

Correct Patient, Correct Procedure and Correct Site

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Functional Sub group Clinical/ Patient Services - Surgical
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Summary Steps that are to be taken to ensure that the indicated surgery/procedure is performed on the correct patient at the correct site and, if applicable, with the correct implant.

Replaces Doc. No. Patient Identification - Correct Patient, Correct Procedure and Correct Site Model Policy [PD2005_380]

Author Branch Quality and Safety

Branch contact Durham Bennett 9391 9200

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Community Health Centres, Dental Schools and Clinics, Public Hospitals

Audience All Staff

Distributed to Public Health System, Community Health Centres, Dental Schools and Clinics, NSW Department of Health, Public Hospitals

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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

CORRECT PATIENT, CORRECT PROCEDURE AND CORRECT SITE POLICY

Purpose

The purpose of this policy is to prevent incorrect patient, incorrect procedure, incorrect site incidents by describing the steps that must be taken to ensure that an intended invasive or diagnostic procedure including surgical operations, endoscopy, dentistry, radiology, nuclear medicine, chemotherapy and radiation therapy procedures are performed on the correct patient, at the correct site and, if applicable, with the correct implants/prostheses and equipment.

Introduction

Incorrect patient, incorrect procedure, incorrect site procedures and the use of incorrect implants/prostheses and equipment are relatively rare serious incidents in healthcare, and may be devastating when they occur, not only for the patient and their families or carers, but also for the staff involved.

In 2004, the NSW Department of Health introduced the [NSW Patient Safety and Clinical Quality Program](#)¹ for managing incident information and to publicly report to the community all serious incidents occurring in public health facilities. Under the *Program*, health services were required to implement and monitor compliance with the [Patient Identification, Correct Patient, Correct Procedure and Correct Site Model Policy \(PD2005_380\)](#) released in November 2004².

This policy was based on best practice principles identified by the Royal Australasian College of Surgeons (RACS), the Veterans Administration (VA) and Joint Commission on Accreditation of Healthcare Organisations (JCAHO) in the United States.

In 2007, the policy was reviewed and amended to address an increasing number of incidents notified in non-surgical areas. The review was undertaken with health service surgical services, radiology, nuclear medicine, radiation oncology, rural health, and oral health, the Greater Metropolitan Clinical Taskforce (GMCT) and The Royal Australian and New Zealand College of Radiologists (RANZCR).

This policy outlines key responsibilities and exceptions, and applies to all procedures that potentially expose patients to harm, including procedures performed in areas other than the operating theatre, such as dental, endoscopic, radiological clinics and rooms, and the ward.

The principles of the policy are applicable to all patient care procedures. Local guidelines and protocols should be developed at health service level to assist with implementation into areas covered by this policy.

¹ NSW Department of Health Patient Safety and Clinical Quality Program PD2005_608

² NSW Department of Health Patient Safety and Clinical Quality Program Implementation Plan PD2005_609

Title: Correct Patient, Correct Procedure and Correct Site Policy

Resources and tools to assist health services are available from the NSW Department of Health Quality and Safety website at <http://www.health.nsw.gov.au/quality/correct/tools.html>

This policy complies with all relevant NSW laws, NSW Health policy and other relevant publications.

Roles and responsibilities

The Chief Executive is responsible for:

- establishing structures to ensure appropriate implementation of this policy
- ensuring all line managers clearly understand they are accountable for effective implementation of the processes outlined in this policy
- ensuring that staff apologise when an incident occurs
- reporting as required to the NSW Department of Health.

The Director of Clinical Governance is responsible for:

- successful implementation of the policy within the organisation
- monitoring the ongoing frequency, incidence and investigation of incorrect site procedures as part of incident reporting systems
- initiation of regular audits to monitor compliance and ensure practices are being sustained

Hospital or Facility and/or Clinical Stream Managers are responsible for ensuring that:

- all steps outlined in the policy are implemented successfully in the hospital or clinical stream
- staff report incidents in accordance with the [Incident Management PD2007_061](#)
- line managers, including Directors of Nursing, Directors of Medical Services, and departmental managers, for example, Directors of Radiology and Imaging, Chief Radiographers, Managers of Operating Theatres and Nurse Unit Managers understand their accountability to ensure the policy is implemented
- there is feedback to staff about incident data and the outcomes of root cause analysis (RCA) drive practice change and to eliminate incidents
- there is continual monitoring of compliance with the policy.

