

AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, and Wrong-Procedure Events

POSITION STATEMENT

AORN believes:

- The recent increase in the number of reported procedural never events, including wrong-patient, wrong-site, and wrong-procedure events, should be a wake-up call for all.
- Health care professionals share an ethical and professional duty to provide safe care that supports optimal outcomes for all patients undergoing operative and other invasive procedures.
- Implementation of standardized evidence-based practices for the prevention of wrong-patient, wrong-site, and wrong-procedure events (ie, those described in the AORN Guideline for Team Communication¹) is imperative.
- Organizational policies and procedures designed to prevent wrong-patient, wrong-site, and wrong-procedure events should be rooted in evidence-based practice recommendations. These policies and procedures should be developed and maintained by interdisciplinary teams that include perioperative registered nurses (RNs), surgeons, anesthesia professionals, quality and risk professionals, and others identified by the organization.
 - Policies and procedures should include standardized practices that detail, at a minimum, preprocedure verification, site marking, and time-out procedures.
- Perioperative RNs are positioned as last-line advocates in their role of leading teams in completing the safe surgery checklist, ensuring that all patient elements are confirmed prior to the start of the procedure.
- Health care organizations and all perioperative professionals have a shared responsibility to cultivate a culture of safety that supports effective team communication and encourages speaking up.

RATIONALE

Wrong-patient, wrong-site, and wrong-procedure events are entirely preventable “never events,” yet they continue to occur² and, alarmingly, appear to be on the rise.^{3,4} The Joint Commission reported 127 wrong surgery events in 2024 (an increase from 112 in 2023), with most due to wrong-site/laterality errors—especially in nerve blocks and urologic procedures—underscoring the need for renewed vigilance across all settings where invasive procedures are performed.²

Additionally, post-pandemic procedural “never events” are on the rise as demonstrated by a global electronic health record study using the TriNetX network, which examined preventable procedural adverse events (ICD-10 codes Y62-Y69) across multiple regions from 2016 to 2024.³ This analysis revealed a significant 125% increase in preventable procedural adverse events, from 0.04 to 0.09 per 100,000 patients between 2016 and 2024, with a notable inflection point during the early post-pandemic period from June 2023 to the end of 2024.³

The Pennsylvania Patient Safety Reporting System (PA-PSRS), one of the largest event reporting databases in the United States, documented 315,418 reports of wrong surgery in 2024, representing a 9.5% increase over 2023.⁴ Hospital reporting rates reached 32.2 reports per 1,000 patient days, while ambulatory surgical facilities reported 11.4 reports per 1,000 surgical encounters.⁴ Recent analysis of PA-PSRS data specifically examining wrong-site events identified 1,166 reports of informed consent and schedule errors over 4 years, with 69% involving laterality errors, 24% procedure errors, 4% site errors, and 3% patient errors.⁵ Additionally, contemporary evidence continues to highlight significant underreporting due to cultural, procedural, and systemic barriers.⁶

Common contributing factors include failure to follow established policies or protocols and failure to review medical records.⁷ Implementing evidence-based, standardized verification strategies is critical to confirm the correct patient, surgical site, and planned procedure, and to prevent errors.^{1,8}

Despite appearing straightforward, implementation of this process in clinical settings can be complex and influenced by power dynamics, individual motivations, and organizational context.⁹ The successful adoption of error prevention strategies for wrong-patient, wrong-site, and wrong-procedure events requires shared team understanding, commitment, and alignment with standardized practices and the organization's culture.⁹ Therefore, preventing wrong-patient, wrong-site, and wrong-procedure events requires a comprehensive, interdisciplinary, organization-wide approach.^{1,8} Perioperative RNs are critical in this process and serve as key members of the interdisciplinary team in developing, performing, and advocating for correct site surgery policies, procedures, and protocols.¹ As patient advocates, perioperative RNs ensure that all elements of the standardized process—preprocedure verification, site marking, and time out—are consistently and correctly completed in collaborative procedures.

Wrong-surgery events persist across hospitals, ambulatory surgery centers, dentistry, interventional suites, and procedural areas outside the OR.¹⁰ National surveillance shows wrong surgeries remain among the top reported sentinel events, with the majority attributable to incomplete or ineffective time outs, policy non-adherence, and lack of a shared mental model across the team.² Consistent, high-fidelity use of the pre-procedure verification, site marking, and time-out steps—adapted to local workflows and reinforced by leadership—reduces preventable harm and strengthens patient and workforce trust.¹

Evidence-based practice recommendations are described in the AORN Guideline for Team Communication¹ and include developing a foundational culture of safety, structuring standardized preprocedure briefings, marking the surgical site, conducting a time out, and developing and implementing a standardized surgical safety checklist.

The number of wrong-patient, wrong-site, and wrong-procedure events underscores the growing need for awareness and heightened vigilance in patient and procedural identification processes.

Glossary

Never events: Adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and preventable. Never events include a surgical or other invasive procedure performed on the wrong site or the wrong patient, a wrong surgical or other invasive procedure performed on a patient, unintended retention of a foreign object in a patient after surgery or another invasive procedure, and intraoperative or immediate postoperative/post-procedure death in a patient classified as ASA Class I.

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Additional Resources

- Agency for Healthcare Research and Quality. Toolkit to Improve Safety in Ambulatory Surgery Centers. Accessed October 24, 2025. <https://www.ahrq.gov/hai/tools/ambulatory-surgery/index.html>
- Agency for Healthcare Research and Quality. What is patient safety culture? June 2024. Accessed October 24, 2025. <https://www.ahrq.gov/sops/about/patient-safety-culture.html>
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