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## Rochester General Hospital Edition

MARCH 2010

### WRONG SITE SURGERY



Wrong site surgery is considered a preventable error involving a surgical procedure performed on the wrong patient, wrong body part, and/or wrong side of the body. It is one of the most devastating events related to patient safety, and has serious consequences for the patient, surgical team and health care system.

Approximately 40 wrong surgery cases happen every week in this country. If you would like copies of any of these articles, or if you would like further information on this topic, please contact any Library staff member.

"Learning from never events: one hospital's reaction to a wrong-site surgery." *Joint Commission Perspectives on Patient Safety*, 8(12):8-10, 2008 Dec.

"Strategies for complying with the time-out before surgery requirements." *Joint Commission Perspectives on Patient Safety*, 7(10):7-9, 2007 Oct.

"Time out! Conducting a final verification before surgery." *Joint Commission Perspectives on Patient Safety*, 9(6):1, 3-4, 11, 2009 Jun.

**Blanco M. Clark JR. Martindell D.**, "Wrong site surgery near misses and actual occurrences." *AORN Journal*, 90(2):215-8, 221-2, 2009 Aug.

**Catalano K.**, "Have you heard? The saga of wrong site surgery continues." *Plastic Surgical Nursing*, 28(1):41-4, 2008 Jan-Mar.

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**Goldberg AE. et al.**, "Attitudes of patients and care providers toward a surgical site marking policy." *Surgical Innovation*, 16(3):249-57, 2009 Sep.

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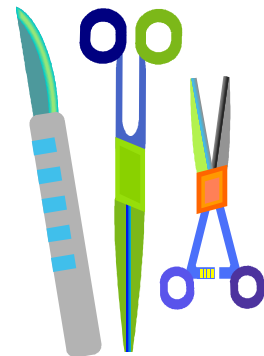
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**Michaels RK. et al.**, "Achieving the National Quality Forum's 'Never Events': prevention of wrong site, wrong procedure, and wrong patient operations." *Annals of Surgery*, 245(4):526-32, 2007 Apr.

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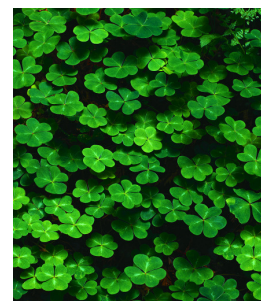


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