

INTERVENTIONAL PROCEDURE CORRECT PATIENT VERIFICATION CHECKLIST

SURNAME		MRN/AUID		
FIRST NAMES				
DOB	SEX	WARD	VMO	

PRE-PROCEDURE BASELINE OBSERVATIONS (Date) (Time)hrs Nurse Initial

T:°C P: R: B.P:/..... SpO₂:% BSL/BGL: Weight:kg Height:cm

ALLERGIES / REACTIONS TO DRUGS, FOODS OR OTHER PRODUCTS: Y Nil known allergies

If YES specify in red pen:

Known infection risk: N/A MRSA MRAB TB VRE UNSURE

STAFF IDENTIFICATION

*All Health Care Professionals making an entry onto this patient verification checklist are required to complete this identification form.
You only need to identify your initials / signatures once.*

1.	Date:	Location:	Designation:
	Time:	Name:	Signature: Initial:
2.	Date:	Location:	Designation:
	Time:	Name:	Signature: Initial:
3.	Date:	Location:	Designation:
	Time:	Name:	Signature: Initial:
4.	Date:	Location:	Designation:
	Time:	Name:	Signature: Initial:

COMPLETE EVERY TIME PATIENT CARE IS TRANSFERRED

and initial in the corresponding column

INITIAL PATIENT VERIFICATION COMPETENCE

Is the patient **able** to participate verbally in the verification process independently Yes No

If no, who is the person legally participating in the verification process: **Name:**

PATIENT IDENTIFICATION		1	2	3	4	5
Patient asked & able to state full name	Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient asked & able to state date of birth	Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient able to state procedure/surgery, side and site to be performed	Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient asked & able to point to the site	Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient Front / Admission / Identification Sheet is present	Y <input type="checkbox"/> N <input type="checkbox"/>					
ID & Allergy / Allergy ID band has been applied <i>checked & correct</i>	Y <input type="checkbox"/> N <input type="checkbox"/>					
Minimum 20 ID Labels	Y <input type="checkbox"/> N <input type="checkbox"/>					
CONSENT FORM is complete and contains documentation of:						
• The procedure/operation	Y <input type="checkbox"/> N <input type="checkbox"/>					
• Contains no abbreviations	Y <input type="checkbox"/> N <input type="checkbox"/>					
The consent is signed by the patient or a legal representative	Y <input type="checkbox"/> N <input type="checkbox"/>					
The consent is signed by the Surgeon / Proceduralist	Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient response is consistent with consent form	Y <input type="checkbox"/> N <input type="checkbox"/>					
WARD CHARTS <input type="checkbox"/> OLD NOTES <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>					
ECG <input type="checkbox"/> Pathology Results Available <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>					
IMAGING DATA With patient <input type="checkbox"/> Other location <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>					
PROCEDURE SCHEDULE / THEATRE LIST	Y <input type="checkbox"/> N <input type="checkbox"/>					
Is the listed procedure consistent with patient response and consent from documentation	N/A <input type="checkbox"/>					
PROCEDURE / SURGICAL SITE MARKING	Y <input type="checkbox"/> N <input type="checkbox"/>					
Is marked by the Surgeon / Proceduralist	Y <input type="checkbox"/> N <input type="checkbox"/>					
Marking is consistent with consent form	Y <input type="checkbox"/> N <input type="checkbox"/>					
OPERATIVE SITE Prepared and checked	Y <input type="checkbox"/> N <input type="checkbox"/>					
FASTING STATUS Time last ate hrs Time last drank hrs						
BLADDER Voided <input type="checkbox"/> Catheterised <input type="checkbox"/> Wet nappy <input type="checkbox"/> (time) hrs						

