Wrong Surgery Performed on Patient

The timeline of events shows a harried day where the surgeon in question performed a carpal tunnel release surgery with a patient who became upset about the use of anesthetic, then briefed the patient who would later receive the wrong surgery, then performed another carpal tunnel release surgery on a second patient. Then the first patient became very agitated, resulting in an emotional conversation for the surgeon. Delays resulted in a change of operating room and operating staff for the third patient, so the nurse who had performed the pre-procedure assessment was no longer participating in the procedure.

The procedure was further delayed when the circulating nurse had to leave to find a tourniquet, since there wasn’t one in the operating room. The surgeon spoke to the patient in Spanish (she did not speak English), which the nurse took as the time-out, so a real surgical time-out did not occur. As per hospital protocol, the patient’s arm, but not the specific surgical site, was marked, but it washed off while her arm was being prepped for surgery.

It’s easy to see how this sets the scene for mistakes. Unfortunately, these kind of things happen, and so it is important that there are procedures in place to minimize errors. The procedures shown here are the universal protocol. Additionally, the parts of the process that were not performed, or were performed improperly, are noted in red.