

SSWAHS CLINICAL GOVERNANCE UNIT

Patient Identification - Correct Patient, Correct Procedure and Correct Site Policy

Expected Outcome

All staff within SSWAHS will take the necessary steps to ensure that the intended surgery/procedure is performed on the correct patient at the correct site and, if applicable, with the correct type and size of prosthesis or implant.

Policy Statement

Responsibility for ensuring correct person, correct procedure, correct site and correct type and size of prosthesis verification rests with all team members. However, the person in charge of the interventional procedure carries ultimate responsibility.

Active involvement and effective communication among all members of the surgical or procedural team as well as the patient (or authorised representative) is essential for success.

Definitions

Adverse event – an adverse event is an incident in which harm resulted to a person receiving health care.

Incident – an incident is an event or circumstance which could have, or did, lead to unintended and/or unnecessary harm (death, disease, injury, suffering and/or disability) to a person, and/or a complaint, loss or damage.

Interventional procedure – a procedure involving any invasive contact with a patient. Examples include surgical operations, endoscopy, dentistry and certain radiological procedures.

Person performing the procedure – this is either the surgeon/proceduralist or his/her delegate who is performing or assisting in the surgery or procedure.

Procedure team – the procedure team includes all health professionals participating in the delivery of care during the surgery /procedure.

Wrong site procedure – a procedure performed on the wrong area of the body of a patient or on the wrong patient. This can occur at any procedure but is more likely in patients undergoing orthopaedic, spinal, urological, ophthalmic, ENT and dental procedures.

Principles

Valid consent must be obtained for the procedure (NSW Department of Health Policy Document 2005_406) and this should directly identify the body part involved.

'Left' or 'Right' should be written in full on all documentation. The only abbreviations and symbols to be used are those endorsed and published by the facility / service.

The person performing the interventional procedure must review the following data after scheduling the patient for the procedure and prior to the procedure:

- x-rays and other imaging reports
- pre-procedure history and other clinically relevant material (consults, progress notes, pathology etc)
- consent form stating the procedure site, including laterality if applicable, name of the procedure and reason for the procedure

Site marking is essential in cases where there is potential for error involving left / right distinction, multiple structures (fingers, toes, lesions) or levels (spine). To the extent possible, the patient (or their authorised representative) should be involved in site identification.

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These guidelines apply to all operative and other invasive procedures including those undertaken outside the operating room including dental procedures.

These procedures are in addition to those already in place for the establishment of patient identity, planned operation/procedure and consent at the perioperative unit, the hospital ward and arrival at the operating room reception.

Procedure

1. Consent Form & Procedure Request Documentation

Consent form, Recommendation for Admission form, Emergency Booking forms and Operating Theatre Lists must include:

- The patient's full name and medical record number or date of birth.
- The name of the procedure, the correct site (using precise anatomical location, eg specific vertebral body or finger) and, if applicable, side (ie "left" or "right") and/or level. Only approved abbreviations may be used.
- The proceduralist or their delegate must wholly complete the consent form and the operation details on the Recommendation for Admission form (if applicable).

Except in cases of emergency surgery, Consent forms must be completed prior to the patient entering the operating theatre.

2. Pre-Procedure Verification

All departments involved in preparation of the patient prior to a procedure, including pre-admission units, peri-operative units and patient wards must have procedures in place whereby the above documentation is cross-checked with any relevant clinical notes with the patient (where possible) or their authorised representative and with the patient's identification armband to confirm the patient identification and the site, side and / or type of surgery.

For non-English speaking patients an appropriate interpreter, accompanying family member or friend should confirm the above where practical.

The above verification of the correct person, procedure and site should occur:

- at the time the procedure is scheduled
- at the time of admission into the facility (if applicable)
- anytime the responsibility for care of the patient is transferred
- during preparation of the patient for their procedure
- on entry to the procedure suite
- just 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 anaesthetic.

At each verification staff must always ask the patient /authorised representative to state:

- their full name
- their date of birth
- the site (and side) of the procedure

Staff must NOT state the patient's name, date of birth and procedure and ask them if this information is correct.

All the documentation referring to the patient and the intended procedure, including **consent forms**, **admission notes** and **identification bands**, must be checked and be consistent with each other, with the patient's and team's expectations and understanding of the intended patient, procedure, site and implants (if applicable).

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In the operating theatre/procedure suite, confirmation that this process has been undertaken prior to the patient entering the procedure room (or as soon as practical after entering the procedure room) and must be documented in the medical record or on the operating theatre pre-operative check list.

