Case Example #2
Patient undergoes additional procedure after wrong lung biopsy

A patient was scheduled for a transbronchial biopsy of the right upper lung to obtain specimens for determining if a lung mass was malignant. The patient was consented for the bronchoscopy procedure (using fluoroscopy).

The consent only spoke to the procedure and did not include laterality.

The pulmonologist had just completed a left-sided needle biopsy on another patient prior to this procedure.

The more senior physician had a history of bumping cases.

Only one DRT was available for three OR suites. This was a known concern expressed to leadership in the past. Staff had grown accustomed to sharing tasks when the DRT was unavailable.

Each team member was focused on his/her specific task.

The more senior physician had a history of bumping cases.

Though correct laterality was noted on the whiteboard in the room, confirmation of laterality was not communicated during the time-out process as the consent was the document used to guide the time-out. There was no standardized process for what documents were used or how visual aids (such as the whiteboard and images) were incorporated to verify laterality, nor were there clear expectations as to who was expected to participate during the time-out process.

After the room was prepped, the pulmonologist entered the room and a time-out was performed.

The pulmonologist inserted the scope entering the left lung, obtaining biopsy specimens. The DRT entered the suite at this time to provide additional assistance with fluoroscopy. When the pulmonologist communicated completion of the left lung specimen collection, the DRT noted the discrepancy with the whiteboard, yet assumed it was the correct site as the images aligned with the pulmonologist's communicated location and no one else appeared concerned.

During the post-procedure debrief within the OR, it was discovered that the wrong lung had been entered. The patient was reprepped and the correct specimens were obtained.

Disclaimer: This case example is aggregated and is not representative of a single report or incident. Any likeness to an actual event is purely coincidental.
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The appointment was scheduled to be the first case of the morning; however, despite a full caseload that day, the case was delayed approximately one hour due to another physician’s need to use the endoscopy suite — bumping the procedure.

Pre-op verification was completed by the nurse. When the endoscopy suite became available, other cases were beginning to delay significantly, and the team felt a sense of urgency to turn over the room quickly. The circulating nurse set up the C-arm and laterality of images, as the diagnostic radiology technician (DRT) was in the next room assisting with the completion of another procedure. The images portrayed left side laterality, in error.

After the room was prepped, the pulmonologist entered the room and a time-out was performed. The pulmonologist inserted the scope entering the left lung, obtaining biopsy specimens. The DRT entered the suite at this time to provide additional assistance with fluoroscopy. When the pulmonologist communicated completion of the left lung specimen collection, the DRT noted the discrepancy with the whiteboard, yet assumed it was the correct site as the images aligned with the pulmonologist’s communicated location and no one else appeared concerned.

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RESOURCES

1. Joint Commission Center for Transforming Healthcare: Safe Surgery Targeted Solutions Tool®


4. The Joint Commission. Sentinel Event Alert #57, "The essential role of leadership in developing a safety culture," March 1, 2017


The Joint Commission: Quick Safety, Issue 34, "Daily safety briefings — a hallmark of high reliability," June 2017

Joint Commission Center for Transforming Healthcare: Facts about the Safe Surgery Project, November 2016