Performance Indicators

The following process performance measure is to be developed and reported to the Chief Executive by the health service:

- Documented local policies and procedures consistent with this policy directive are in place in each health service by **31 December 2007**

Title: Correct Patient, Correct Procedure and Correct Site Policy

The following performance indicators are to be included in the quarterly reports to the local Health Care Quality Committee, and reported to the NSW Department of Health through the Sustainable Access Program (SAP) Performance Agreements:

- Antibiotic prophylaxis assessment at “Time Out” 100%
- Venous thromboembolism prophylaxis assessment at “Time Out” 100%

Principles

Incorrect patient, incorrect procedure, incorrect site incidents are preventable occurrences and largely the result of miscommunication and unavailable or incorrect information. Analyses of these cases indicate the major contributing factors are the lack of a standardised checking process and a degree of staff automaticity (checking without thinking) in the pre-procedure check routines³.

The following principles will ensure that the patient is safe and minimises the risk of system error:

1. There is line manager responsibility for ensuring that the correct patient, correct procedure and correct site process is followed.
2. Responsibility for ensuring correct patient, procedure and correct site verification rests with both the individual and with team members. The person in charge of the procedure carries ultimate responsibility for the verification process.
3. Active involvement and effective communication amongst all team members, as well as the patient or their “person responsible” will ensure success.
4. To the extent possible, involve the patient or their “person responsible” at all points in the verification process, during the informed consent process, and the marking of the surgical site to reconfirm with staff their understanding for the planned procedure.
5. Valid consent must be obtained for the procedure.
6. Patient identification must be verified at each step in the patient journey and prior to the procedure commencing.
7. Site marking is essential in cases where there is the potential for error involving left/right distinction, multiple structures (fingers, toes, or lesions) or levels (spine). Exceptions to site markings are listed in section 2.8.

³ [World Health Organization Collaborating Centre for Patient Safety Solution](#) May 2007 Performance of Correct Procedure at Correct Body Site

Title: Correct Patient, Correct Procedure and Correct Site Policy

8. If pre-procedure imaging data is to be used for the procedure, the data must be available and correctly identified before commencement of anaesthesia/sedation or the planned procedure.
9. If prostheses, implants, special equipment or medications are required for the procedure, they must be available before commencement of anaesthetic/sedation or the planned procedure.
10. The final patient safety check or “Time out” is undertaken and occurs immediately before the commencement of the planned procedure.

Key components

Key components of the policy are:

1. Pre-procedure verification process

- 1.1 Valid consent must be obtained for any procedure as directed by the [Consent to Medical Treatment—Patient Information PD2005 406](#) and must include correct identification of the body part involved. Where procedures or investigations are undertaken that do not require written consent, other documentation, for example, treatment plans or request forms/referrals must be completed according to codes or practice, policy or defined legislation and checked with the patient prior to the procedure being performed.

All treatment plans and request forms/referrals for procedures are to include the patient name, address, date of birth or medical record number (if applicable), sex, the procedure laterality and site, reason for the procedure, details of the examination/test/s required, the date the test/s were ordered, and the exact anatomical location for the test/s.

All required information on the request forms should be legible and complete, including a relevant clinical history (where requested) and the contact details of the requesting practitioner.

Where the details on the request form or referral are incomplete for the following:

- **Patient details**
The patient or their “person responsible” must provide the correct information prior to commencing the procedure.
- **Procedure details**
The requesting practitioner or a member of their team must be contacted to clarify the information on the request form/referral prior to commencing the procedure.

- 1.2 Abbreviations must **not** be used on the consent form, as specified in the [Consent to Medical Treatment—Patient Information PD2005 406](#). “Left”

or “Right” should be written in full on all documentation, including the consent form, request form for procedures and treatment plans. The only abbreviations and symbols to be used on other documentation are those endorsed and published by the facility/service (see the [Records - Principles for Creation, Management, Storage and Disposal of Health Care Records PD2005 127](#)) and the Federation Dentaire Internationale (FDI) notation for the recording of teeth.

