

Wrong Site Spinal Injections, Not on My Watch!

Mr Oliver Flannery, Mr Paul Thorpe - Musgrove Park Hospital, Somerset.

Background

Wrong site surgery is a rare but potentially devastating event occurring with an incidence of 1 in 112994 operations ⁽¹⁾. Wrong site nerve blocks are reported to be even more frequent with an incidence of 0.52 to 7.5 per 10,000 blocks quoted in the literature ^(2,3). A number of preventative measures have been introduced including marking, WHO checklists and 'stop before you block' timeouts but never events such as this still occur.

This projects aims to highlight the experiences of our local unit and the changes we made to practice following a never event of wrong site spinal injection.



The Never Event Episode

In 2016 a wrong site spinal nerve root block was performed in theatres with a patient under conscious sedation. The patient had been marked and consented by the surgeon appropriately and the relevant WHO checklists carried out prior to the procedure. Despite these measures the needle was inserted in to the wrong side and it was only once the injection had started that the patient themselves pointed out the mistake and the needle was removed.

After the event some of the theatre staff and the anaesthetist reported they thought the surgeon may have been on the wrong side. They did not feel confident to challenge them at the time though and had doubts themselves given all the usual checks appeared to have been made pre-procedure.

The mistake was discussed in full with the patient and a formal apology made.

Implemented Change - The Watcher

Following an internal review a new system was introduced in addition to the usual checks – The Watcher.

This is a designated member of the theatre team who is actively briefed by the surgeon to speak up and challenge the surgeon if they are about to place the needle on the wrong side.

The Watcher is an empowered member of staff with no other theatre responsibilities at that moment In time.

They are positioned at the foot of the bed and a final check is made with them prior to needle insertion.

Moving Forwards

The Watcher system has been well received by all members of the team and has clearly influenced our practice. Over 1000 spinal injections have been performed since in theatres with no cases of wrong site injection.

We aim to expand the use of this simple but effective system around the hospital where we think it will be useful for peripheral nerve blocks and simple biopsies.

References

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