

Incorrect surgical procedures within and outside of the operating room: a follow-up report.

November 21, 2011

Neily J, Mills PD, Eldridge N, et al. Incorrect surgical procedures within and outside of the operating room: a follow-up report. Arch Surg. 2011;146(11):1235-9. doi:10.1001/archsurg.2011.171.

<https://psnet.ahrq.gov/issue/incorrect-surgical-procedures-within-and-outside-operating-room-follow-report>

This analysis of incorrect surgical procedures in the Veterans Affairs (VA) system found an overall decline in the number of reported [wrong-site, wrong-patient, and wrong-procedure errors](#) compared with the authors' [prior study](#). As in the earlier report, half of the incorrect procedures occurred outside of the operating room. [Root cause analyses](#) of errors revealed that lack of standardization and [human factors](#) issues were major contributing factors. During the time period of this study, the VA implemented a [teamwork training](#) program that has been [associated](#) with a significant decline in surgical mortality. The authors propose that additional, focused team training may be one solution to this persistent problem.