Wrong organ removed, patient sepsis, death

See timeline

Open surgery performed by two trainees
Romford, UK
Hospital
Open surgery to remove appendix

Patient death
Wrong organ removed

Pathologist did not notify of unusual results
Pathology report not read when available
Pathology report only read at miscarriage

Appendix not removed for 19 days
Appendix not removed in initial surgery
Patient suffering from appendicitis
Sepsis

Inadequate expertise in surgery
Inflammation?
Patient was 5 months pregnant

Ovary removed instead of appendix
Ovary confused for appendix
Operated as open, rather than laparoscopic

Surgeons identified organ by feel
Patient suffering from appendicitis

Inadequate expertise in surgery
Patient was 5 months pregnant
Not required for senior staff to be present in operating room

Senior medical staff had left for the day
No senior medical staff present

Surgery performed by trainees

Appendix not removed in initial surgery
Appendix not removed for 19 days
Sepsis
Patient suffering from appendicitis

Patient Safety Goal Impacted
Patient death
Miscarriage
Investigation into 8 hospital staff

Employee Impact Goal Impacted
Hospital Trust liability for death

Compliance Goal Impacted
"Never event"

Organization Goal Impacted
Hospital Trust liability for death

Patient Services Goal Impacted
Wrong organ removed

Labor, Time Goal Impacted
Additional surgeries required

Timeline
Date Description
October 23, 2011 Initial operation to remove patient's appendix
October 29, 2011 Patient discharged from hospital
October 31, 2011 Pathology tests that showed appendix was not removed available
November 7, 2011 Patient returns to hospital in pain
November 9, 2011 Patient suffers miscarriage
Pathology report read
Emergency operation to remove septic fluid
November 11, 2011 Operation to remove appendix
Patient dies on operating table

Wrong organ removed, patient sepsis, death

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Problem
1. Problem
What
What is the Problem? Why did it happen? What will be done?

When
Step 1. Analysis
Step 2. Solutions

Where
Step 3. Goals

Impact to the Goals
Patient Safety
Patient death

Hospital Trust
Hospital Trust liability for death

"Never event"

Investigate Problems. Prevent Problems.
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