Patient Safety Alert

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Surgeries involving the wrong patient/body part/procedure and foreign objects retained following surgery present significant risk to patients, have the potential to cause significant harm, and can lead to future surgical procedures that would have been otherwise avoidable.

In Saskatchewan, critical incidents are reported to the Ministry of Health through the *Saskatchewan Critical Incident Reporting Guidelines, 2023*. Since 2019, 11 critical incidents involving the wrong body part/patient/procedure and 19 critical incidents of retained foreign objects were reported in Saskatchewan.

Surgery is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

In 2010, Accreditation Canada recognized the use of the surgical safety checklist as essential to patient safety and established it as a required organizational practice (ROP). A surgical safety checklist is used to confirm that safety steps are completed for all surgical procedures. Accreditation Canada surveys conducted in 2022 found that Saskatchewan health care organizations do not meet this ROP. To reduce the potential for erroneous and potentially harmful outcomes for patients, the use of a surgical safety checklist involving standardized best practices, surgical counts, and double-checks reduce the likelihood of harm to patients following surgery.

RECOMMENDATIONS

The Ministry of Health recommends the Saskatchewan Health Authority and health care organizations:

- **Develop and implement a provincial policy for surgical counts and use of a Surgical Safety Checklist.**
- **Implement the Surgical Safety Checklist in ALL areas that perform surgical procedures.**
- **Always check the signed consent form when confirming patient information (e.g., identity, surgical site, procedure).**
- **The definition of surgery needs to be expanded within the organization so that specific areas that traditionally do not consider procedures as surgical can be taken into account. This definition should be in line with the one provided above.**
- **Actively track and/or audit whether areas required to have the Surgical Safety Checklist are using it for all procedures, and whether it is utilized appropriately when used.**

Saskatchewan Health Authority Sask cancer AGENCY Saskatchewan

- **Ensure that all applicable CIs in these categories are reported to the Ministry of Health.**

SUPPORTING DOCUMENTS

- *Healthcare Excellence Canada, Never Events for Hospital Care in Canada,* 2015: https://www.healthcareexcellence.ca/media/eceoshdc/never-events-for-hospital-care-in-canada.pdf
- *ORNAC, Guidelines for Perioperative Practice in Canada,* 2025 (accessible only to those with access to the SHA library): https://library.saskhealthauthority.ca/az/ornac-standards
- *World Health Organization, Surgical Safety Checklist,* 2009: https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources

BACKGROUND

*Below are the summaries of 4 selected critical incidents. The examples are provided to give context, and do not represent an exhaustive list of all critical incidents in these areas.

Incident 1

During a procedure to remove screws from a patient's right ankle, an incision was made to the patient's left ankle instead. On the day of the surgery, the surgeon did not meet with the patient to review the procedure and mark the surgical site. The patient's chart indicated the procedure was to be performed on the incorrect ankle. Further, the surgeon did not wait for the Surgical Pause to be completed and made an incision into the patient's left ankle before the error was realized.

Incident 2

A patient experienced a complicated vaginal delivery that involved a postpartum hemorrhage requiring placement of a Bakri balloon. A surgical count was not performed. Approximately one month later, the patient presented to the emergency department with concerns of ongoing pain in her abdomen, fever, and chills. Further clinical investigation revealed a large laparotomy sponge had been left inside the patient at the time of her previous procedure.

Incident 3

During a surgical procedure in ambulatory care gauze was left in the patient's wrist. The surgical count performed only included the counting of sharps, not gauzes/sponges or other surgical equipment. The patient experienced severe ongoing swelling and pain for 4 months. Surgery for a query hematoma on his wrist revealed a 3 cm x 3 cm sponge has been retained in the surgical site.

Incident 4

Following two surgeries 11 months prior, a patient experienced continued abdominal pain. In both surgeries, the surgical count performed in the operating room was recorded as correct. A CT scan revealed a large (18" x 18") laparotomy sponge that had been previously retained. Surgery was required to remove the sponge.

SUMMARY OF CONTRIBUTORY FACTORS AND ANALYSIS

In incident 1, the surgeon did not meet their patient to review the procedure and mark the surgical site. Further, the surgeon did not wait the Surgical Pause to be completed. Surgical site verification and the Surgical Pause are intended to prevent wrong site, wrong side, or wrong patient surgery from occurring.

The surgical count is the process of accounting for all surgical items prior to starting a surgical procedure, intra-procedure, and post-procedure to ensure that no items have been left in the patient. As counting is

done manually, it is prone to human error. These errors can occur for many reasons, such as items constantly moving, items such as sponges sticking together once they become saturated, and distractions in the operating room.

In the second incident, a surgical count was not performed given the urgency of the situation and the patient's high acuity level. In the third incident, a surgical count was performed, but it was incomplete. In the fourth incident, a surgical count was performed, but it was incorrect. All three incidents were caused by a lack of adherence to best practices regarding surgical counts.