- 1.3 The person performing the procedure must review the following data **after** the patient has been scheduled for their procedure and **prior to** commencing the procedure:
 - The consent form states the procedure site (including laterality, if applicable) and the name of the procedure. The consent form must not contain any abbreviations.
 - For radiation treatment, other documentation will outline the specific site treatment to be provided (see [Development of Prescription and Treatment Sheets for NSW Health Radiation Therapy Facilities PD2006 039](#)).
 - Where a consent form is not required (eg. for certain dental and radiology procedures), other documentation, such as treatment plans and request forms should be available.
 - Other relevant clinical information including documentation recorded electronically must be available prior to the planned procedure.
 - X-rays, other imaging and reports.
- 1.4 If the patient wishes to alter the content of the signed consent form after the administration of a pre-medication, the procedure should be postponed unless a life threatening or emergency situation exists.
- 1.5 Verification of the correct patient, correct procedure and correct site should occur:
 - at the time the procedure is scheduled and/or referral is written;
 - at the time of admission into the facility (if applicable);
 - any time the responsibility for care of the patient is transferred during preparation of the patient for their procedure;
 - prior to the competent patient receiving medication that could affect their cognitive function. This does not preclude the administration of analgesics if the patient’s clinical condition requires;
 - on entry to the procedure suite or treatment area;

Title: Correct Patient, Correct Procedure and Correct Site Policy

- immediately **before** entering the room in which the procedure will occur, or as soon as practicable **after** entering the procedural room but prior to the commencement of the anaesthesia/sedation (if applicable).
- 1.6 Verification should be documented in the patient's medical record.
- 1.7 The verification process means that the staff member must always:
- ask the patient to state their full name, date of birth and site and side of the planned procedure/s. If this is not possible, the patient's "person responsible" is to respond. Staff **must NOT** state the patient's name, date of birth and site and side of planned procedure/s and ask the patient/"person responsible" if this information is correct;
 - check the patient's stated name, date of birth and medical record number with the identification band, admission/consent and/or request form or treatment plans (where applicable);
 - confirm written consent for the planned procedure from the patient or "person responsible" has been completed (where applicable);
 - confirm x-ray and other imaging data is for the correct patient and are the correct images (where applicable);
 - confirm imaging data, prosthesis and implant is for the correct patient and that any implant/prosthesis required is the correct type, side and size (where applicable);
 - ensure that all the relevant documents and where applicable, prostheses/implants, any special equipment or medication are available **prior** to the commencement of the anaesthesia/sedation or the planned procedure/s;
 - ensure the above information has been reviewed and is consistent with the patient's and team's expectations and understanding of the intended patient, procedure, site, prostheses, implants, special equipment and medications where applicable;
 - ensure missing information or discrepancies are resolved before commencement of anaesthesia/sedation or planned procedure/s.
- 1.8 The verification process occurs in all settings and interventions involved in the preparation of the patient up to and immediately prior to commencement of the procedure.
- 1.9 The patient involved should be awake and aware during the verification process. If this is not possible, the reason should be documented.

Title: Correct Patient, Correct Procedure and Correct Site Policy

- 1.10 If the patient is incapable of participating in the verification process due to being comatose, competence or language issues, or is a child, their “person responsible” must verify the details. For this group of patients, if the patient has no “person responsible” present, a member of staff from the preceding location of the patient (for example, ward or emergency department) must act as the patient’s representative to verify the patient’s identification.
- 1.11 If the patient is unable to participate in the final verification step prior to the planned procedure/s due to being comatose, or has competence and/or language issues, then the patient’s identification bands should be used to check their identification.
- 1.12 Where applicable, the **patient’s identification band must be used to verify their identity.**
- 1.13 If the patient’s identification band is missing, the procedure must not commence until verification details are confirmed with the appropriate personnel.
- 1.14 A record of the individuals involved in the verification process should be made in the patient’s medical record.

2. Marking the procedure site

- 2.1 Site marking is essential in cases where there is the potential for error involving left/right distinction, multiple structures (fingers, toes, or lesions) or levels (spine). In these cases, where practical, the site should be marked except as per exceptions listed in Section 2.8. For certain radiotherapy treatments, the immobilising device may be marked.
- 2.2 The site must be marked by either the surgeon/proceduralist or nominated member of the team who is performing or assisting in the surgery or procedure, except in ocular surgery under prescribed circumstances, so that:
 - the intended site of incision, site of insertion or radiotherapy is **unambiguous;**
 - the mark is on or near the incision site or radiotherapy entry;
 - the mark is visible and sufficiently permanent so as to remain visible following skin preparation and draping;
 - at a minimum, all cases involving laterality, multiple structures (fingers, toes or lesions) or levels (spine) are marked;
 - marking takes place with the patient involved awake and aware, if possible, however, some paediatric patients may find this

Title: Correct Patient, Correct Procedure and Correct Site Policy

distressing and marking may be best done after the patient is anaesthetised;

- marking occurs before the patient enters the procedure room, except in an emergency.

