Ensuring Correct Surgery Frequently Asked Questions

**Q: One of the requirements for the consent form is that it states the reason for the procedure; what does this mean?**

**A:** The reason can be: 1) the diagnosis, in terms understandable to the patient, or 2) the intended outcome. An example of the diagnosis is "total replacement of the left hip for advanced osteoarthritis," the reason in this case is "advanced osteoarthritis." An example of the intended outcome is "surgical release of a tendon to increase the range of motion in the left thumb." This information is included so that patients will speak up if they believe that the wrong procedure is on the form. For example, if the consent form says that the procedure is to address severe osteoarthritis and the patient knows that he has never been diagnosed with arthritis and is in the hospital for a heart procedure, it is likely that he will speak up. Keep this in mind when writing the reason on the consent form.

**Q: What should we put in for the procedure site?**

**A:** The site should be understandable to the patient. If it's an operation to repair a patellar fracture, you also should note that this is the kneecap. Many patients will not know the medical names for parts of the body. Be sure to include the side (left or right, if applicable) when you indicate the site.

**Marking the site**

**Q: Why do we have to mark all sites, even ones on the midline, like for a coronary artery bypass graft?**

**A:** Because the correct patient getting the correct operation on the wrong side is not the only thing we need to prevent. Over 50% of incorrect surgeries are not laterality mistakes but something else, such as the wrong patient or wrong procedure. In fact, in a review of the VA database, 36% of the incorrect surgeries were done to the wrong patient, usually one who was scheduled to get a different procedure. A patient is likely to speak up if he understands that he is supposed to have an operation on his chest at the midline and the surgeon wants to mark a site on his abdomen or leg.

**Q: What kind of pen or marker should we use?**

**A:** A non-toxic marker that meets FDA requirements for medical use and will not wash off when the site is prepped can be used for marking the site. For instance, surgical pens are available from surgical supply houses.

**Q: Is it Ok to re-use markers? Does the marker have to be sterile?**

**A:** We searched the literature on this topic. There is no evidence that markers have transmitted disease from one patient to another. The site will be prepped with an antiseptic after the mark has been applied. But just in case, common sense would dictate that if a mark is being applied to a patient's broken skin or to a patient known to have a communicable skin disease, the marker should be discarded after that use.

**Q: How about marking the skin of patients with very dark skin?**

**A:** It is true that the mark may not be as readily apparent as the mark on a light-skinned patient, but a dark blue or black marker will provide a discernible mark on any patient. If the mark is not visible and the staff or patient is concerned, a special-purpose wristband can be used in addition to the mark.

**Q: Other than a physician, what kind of privileged providers can mark a site?**

**A:** It must be a privileged provider that is scrubbed in as part of the OR team and scheduled to be in the OR for the procedure. Depending on local VA facility policies, privileged providers may include, for example, Podiatrists, Nurse Practitioners, and Physician Assistants.

**Q: What if the person who marked the site is not available to do the surgery?**

**A:** The absence of the person who marked the site is not a reason to cancel the operation. If the person who marked the site cannot participate in the surgery as planned, then the surgery should take place with another provider filling in, if this would normally occur. The change in staff should be documented and discussed in the "time-out" in the OR. It is expected that this would be an unusual occurrence.

**Q: What kind of mark is acceptable?**

**A:** We recommend that the physician or other privileged provider use their two or three letter initials. The use of an “X” is unacceptable because it is unclear, is this the side for the operation or the side to avoid? The most important thing is that the mark be unambiguous.

**Q. Where should we mark?**

**A.** The mark should be as close as possible to the site of the incision. A significant fraction of incorrect site surgeries are on sites close to the intended site, for example the wrong intervertebral space, the wrong finger on the correct hand, or the wrong side of the knee. Marking very close to the site (on the correct finger) rather than just in the general area (like the back of the hand for a procedure involving the finger) can help prevent some wrong site surgeries.

**Q: How about marking embarrassing sites?**

**A:** You must mark the site or very near to it. A surprising number of the incorrect surgeries in VA over the last three years have been to sites in the groin, genitals, or somewhere on the buttocks. Patients with illnesses or other medical problems in these areas are used to having themselves examined in otherwise private areas. If an awkward conversation is necessary to do this, contrast this with how unpleasant it would be to explain to the patient why the wrong side of his scrotum was operated on or why his hemorrhoid was removed when he was scheduled for surgery on his lower back. If the patient doesn't want his or her site marked then a special-purpose wristband can be used instead. A special purpose wristband can also be used when it is clinically impossible to mark a site due to broken skin, etc. A special purpose wristband should not be used instead of a mark solely based on convenience of the practitioner or reluctance of the practitioner to mark a site (in the absence of reluctance from the patient).

**Patient Identification: Asking the Patient Questions**

**Q. Why do we have to ask the patient to state their name instead of just having the patient confirm their name?**

**A:** People sometimes say "yes" or mumble affirmatively to incorrect information, such as a name that sounds similar to their own. Some patients are also hard of hearing or may not be listening carefully to what seems like another routine question. Making the patient state their name and other identifying information and having the nurse or other caregiver check the answers is a better approach and the required step.

**Q: Where and when should the patient identification step occur?**

**A:** We believe that the best time to do this is just before the patient is wheeled into the OR. This minimizes the chance of a patient mix-up occurring in a holding area or hallway after the patient has stated their identifying information but before they are brought into the OR. This is especially important in cases where a number of patients will be operated on in relatively quick succession and on the same general site, as in eye or knee procedures. The data suggest that eye operations are especially vulnerable to wrong-patient, wrong-side, and wrong-implant mix-ups - especially when the patient has disease on both sides but only one side is scheduled for surgery on that day.

**Time-Outs**

**Q: Does the patient have to be awake for this?**

**A:** No. The interactions at this point may involve only the personnel in the operating room, (i.e., anesthesia, nursing, and surgical staff.) If the patient is awake or lightly sedated, their participation is welcomed and encouraged.

**Q: How do we check the implant in the cases when it isn't supposed to be in the room at the outset of the procedure?**

**A:** Obviously you can't check what is not present. People should be aware of this special vulnerability. Separately, it is important to verify prior to starting the procedure that the implant/prostheses that may be required are readily available on-site in the immediate area. But having multiple implants, perhaps some from other cases, in the OR at the same time is a real vulnerability for wrong implant surgery.

**Checking Imaging**

**Q: What are we supposed to do when we check images?**

**A:** Check that it is the correct patient, correct site, correct image (for example a recent image rather than an old one), and that the image is oriented correctly and labeled as to the patient's identity and side. Two team members must be involved. One is the physician performing the procedure. The second confirming member does not need to be a physician.

**General**

**Q: Does this Directive apply to invasive procedures such as chest tubes?**

**A:** Yes. VHA Directive 1039 lists the invasive procedures to which the Directive applies.

**Q: Are wrong surgeries really a problem? How often does this really happen?**

**A:** This is not the biggest issue in patient safety, but it is not trivial. In 2001 in New York State a wrong surgery occurred at a rate of 1 in 15,500 surgeries. In VA in 2001 it was about 1 in 30,000 surgeries; that's about one a month. We cannot be satisfied with this rate. The VA National Surgery Office and the National Center for Patient Safety believe that these steps will significantly reduce the incidence of wrong surgeries in VA. We also hope that other organizations will find our approach useful.