**ASC Quality Collaboration**

**FAQ Scenarios/ Wrong Site Reporting Guidance**

**March 2024**

The definition of a wrong site surgery varies slightly across facilities, organizations and ASC management companies, but the definition consistently includes Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, and Wrong Implant. In addition, the definition includes “**not in accordance with intended site, side, patient, procedure, or implant”.**

Further interpretation of what constitutes a wrong site surgery is needed as individual cases are reviewed and reported. For cases in which the organizational processes failed in some way, analysis of the case must be conducted in order to identify needed improvements.

Additionally, consistent interpretation and reporting are needed to produce accurate benchmarking data. The ASC Quality Collaboration has assembled this FAQ document in an effort to promote consistency of reporting among all ASCs. The following are scenarios that highlight the need to analyze each case and assign it to the appropriate reporting category. The determination of categorization for each case was agreed upon by a workgroup of the ASCQC Technical Expert Committee in October 2023 and confirmed in February 2024.

**Scenario #1**

Patient A is expected, patient B is brought into the OR.  Prep and drape are started. Physician enters the OR and a time out is performed-the wrong patient mistake is identified. Lens and all documentation are swapped for patient in the room, no harm.  Should this be reported as a wrong patient or a near miss/good catch?

*This case would be reported as a* ***near miss/good catch*** *because the mistake was identified and everything was subsequently done correctly for the patient who was brought into the OR. There was no harm to the patient. The evaluation of the near miss should include a review of the process by which the wrong patient was brought into the OR.*

*Note AHRQ definition of near miss: Near miss: an unsafe situation that is indistinguishable from a preventable adverse event except for the outcome. A patient is exposed to a hazardous situation, but does not experience harm either through luck or early detection.*

**Scenario #2**

The OR is set up for patient A.  Pt B is wheeled in.  They are for the same procedure on the same side (no implant or the exact same implant).  Identity is discovered at the end of the procedure.  No harm occurred. Should this be reported as a wrong patient?

*Yes, this case would be reported as a* ***wrong patient*** *despite the fact that the procedure for which the patient consented was performed. However, all of the pre-op checks should have identified the incorrect patient prior to start of the case. The process needs evaluation and development of a corrective action plan to prevent similar incidents that could result in more significant outcomes.*

**Scenario #3**

Patient scheduled for cataract surgery on the left eye. Patient received two sets of drops in left eye. Provider administered one drop of compounded drop (phenylephrine, tropicamide lidocaine) in right eye just prior to procedure. Should this be reported as a wrong site?

*No, this would be reported as a* ***medication administration variance****. (correlates with language in the ASC Quality Collaboration Implementation Guide) found on the website at ascquality.org*

**Scenario #4**

Tropicamide 1% and phenylephrine 2.5% drops were given to patient in right eye. Should have been pilocarpine drop. Should this be reported as a wrong site?

*No, this would be reported as a* ***medication administration variance****.*

**Scenario #5**

Avastin Injection (not on ASC formulary) was administered to several patients. The medication was being transported from one location to another by the physician. The MD felt in her professional opinion that the medication was still at an adequate temperature for use. Should this be reported as a wrong site?

No, this would be reported as a **medication administration variance**.

**Scenario #6**

Right shoulder surgery was scheduled and consented for. The anesthesia provider, in error, injected the local anesthetic (block) in the left shoulder. Should this be reported as a medication error, or is this a wrong side?

*This would be reported as a* ***wrong side****. This is an invasive procedure that was intended for the right shoulder and the block was performed on the left.*

**Scenario #7**

An intraocular lens was placed in the patient and after insertion, it was identified to be the wrong lens. Prior to leaving the operating room, the incorrect lens was removed and replaced with the lens intended for the patient. Should this be reported as a near miss/close call or wrong implant?

*This would be reported as a* ***wrong implant*** *because an unintended lens was placed in the patient. The patient had to undergo a second procedure because of the error. The fact that the patient had not left the OR does not impact the determination of wrong implant vs close call/near miss.*

**Scenario #8**

Patient was scheduled for cataract removal/IOL. During the time out, an error in lens power was caught before it was placed in the patient. The correct lens was placed in the patient. Should this be reported as a wrong implant or a near miss/good catch?

*This would be reported as a* ***near miss/good catch****.*

**Scenario #9**

Following the insertion of an IOL, it was discovered that the lens that had been implanted was expired. The expired lens was replaced. Should this be reported as a wrong implant?

*The placement of an expired implant should be reported as a* ***wrong implant*** *event. Such an occurrence is not considered to be in accordance with the intended implant.*

**Scenario #10**

Tympanoplasty right ear with right ear skin graft was scheduled and consented for. Local injection for graft site was done behind left ear. Should this be reported as a medication error, near miss/close call, or wrong site?

*This would be reported as a* ***wrong site (wrong side)****. This is an invasive procedure that was consented to by the patient and intended for the right side.*

**Scenario #11**

Epidural Steroid Injection- The physician starts the procedure by inserting a needle and then identifies this is the incorrect side and proceeds to do the injection on the correct side. Would this be reported as a near miss/good catch or a wrong site?

*This would be reported as a* ***wrong site (wrong side)****. This is an invasive procedure that was* *consented for by the patient and intended for the other side.*

*Determination would be the same if injection of the local had occurred (not just insertion of needle).*

**Scenario #12**

Patient admitted for a Right Knee Replacement. In the OR, prior to closure of the incision, the incorrect tibial insert (poly) was handed to the surgeon for implantation. Even though the correct measurements had been used, the incorrect implant was inserted. The incorrect poly was removed, and the correct implant was inserted. Should this be reported as a near miss/close call or a wrong site?

*This would be reported as a* ***wrong site (wrong implant).*** *It did not involve an intentional decision to place the first (incorrect) implant. An error was made. See Scenario #12 below in which there was an intentional decision by the surgeon to place a second implant.*

**Scenario #13**

During an Orthopedic case, a screw is placed but then replaced with one that is determined by the surgeon to be a better fit. The screw was intentionally changed. Should this be reported as a wrong implant?

*No, this would not be reported as a wrong implant. The choice by the physician to change the screw was intentional and based on what was determined to be a better fit. The change did not result from an error in implantation of the first screw. This was an intentional change in the plan.*

**Scenario #14**

Patient is scheduled for a right carpal tunnel release, but the left side was done. It was not discovered until the surgery was complete. The patient was going to need the left one done in the future. Should this be reported as a wrong side?

*Yes, this would be reported as a* ***wrong site (wrong side)****. It was not the procedure that was consented for or intended to be performed that day, despite the fact that both sides were eventually going to be done.*

NOTES:

1. Regarding injections administered for local anesthesia, if a needle is inserted into the wrong site or side without injection of any medication, this should be reported as a wrong site/side. The intent was not to administer a local to that site. It would be reported the same way if the needle is inserted and local medication is administered to the wrong site.
2. If a physician changes the plan of care during the surgery based on what is best for the patient or incidental findings during the surgery, this is not considered an error/wrong site.
3. If the ASC receives incorrect information from a surgeon’s office, but the office does not realize or correct it until after the patient’s surgery, and the ASC performs the procedures as ordered, the ASC would not need to report this as a wrong. This assumes that all of the established safety checks were undertaken by the ASC staff.
4. Evaluation needs to take place on a case by case basis.