2.3 For intra-ocular surgery where pre-operative mydriatic drops have been ordered, the correct site can be marked by a registered nurse, and the marking checked by a second registered nurse before the drops are given, in conjunction with the proper confirmation of the patient's identity, checking of the consent, and verbal confirmation by the patient or "person responsible" of the side to have surgery. The mark must be subsequently checked as the correct side for the surgery with the proper confirmation of the patient's identity, checking of the consent, and verbal confirmation by the patient or "person responsible", before the anaesthetic (regional or otherwise) is given and during the "Time out". These checks must involve the anaesthetist and operating surgeon, respectively.

2.4 The method of marking should be consistent throughout the organisation. Initials should **not** be used in marking.

2.5 If imaging data are used to confirm the site or procedure, the person performing the procedure or their nominated delegate must confirm with another member of the procedure team that:

- the images are correct and properly labelled;
- the patient's identity, the site of the procedure and the date of the image in relation to the procedure all match;
- the images are for the correct side of the body, oriented correctly, and labelled with the patient's name and date of birth.

2.6 Non-procedure sites must **not** be marked.

2.7 On completion, marking must be documented in the patient's medical record.

2.8 Exceptions

Site marking is not required, although it can be used, in the following circumstances:

- to avoid confusion, (for example, if a procedure requires a regional anaesthetic, then only the procedure site should be marked);
- for radiology procedures or investigations where marking the site could add to the ambiguity of subsequent procedures;

Title: Correct Patient, Correct Procedure and Correct Site Policy

- for single organ cases, (for example cardiac surgery, caesarean section);
- if the site is obvious, (for example open trauma wound, large tumour);
- for interventional cases where the catheter/instrument site is not predetermined, (for example, cardiac catheterisation, epidural/spinal analgesia/anaesthesia);
- where the site of surgical entry is unambiguous, (for example, midline incisions, cystoscopies, laparoscopies);
- when intra-procedure imaging for localisation, (for example, radiological, MRI, stereotaxis, ultrasound, radiation detection will be used);
- where the procedure site cannot be marked (eg. teeth). In these cases, relevant radiographs or other scans must, **if possible**, be marked to indicate the site. Where this is not possible, a diagram clearly indicating the site and side must be prepared and entered into the patient's medical record;
- for premature infants, and some oral and maxillofacial surgery, where marking may cause permanent tattoos;
- for multiple fractions of radiotherapy, where markings usually need only be done before the first fraction and only reapplied as necessary and where markings are applied to the immobilisation device rather than on the patient skin;
- where the patient refuses marking. Such refusal must be documented in the patient's medical record;
- in a life-threatening emergency where the patient enters the procedure room directly. This must be documented in the patient's medical record.

3. “Time Out” immediately prior to starting the procedure

3.1 “Time Out” is the *final patient safety check* undertaken **immediately before** commencing the procedure by the team or single operator involved in the procedure to ensure the correct patient, procedure, site, size, side/level, prosthesis, implant, any special equipment, prophylactic antibiotics, and that special medication/s and venous thromboembolism prophylaxis have been administered (if applicable).

3.2 “Time Out” must be conducted in the room where the procedure will be done. For surgical, interventional procedures, this will usually occur after the patient has been sedated or anaesthetised. All staff involved with the

Title: Correct Patient, Correct Procedure and Correct Site Policy

procedure must **STOP** and conduct a final verification. The person who initiates “Time Out” should be designated by the organisation.

- 3.3 Each participating member of the team, for example, clinicians, proceduralist, anaesthetist, radiologist, radiation oncologist, nurse and technician should independently verify the patient, procedure and site.
- 3.4 The final patient safety check during “Time Out” must involve the whole team and include, at a minimum:
 - correct patient identity;
 - agreement on the intended procedure to be done;
 - correct side and site/level;
 - confirmation of imaging data (where applicable);
 - availability of the correct prostheses/implant, including **type, side**, and/or any specialised equipment or requirements (where applicable). This must be confirmed by the person performing the procedure and with at least one other member of the procedure team;
 - venous thromboembolism prophylaxis assessment (where applicable);
 - prophylactic antibiotic assessment (where applicable);
 - if applicable, check that special medication/s have been administered.
- 3.5 Success is reliant on active communication amongst all members of the procedure team. “Time Out” must be initiated and completed by a designated team leader. This should be the most senior proceduralist present. It is the team leader’s responsibility to ensure that “Time Out” is completed. The procedure should not commence until all team members are satisfied that the patient verification process has been completed and that patient verification is correct.
- 3.6 All members of the procedure team share responsibility for ensuring that “Time Out” occurs. This means that if the team leader fails to initiate “Time Out” for any reason, team members all share responsibility for reminding the team leader that it should happen.
- 3.7 For single-operator procedures, for example, in radiology departments, the operator must **STOP** and verify all the minimum requirements immediately before commencing the procedure.

