Case Study – Wrong Body Part
The patient name in this event is fictitious

Previous medical history
History of COPD and heavy smoker, with possible lung cancer. Recent CT scan noted left lung nodule.

Event description
Bud Larson, 82 year old male, presented for a left lung biopsy. After completion of the biopsy the patient complained of chest pain and was suspected of having a left pneumothorax. Patient was repositioned from prone to supine in an attempt to improve symptoms. Symptoms continued and were worsening and decision was made to place chest tube. The chest tube was placed but was discovered it was placed on the right side rather than the left side. A second chest tube was placed.

RCA discussion
The patient’s identification was confirmed per protocol. The informed consent indicated left lung biopsy. Source documents were available to the staff and were examined prior to the procedure.

The patient was positioned in the prone position for CT scan to confirm the location of the nodule. The location was verified in the left lung. A time out was done and the site marking was noted. The biopsy procedure was then started and went well. However, after the procedure the radiologist noted a pneumothorax that was enlarging on the left side forming from the biopsy site. The physician determined that chest tube placement may be needed to resolve the pneumothorax. The patient was placed in the supine position to hopefully seal off the site and stabilize the pneumothorax, but this was unsuccessful. The patient was noted to be increasingly symptomatic so the chest tube was placed.

When the radiologist re-imaged to confirm placement of the chest tube, it was noted that the pneumothorax was still present. The radiologist realized the chest tube had been placed on the wrong side.

When the patient was placed on his back, the site marking was no longer visible. Staff present during the procedure were each performing their individual responsibilities and were not aware of the details of what others were doing. Each trusted and assumed the other staff in the room would detect if anything was amiss. It was not routine for another time out to be performed in this situation. The staff did not take into account the impact of the patient’s position change on the chest tube placement. The staff remained on the same side of the patient’s body and continued with their work, not recognizing they had lost situational awareness of the correct side for the chest tube placement.
**RCA Exercise**

- Review the case study information
- Using the information provided, identify root cause statements for this event
- Refer to the RCA Resources in the Resource Guide including:
  - RCA Categories
- For any human factors or deviation from expected process, provide the preceding cause(s) as part of the root cause finding.

**Identify the possible RCA Statements for this event:**

**CAP Exercise**

- Review root cause findings
- Develop corrective actions and measurement strategy
- Refer to the Corrective Action Categories in the Resource Guide (Tab 4) as you develop your interventions
- Determine whether the corrective action proposed is a stronger action, an intermediate/moderate action or a weaker action.
- Determine the process and outcome measures for the action plan.

**Develop the Corrective Action Plan for this event:**