College of Physicians and Surgeons of British Columbia

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NHMSFAP Update

Patient safety incident review: ensuring correct surgical implant placement at non-hospital facilities [1]

The following information and recommendations are being shared to assist facilities in their efforts for continuous quality improvement.

The Non-Hospital Medical and Surgical Facilities Patient Safety Incident Review Panel recently reviewed an incident involving placement of a temporary single-use sizer instead of the permanent implant in breast augmentation surgery. The patient was returned to the operating room for removal of the sizer and placement of the permanent implant.

Contributing factors to this incident included:

- The packaging of the temporary sizer and permanent implant were similar.
- The sizer and implant were kept in the same area in the operating room.
- The use of a Keller funnel for placement may have obscured complete visualization of the prothesis being implanted.
- There was a lack of communication between the nurses and surgeon when passing the implant.

In reviewing the potential impact of the contributory factors on the patient safety incident, the panel made the following recommendations for the facility and others to consider:

- Required implants and sizers must be double checked prior to the procedure.
- Sizers and implants should be kept in separate areas of the operating room.
- Prothesis to be used during surgery must be reviewed as part of the Surgical Safety Checklist.
- A surgical pause should be observed to verify that the prothesis requested by the surgeon is the one being opened. This should be verified by the surgeon, the circulating nurse and the scrub nurse.
- There must be clear communication between the surgeon and nurse when passing the prosthesis.
- Prior to wound closure, the device identifiers should be verified to ensure that the correct prothesis has been placed.

The facility involved recognized the contributing factors and proactively initiated system changes. These changes and a draft policy were submitted with the patient safety incident report for review. All facilities must have a process in place to ensure the correct placement of a surgical prosthesis. Facility review and identification of contributing factors, and proposed changes to improve patient safety, should be initiated immediately and submitted with patient safety incident reports.

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