Title: Correct Patient, Correct Procedure and Correct Site Policy

- 3.8 The result of the “Time Out” process must be documented in the patient’s medical record. A suggested template is attached at Appendix A.
- 3.9 Where discrepancies are noted or disagreements occur in verification at “Time Out” or at any point in the patient journey, the procedure must be delayed until the issues are resolved. Only for reasons of clinical urgency should the procedure commence. The justification for proceeding in the presence of such discrepancies must be documented, by the proceduralist, in the patient’s medical record as soon as the procedure is completed and an incident report must also be completed.
- 3.10 Where previous verification steps have occurred satisfactorily but a discrepancy in information or disagreement in verification occurs at “Time Out”, an incident report should also be completed even if the issues are resolved satisfactorily.
- 3.11 If disagreement occurs in an extreme emergency situation, the most senior member of the procedure team is responsible for the care of the patient and should decide the most appropriate course of action.
- 3.12 The above processes should not preclude the use of discretion by the treating proceduralists to alter the procedure for reasons of clinical judgement. However, significant changes to the documented procedure must be communicated to all members of the procedural team and recorded in the patient’s medical record.
- 3.13 Each organisation must have a process in place for resolving disagreements in the management of patient identification.

4. In the event of a serious incident

- 4.1 If the patient’s condition permits, an immediate plan to rectify the error should be made by the most senior member of the procedure team. Wherever possible, the patient and the patient’s family should be involved in the management plan.
- 4.2 An apology and explanation of the incident must be given to the patient and family in accordance with the [Open Disclosure PD2007_040](#).
- 4.3 An incident report and Reportable Incident Brief (RIB) must be completed and an appropriate review undertaken, as indicated in the [Incident Management PD2007_061](#).
- 4.4 Appropriate details must be recorded in the patient’s medical record.
- 4.5 The serious incident must be discussed at appropriate patient safety or clinical review meetings.

Title: *Correct Patient, Correct Procedure and Correct Site Policy*

Key definitions

Serious incident	An incident in which harm resulted to a person receiving health care.
Must	“Must” means that the requirements stated in this policy are mandatory and must be carried out.
Should	Refers to recommended best practice, but allows a degree of flexibility when applied in the health service
Organisation	Any NSW Health facility where a procedure is performed.
Procedure	For the purpose of this policy, the term “procedure” includes all surgical, dental surgical, radiological, radiation therapy, radionuclide therapy, chemotherapy or endoscopic manoeuvres that potentially expose a patient to harm or risk. It does not include ultrasound investigations, placement of a peripheral venous cannula or taking of blood.
Person performing the procedure	This is either the surgeon/proceduralist or a nominated member of the team who is performing or assisting in the procedure.
“Person responsible”	If a person is less than 16 years of age or is 16 years of age or over and incapable of giving consent, the provisions of the Guardianship Act 1987 apply and the consent of the patient’s “person responsible” may then be required. The Act establishes a hierarchy for determining who is the “person responsible”. See Consent to Medical Treatment—Patient Information PD2005 406 for details.
Procedure team	Includes all professionals participating in the delivery of care during the surgery/procedure or delivery of radiotherapy treatment.
“Time Out”	Is the suspension of activity immediately before commencing the procedure by the team or single operator involved in the procedure to undertake a final verification of the correct patient, procedure, site, size, side/level, prosthesis, implant, any special equipment, prophylactic antibiotics, special medication/s and venous thromboembolism (VTE) prophylaxis have been administered (if applicable).
Incorrect site procedure	A procedure performed on the incorrect area of the body of a patient or on the incorrect patient. This can occur for any procedure but is more likely in patients undergoing orthopaedic, spinal, urological, ophthalmic, ENT, dental, radiotherapy and radiology procedures.
Venous thromboembolism (VTE) prophylaxis	The intention of this is that each patient will be assessed for the need for venous thromboembolism prevention measures and that, if needed, they have been provided.
Prophylactic antibiotics assessment	The intention of this is that each patient will be assessed for the need for prophylactic antibiotics and, if needed, these have been administered.

