SAVES, SYSTEM IMPROVEMENTS, AND SAFETY II

"Saves, System Improvements, and Safety II" is an occasional feature of the *Pennsylvania Patient Safety Advisory*, highlighting successes by healthcare workers in keeping patients safe. The Safety II approach assumes that everyday performance variability provides adaptations needed to respond to varying conditions and that humans are a resource for system flexibility and resilience.

Site Marking: Undoing an Error

A patient was scheduled for a right hip replacement but the surgeon marked the left (incorrect) side. Recognizing the error, the surgeon immediately drew an "X" through the incorrect mark, added the word "wrong," and marked the right (correct) hip. The nurse recognized the potential for confusion and used alcohol to remove the incorrect mark, including the word "wrong."*

This event narrative exemplifies correcting an error before harm could occur. Although members of the surgical team can do their best to prevent errors, errors may still occur. In this instance, the surgeon immediately corrected the error, before harm occurred, and the nurse reinforced the correction. There is limited information in the event report, but it's intriguing to consider the participants' possible thought processes. When the surgeon not only crossed out the incorrect mark, but wrote the word "wrong," it's possible that he or she anticipated that crossing out the mark alone might still be incorrectly interpreted as "X marks the spot" so the word "wrong" may have been added to provide additional clarification. When the nurse saw two site marks, he or she may have considered the possibility that additional team members might proceed based on the first mark they saw, which could be either the correct or incorrect mark, and not look for an additional site mark. Advisory information that may help prevent wrong-site procedures is available at http://patientsafetyauthority.org/EDUCATIONALTOOLS/PATIENTSAFETYTOOLS/PWSS/Pages/home.aspx. Part of keeping patients safe involves following evidence-based processes, and part involves being able to effectively manage uncommon or unanticipated conditions.

This is a good catch because the surgeon and nurse corrected the site-marking error before harm occurred (i.e., preventing a wrong-site event). Often protocols describe the expected course of action; it's much less common for protocols to provide guidance on how to correct errors. Kudos to the team's members for their situational awareness in an uncommon situation.

* The details of the PA-PSRS event narrative in this article have been modified to preserve confidentiality.

PENNSYLVANIA PATIENT SAFETY ADVISORY

THE PENNSYLVANIA PATIENT SAFETY AUTHORITY AND ITS CONTRACTORS

PATIENT SAFETY AUTHORITY
An Independent Agency of the Commonwealth of Pennsylvania

The Pennsylvania Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error (Mcare) Act. Consistent with Act 13, ECRI Institute, as contractor for the Authority, is issuing this publication to advise medical facilities of immediate changes that can be instituted to reduce Serious Events and Incidents. For more information about the Pennsylvania Patient Safety Authority, see the Authority's website at http://www.patientsafetyauthority.org.

ECRI Institute
The Discipline of Science. The Integrity of Independence.

ECRI Institute, a nonprofit organization, dedicates itself to bringing the discipline of applied scientific research in healthcare to uncover the best approaches to improving patient care. As pioneers in this science for nearly 50 years, ECRI Institute marries experience and independence with the objectivity of evidence-based research. More than 5,000 healthcare organizations worldwide rely on ECRI Institute's expertise in patient safety improvement, risk and quality management, and healthcare processes, devices, procedures and drug technology.

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP's efforts are built on a nonpunitive approach and systems-based solutions.

Scan this code with your mobile device's QR reader to subscribe to receive the Advisory *for free.*