VRINDAVAN AYURVEDA CHIKITSALAYAM (Unit of R.P Garg and Associates) Shivalik Foothills, Village Thana, EPIP-2, Baddi, Himachal Pradesh – 173205	**Quality Operating Process**	**Document No: NABH/VAC/023**
	Wrong-Site, Wrong-Procedure, & Wrong-Patient Policy	**Date of Issue: 10/04/2022** **Issue No.: VAC/022** **Date of Revision: 10/04/2023** **Revision No.: 00**

SERVICE NAME :	**Wrong-Site, Wrong-Procedure, & Wrong- Patient Policy**
DATE CREATED :	**10/04/2022**
APPROVED BY :	**DR. AKANKSHA**
RESPONSIBILITY OF UPDATING :	**DR. AISHWARYA KAMAL**

AMENDMENT SHEET

S No.	Section and Page	Date	Amendment	Signature

A. Purpose:

To provide guideline instruction for ensuring uniform Wrong-Site, Wrong-Procedure, & Wrong- Patient.

B. Scope: Hospital Wide

C. Policy:

- Few medical errors are as vivid and terrifying as those that involve patients who have undergone Treatment on the wrong body part, undergone the incorrect procedure, or had a procedure intended for another patient.
- These "wrong-site, wrong-procedure, wrong-patient errors" (WSPEs) are rightly termed never events—errors that should never occur and indicate serious underlying safety problems.
- Wrong-site Treatment may involve Procedure on the wrong side, as in the case of a patient who had the right side of her vulva removed when the cancerous lesion was on the left, or the incorrect body site.

Preventing Wrong-Site, Wrong-Procedure, and Wrong-Patient Treatment

- Early efforts to prevent WSPEs focused on developing redundant mechanisms for identifying the correct site, procedure, and patient, such as "sign your site" initiatives, that instructed Procedure to mark the right site in an unambiguous fashion. However, it soon became clear that even this seemingly simple intervention was problematic.
- Root cause analyses of WSPEs consistently reveal communication issues as a prominent underlying factor.
- The concept of the Treatment timeout— a planned pause before beginning the procedure in order to review important aspects of the procedure with all involved personnel—was developed to improve communication in the operating room and prevent WSPEs.
- Although initially designed for Treatment room procedures, timeouts are now required before any invasive procedure.
- Comprehensive efforts to improve Treatment safety have incorporated timeout principles into Treatment safety checklists; while these checklists have been proven to improve Treatment and post procedure safety, the low baseline incidence of WSPEs makes it difficult to establish that a single intervention can reduce or eliminate WSPEs.
- Preventing WSPEs depends on the combination of system solutions, strong teamwork and safety culture, and individual vigilance.

Current Context

- Wrong-patient, wrong-site, and wrong-procedure errors are all considered never events by the National Quality Forum, and are considered sentinel events by The Joint Commission.
- Wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events (WSPEs) are devastating, unacceptable, and often result in litigation, but their frequency and root causes are unknown. Wrong-side/wrong-site, wrong-procedure, and wrong-patient events are likely more common than realized, with little evidence that current prevention practice is adequate.
- Wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events, although rare, are more common than health care providers and patients appreciate.
- Performing a procedure on the wrong side of a patient's body, performing a wrong procedure, or performing the correct procedure on the wrong patient constitute some of the worst medical errors that clinicians and patients experience.
- Although these events seem preventable, they continue to occur.
- We have few data on how often and why they occur and on why the safety mechanisms in place fail to prevent them.
- This report presents data demonstrating that there are many more wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events (WSPEs) than generally appreciated.
- The data indicate that current practices and guidelines for WSPE prevention are insufficient to prevent future events.

- We define a WSPE as any procedure that has been performed on the opposite side, incorrect site, or incorrect level of the body; is performed on the wrong patient; or is the wrong procedure.
- Wrong-side/wrong-site Treatment is the most infamous, but wrong-side anesthetic procedures also occur, and cases continue to occur outside the Procedure room in virtually all areas of health care.
- Wrong-procedure and wrong-patient errors might stem from different causes but often share a root error pathology related to ambiguous and imprecise identification.
- The similarity is often rooted in communication breakdowns or lack of safety systems that could have prevented these errors.
- A procedure performed on the wrong patient or wrong side is a wrong procedure, just as when procedure A is intended and procedure B is performed instead. Therefore, all such errors can appropriately be called WSPEs.
- The exact incidence and prevalence of WSPEs remains unknown.