Information Resources

NSW Department of Health Policy Directives and Guidelines

- [Consent to Medical Treatment—Patient Information - PD2005_406](#)
- [Operating Suite & Other Procedural Areas - Handling of Accountable Items - Standard Procedures - PD2005_571](#)
- [Development of Prescription and Treatment Sheets for NSW Health Radiation Therapy Facilities - PD2006_039](#)
- [Records - Principles for Creation, Management, Storage and Disposal of Health Care Records - PD2005_127](#)
- [Medical Records in Hospitals and Community Care Centres PD2005_004](#)
- [A framework for managing the quality of health services in NSW PD2005_585](#)
- [Clinician's Toolkit for Improving Patient Care - GL2005_062](#)
- [Safe Introduction of New Interventions \(Model Policy\) - PD2005_333](#)
- [Easy Guide to Clinical Practice Improvement, 2002](#)
- [NSW Patient Safety and Clinical Quality Program - PD2005_608](#)
- [NSW Patient Safety and Clinical Quality Program – Implementation Plan PD2005_609](#)
- [Incident Management - PD2007_061](#)
- [Online Easy Guide to Clinical Incident Management](#)
- [Reportable Incident Definition under section 20L of the Health Administration Act - PD2005_634](#)
- [Complaint or Concern about a Clinician - Principles for Action PD2006_007](#)
- [Complaint or Concern about a Clinician - Management Guidelines - GL2006_002](#)
- [Open Disclosure - PD2007_040](#)
- [Open Disclosure Guidelines - GL2007_007](#)
- [Lookback Policy - PD2007_075](#)
- [Complaint Management Policy - PD2006_073](#)
- [Complaint Management Guidelines - GL2006_023](#)
- [Safety Alert Broadcasting System - PD2006_102](#)

NSW Department of Health Quality and Safety websites

- Intranet: <http://internal.health.nsw.gov.au/quality/>
 - Internet: <http://www.health.nsw.gov.au/quality/>
 - [Correct Patient, Correct Procedure, Correct Site](#)
<http://www.health.nsw.gov.au/quality/correct/>
 - [Lessons Learned in Quality and Safety](#)
<http://internal.health.nsw.gov.au/quality/lessons/>
 - [Safety Alert Broadcasting System](#)
<http://www.health.nsw.gov.au/quality/sabs/register.html>
- Email: quality@doh.health.nsw.gov.au

Title: Correct Patient, Correct Procedure and Correct Site Policy

Appendix A – Template Time Out Checklist for Surgical Procedures

Overleaf.

Time Out Checklist for Surgical Procedures

If the checklist is **NOT COMPLETED** or any check is **INCORRECT**, record in **IIMS** and the reason(s) **why not**.

Patient's name	Label
Date of birth/Sex	
MRN	
Ward	

The most senior proceduralist in theatre leads the completion of the following checklist. Time Out is to be completed immediately before the surgery or procedure starts.

Correct patient?	<input type="checkbox"/> yes	
Correct procedure?	<input type="checkbox"/> yes	
Correct Site / Side / Level?	<input type="checkbox"/> yes	
Site marked?	<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> n/a
Imaging data confirmed?	<input type="checkbox"/> yes	<input type="checkbox"/> n/a
Correct implants / prostheses (Type / Size / Side) are available?	<input type="checkbox"/> yes	<input type="checkbox"/> n/a
Any special equipment needed is available?	<input type="checkbox"/> yes	<input type="checkbox"/> n/a
Does the patient need antibiotic prophylaxis? <i>If yes, has it been given?</i>	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no
Does the patient need Venous Thromboembolism prophylaxis? <i>If yes, are graduated stockings on?</i> <i>Are compression device(s) attached and on?</i> <i>Has preoperative Subcutaneous LDU / LMW* Heparin been given?</i>	<input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> n/a <input type="checkbox"/> n/a <input type="checkbox"/> n/a
Does the patient need any special pre-operative medications? <i>If yes, have they been given?</i>	<input type="checkbox"/> yes <input type="checkbox"/> yes	<input type="checkbox"/> no

* Low Dose Unfractionated / Low Molecular Weight

Date	/	/	Time (24hr)	:	Time Out Lead by	Form completed by
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Record the results of Time Out in the patient's Operating Suite Nursing Record.

Place this checklist in the patient's medical record.