**BINDING MARGIN
DO NOT WRITE**

SURNAME		MRN/AUID	
FIRST NAMES			
DOB	SEX	WARD	VMO

	1	2	3	4	5
PREMEDICATION	Y <input type="checkbox"/>	N <input type="checkbox"/>			
PERSONAL ACCESSORIES <i>Removed</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>			
Glasses <input type="checkbox"/> Hairclips <input type="checkbox"/> Jewellery <input type="checkbox"/> Personal Effects <input type="checkbox"/>					
Make-up <input type="checkbox"/> Body Jewellery <input type="checkbox"/> Nail Polish <input type="checkbox"/> Other					
CLOTHING Patient prepared in procedural attire	Y <input type="checkbox"/>	N <input type="checkbox"/>			
PROSTHESIS Other					
Hearing Aid <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Eye <input type="checkbox"/> Wig <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>			
Implants <input type="checkbox"/> AV Shunt <input type="checkbox"/> Orthopaedic <input type="checkbox"/>					
DENTURES	Y <input type="checkbox"/>	N <input type="checkbox"/>			
Full - Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial - Upper <input type="checkbox"/> Lower <input type="checkbox"/>					
Location: Home <input type="checkbox"/> Insitu <input type="checkbox"/> In Ward <input type="checkbox"/> In Cup <input type="checkbox"/>					
TEETH Loose <input type="checkbox"/> Capped <input type="checkbox"/> Chipped <input type="checkbox"/> Crowns <input type="checkbox"/> Bridges <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>			
PRESSURE AREA ASSESSMENT: <i>please tick appropriate scale</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>			
Waterlow Score <input type="checkbox"/> Braden Score <input type="checkbox"/> PSPS <input type="checkbox"/>					
Score: Score: Score:					
SKIN DESCRIPTION:					

DISCREPANCIES

If there is a discrepancy in any part of the patient verification process the following interventions are to occur. Document discrepancies in the Patient Medical Record and complete a near miss and/or incident form. If a discrepancy cannot be rectified the procedure should be delayed until resolved.

Is there any **DISCREPANCY** in the interventional procedure correct patient verification checklist? Y N

If answered Yes - has the surgeon/proceduralist being notified? N *please notify ASAP* Y *complete following*

Proceduralist/Surgeon name: *notified at (time) hrs on (date) initial*

Has the Surgeon/Proceduralist rectified the discrepancy and verified site and side and communicated with team?

N *Document in Patient Medical Record* Y *rectified at (time) hrs on (date) initial*

Has the completion of a near miss/incident form been attend and documented in Patient Medical Record? Y N

Comments:

PROCEDURAL AREA/OPERATING SUITE ONLY

Additional equipment/implants available?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Nurse Signature:		
CORRECT PATIENT & TIME OUT DETAILS				Y	N
TIME OUT ATTENDED Called at (time) hrs					
STAFF INVOLVED: <input type="checkbox"/> Instrument/Procedure Nurse <input type="checkbox"/> Circulating Nurse <input type="checkbox"/> Anaesthetist					
<input type="checkbox"/> Proceduralist/Surgeon <input type="checkbox"/> Procedural Assistant <input type="checkbox"/> Anaesthetic Nurse					
ID band insitu			<i>Checked and correct</i>		
ALLERGIES / Allergy ID band insitu			<i>Checked and correct</i>		
CONSENT FORM contains Procedure/Operation					
Side					
No Abbreviations					
Is signed by patient or a legal representative					
Is signed by Surgeon/Proceduralist					
PATIENT INVOLVEMENT Y <input type="checkbox"/> N <input type="checkbox"/> Patient Anaesthetised Y <input type="checkbox"/> N <input type="checkbox"/>					
Patient able to state full name					
Date of birth					
Patient able to state procedure/surgery, side and site to be performed					
Patient able to point to the site					
PROCEDURAL/SURGICAL TEAM AGREEMENT on the intended procedure/surgery to be done					
SITE MARKED Procedure/Surgical site is marked					
Procedure/Surgical site mark is consistent with consent form					
IMAGING DATA Confirmation of imaging data					
ADDITIONAL EQUIPMENT/PROSTHESIS available					
COMMENTS PERTAINING TO TIME OUT:					
<i>Near Miss or Incident reported to in-charge nurse</i> Y <input type="checkbox"/> N <input type="checkbox"/>					
Name of person who initiated time out:					

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DO NOT WRITE