Notes:

- The preparation of the competent patient for a procedure should be completed before they receive any medication that could affect their cognitive function. This does not preclude the administration of analgesics if the patient's clinical condition requires it.
- Should the patient wish to alter the content of the signed consent form after the administration of a premedication, the procedure should be postponed unless a life threatening or emergency situation exists.
- For patients transferred from locations within the hospital who are incapable of personally participating in the verification process and with no authorised representative present, a member of staff from the preceding location (eg ward or Emergency Department) must act as the patient's representative for the verification.
- If the patient is unable to participate in the final verification step (due to competence or language issues), then the patient's identification bands should be used to check their identification.
- Where there are discrepancies in information or disagreements in verification, the procedure should normally be delayed until the issues are resolved. This decision should be in keeping with the degree of urgency of the procedure. If disagreement occurs in an extreme emergency situation, the most senior member of the procedural team is responsible for the care of the patient and should decide the most appropriate course of action. The justification for proceeding in the presence of such discrepancies must be documented in the patient's medical record and an incident report completed.

3. Marking the procedure site

Site marking is essential in cases where there is potential for error involving left / right distinction or multiple structures (fingers, toes, lesions) or levels (spine). In these cases the site should be marked with an indelible skin marker wherever practical or as per exceptions listed on page 4.

The site must be marked by the person performing the interventional procedure so that:

- the intended site of incision or site of insertion is **unambiguous**
- the mark is **on or near the incision site**
- the mark is **visible and sufficiently permanent** so as to remain visible following skin preparation and draping
- where practical, marking should take place with the patient involved awake and aware. Some paediatric patients may find this distressing and marking may be best done after the patient is anaesthetised.
- marking should occur before the patient enters the procedure room. The patient should not enter the procedure room until this has been completed except in an emergency,

If imaging data are used to confirm the site or procedure, two or more members of the procedure team must confirm the images are correct and properly labelled. One member of the team for this purpose must be the proceduralist. Strong preference must be given for the second person to have appropriate interpretive skills for the image involved.

Do not mark non-procedure sites.

Once appropriate marking has been completed this must be documented in the medical record or operating theatre nurses report ("count sheet").

Exceptions:

- to avoid confusion if a procedure requires a regional anaesthetic then only the procedure site should be marked

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- interventional cases for which the catheter/instrument site is not predetermined (eg cardiac catheterisation, epidural/spinal analgesia/anaesthesia, etc)
- where the procedure site cannot be marked (eg teeth), 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)
- premature infants where marking may cause permanent tattoos
- if the site is an obvious surgical site, (eg, traumatic site)
- where the site of surgical entry is unambiguous, (eg midline incisions, cystoscopies, laparoscopies)
- when intra-procedure techniques for localisation will be used (eg radiological, MRI, stereotaxis, ultra-sound, radiation detection)
- where the patient refuses marking (this must be documented in the medical records)
- in a life-threatening emergency where the patient enters the procedure room directly. The patient's medical record must be documented as indicated on page 5.

4. 'Time Out' immediately prior to starting the procedure

This must be conducted in the room where the procedure will be done, immediately before starting the procedure (this will usually occur after the patient has been anaesthetised). All participating clinicians (eg proceduralist, anaesthetist, nurses) must STOP and independently verify, at a minimum:

- correct patient identity
- agreement on the intended procedure to be done
- part of body for procedure
- side of procedure (where relevant) and/or level of procedure (where relevant)
- confirmation of imaging data and
- availability of any required prostheses or implants (correct **type**, **side** and **size**) and/or any specialised equipment or other requirements must be confirmed by the proceduralist and the assisting nursing staff.

Success is totally dependant on active communication amongst all members of the procedure team. The most senior proceduralist present should consistently initiate 'Time Out'. The procedure should not be commenced until all questions or concerns are resolved. It is the responsibility of the most senior proceduralist present to ensure this is done.

The result of the 'Time Out' process must be documented in the medical record or operating theatre nurses report ("count sheet").

5. Disputed Patient or Site Protocol

If the team is unable to reach full agreement as to the correct patient, site or side, the operation should be abandoned and the patient returned to the ward or pre-operative unit. ***Only for reasons of urgent clinical need should the procedure commence and the proceduralist must document and sign the medical record with the reasons for going ahead with the procedure.***

An incident report should be completed in IIMS and investigated for every instance of a procedure being undertaken where such a dispute occurs.

Nothing in the above procedures should interfere with the use of discretion by the treating proceduralist to alter the procedure during its performance for reasons of clinical judgement. However, significant changes to the documented procedure must be communicated to all members of the operating room team and recorded in the medical record or operating theatre report.

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6. In The Event of Wrong Patient, Wrong Procedure, Wrong Site or Wrong Type or Size of Prosthesis Incident

If the patient's condition permits, an immediate plan to rectify the mistake should be made by the most senior member of the procedural team. Wherever possible, the patient and the patient's family should be involved in the management plan.

An Incident Report and Reportable Incident Brief (RIB) should be completed in IIMS and appropriate review undertaken.

Appropriate details should be recorded in the patient's medical record.

The adverse event should be discussed at appropriate patient safety or clinical review meetings.

References

NSW Health (2004) Patient Identification - Correct Patient, Correct Procedure and Correct Site Model Policy PD2005_380
NSW Health (2005) Incident Management Policy PD2005_380
SSWAHS (2005) Incident Management Policy

Policy Author

Patient Safety Managers

Policy Reviewer/s

Clinical Quality Council

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