

Clinical Procedure (Model)

Facility/Program:

NORTH COAST
AREA HEALTH SERVICE
NSW HEALTH

Author/s: Clinical Governance Unit – Area Clinical Practice Manager

Authority:

Clinical Authority:

INSERT (For example the relevant facility/program clinical group or committee)

Management Authority:

INSERT (For example a network/facility management committee)

1.0 Title: CORRECT PATIENT, CORRECT PROCEDURE AND CORRECT SITE

2.0 Related Policy

NCAHS Correct Patient, Correct Procedure and Correct Site. Document Registration Number: xxx

NSW Health Correct Patient, Correct Procedure and Correct Site Model Policy PD2005_380 ¹

3.0 Purpose

The purpose of this Procedure document is to support the implementation of the NCAHS Clinical Policy on Correct Patient, Correct Procedure and Correct Site. The purpose of the policy is to ensure that an intended procedure is performed on the correct patient, at the correct site and if applicable with the correct implant.

Key Components

- Valid consent must be obtained for the procedure (PD2005_406) ² and this should directly identify the body part involved.
- The person performing the interventional procedure must review the following data after scheduling the patient for the procedure and prior to the procedure:
 - xrays and other imaging reports
 - pre procedure history and other clinically relevant material (consults, progress notes, pathology etc.)
 - consent form stating the procedure site, including laterally if applicable, name of the procedure and reason for the procedure.
- Site marking is essential and should be done with a surgical skin marker wherever practical or as per exceptions listed on Page 3.

- 'Left' or 'Right' should be written in full on all documentation. The only abbreviations and symbols used are those endorsed and published by the facility/service.
- Prior to the competent patient receiving any medication that could affect their cognitive function, the patient must state their full name and location on the body where the patient understands the procedure will take place. This should be documented in the medical record.
- Should the patient want 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.
- Each facility should ensure participating clinicians (eg Proceduralist, Anaesthetist, Nurse) independently verify the patient, procedure and site ("Time Out").
- Where there are discrepancies in information or disagreements in verification, **the procedure should be delayed until the issues are resolved. This decision should be in keeping with the degree of urgency of the procedure. The justification for proceeding in the presence of such discrepancies must be documented in the patient's medical record and an incident notification (IIMS) completed.**
- 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.
- Each facility must have a process for dispute resolution. Potential areas to address include communication between clinicians, failure to communicate critical information and decision making about whether or not to commence a procedure.

4.0 Procedure

The Correct Patient, Correct Procedure and Correct Site Procedure comprises the following essential steps:

Step 1) Informed Consent

- Valid consent is obtained for the procedure (PD2005_406)².
- The consent form must include: patient's full name and date of birth; name of procedure; procedures site (this should directly identify the body part involved); reason for the procedure; and laterality.
- No abbreviations are used.

✓ ***The signed Consent Form is held in patient's Medical Record***

Step 2) Marking the Procedure Site

- The site is 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 made using surgical skin markers
 - The mark is visible and sufficiently permanent so as to remain visible following skin preparation and draping
 - At a minimum mark all cases involving laterality, multiple structures (fingers, toes or lesions) or levels (spine)
 - Marking must take place with the patient involved awake and aware if possible
 - Marking should occur before the patient enters the procedure room (except in an emergency, the patient should not enter the procedure room until this has been completed).
- **Do not mark non-procedure sites.**
- ✓ ***Once appropriate marking has been completed this must be documented in the patient's Medical Record.***

Marking Exceptions

- To avoid confusion if a procedure requires a regional anaesthetic then only the procedure site should be marked
- 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 a traumatic site (obvious surgical site)
- When intra-procedure imaging for localisation (eg radiological, MRI, stereotaxis) will be used
- Where the patient refuses marking (this must be documented in the medical records).

Step 3) Patient Identification

- Verification of the correct person, procedure and site is conducted:
 - 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
 - Before entering the room in which the procedure will occur, or as soon as practicable after entering the procedure room but prior to the commencement of the anaesthetic (this may be the anaesthetic bay).

- Staff should always ask the patient to state their full name, date of birth and site of procedure. Staff **should NOT** state the patient's name, date of birth and procedure and ask the patient/authorised representative if this information is correct.

Considerations

- The patient involved should be awake and aware, if possible.
 - For patients transferred from locations within the hospital who are incapable of personally participating in the verification process and with no authorised representative, 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.
- Confirm written consent for the procedure from the patient or person responsible.
 - