and Wrong-Site Surgery"
July 2014	"Wrong-Sided Thoracenteses"
March 15, 2016	"Dental Patient Safety"
May 17, 2016	"Patient Safety Issues in Cataract Surgery"
July 19, 2016	"Infants and Wrong Site Surgery"
September 13, 2016	"Vanderbilt's Electronic Procedural Timeout"
May 2017	"Another Success for the Safe Surgery Checklist"
May 2, 2017	"Anatomy of a Wrong Procedure"
June 2017	"Another Way to Verify Checklist Compliance"
March 26, 2019	"Patient Misidentification"
May 14, 2019	"Wrong-Site Surgery and Difficult-to-Mark Sites"
May 2020	"Poor Timeout Compliance: Ring a Bell?"
September 14, 2021	"Wrong Eye Injections"
October 5, 2021	"Wrong Side Again"
November 9, 2021	"Ensuring Safe Site Surgery"
February 15, 2022	"Wrong-Side Chest Tubes"
May 2022	"PPSA: Updated Wrong-Site Surgery Recommendations"
June 13, 2023	"Preventing Wrong-Site Surgery"
November 2023	"Importance of Timeouts Outside the OR"
January 30, 2024	"Is Your Surgical Safety Checklist Working?"

References:

Taylor MA, Yonash RA. Risk Factors for Wrong-Site Surgery: A Study of 1,166 Reports of Informed Consent and Schedule Errors. Patient Safety 2024; 6(1): 117084 https://patientsafetyj.com/article/117084-risk-factors-for-wrong-site-surgery-a-study-of-1-166-reports-of-informed-consent-and-schedule-errors

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