IJ Case Study

Ricardo, a Spanish speaking man that does not understand English well, presented to the ED on June 27th with shortness of breath and admitted to the hospital. He was diagnosed with CHF and COPD.

On June 29, a renal ultrasound was conducted and showed **left** renal cyst.

On July 3, a CT of the chest was conducted and showed a 4.3 X 5.3 cm **left** renal mass.

On July 6, a surgical consultation was obtained and the surgeon wrote "incidentally found **right** sided renal tumor measuring 4 by 5 cm. CT of chest and abdomen otherwise negative for metastases." The surgeon recommended "the patient will require a **right** radical nephrectomy. Due to his multiple comorbidities, he is at risk for post operative complications….."

On July 13, a physician's order was written as "please obtain consent for **right** radical nephrectomy. T.O. (Surgeon A) RN1." A consent form was obtained from the patient but the hospital failed to obtain the services of a Spanish speaking clinician to explain the treatment plans to the patient. The son who assisted the patient in signing the consent form informed the surveyor that they were not informed which kidney was to be removed.

The July 14th Intraoperative Nursing Record showed that the surgery started at 07:49 AM and ended at 09:18 AM. It showed further that the "operative site" was verified as "R", surgical time out "Surgical Site Confirmed." The operative procedure was recorded as "**right** radical nephrectomy"

The hospital's P & P showed that a "pre-procedure checklist is completed prior to surgery**." It requires "documents related to the procedure are available in the medical record** (i.e., imaging studies, lab results, consents, H & P, etc.)." The P & P further required "the anesthesiologist also verifies the correct patient, procedure, and site with the patient/parent/guardian/agent as applicable and **against one of the other documents available** such as consent, surgery schedule, physician's orders, H & P, or diagnostic films."

Review of the July 14th Anesthesia Record showed the pre-op diagnosis as "**Rt. Kidney CA**" and the surgical procedure performed as "**Rt. Radical nephrectomy**." The anesthesiologist told the surveyors on interview that he checked the consent form and matched it with the OR schedule, and both matched.

The Medical Staff Bylaws showed that "a practitioner providing clinical privileges at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Privileges granted to practitioners shall be evaluated on the basis of the member's education, training, experience, and demonstrated clinical competence, subject to approval by the appropriate Chair, Credentials Committee, Medical Executive Committee, and Board of Directors."

Review of the credential file of the surgeon showed that he was not credentialed to perform nephrectomies. The surgeon informed the surveyor during the interview that he "didn't realize I wasn't credentialed." The Medical Staff Clerk informed the surveyor during interview that the surgeon in question "has not had privileges for kidney surgery for the past 3 years." The OR keeps a binder with all physician privileges. The OR staff did not question it."

On July 14 at 4:00 PM, the Director of Quality System was called by the pathologist who stated that she was "looking at a specimen labeled right kidney" and there was no indication of a tumor. The pathologist and the DQS reviewed the medical record and discovered the error.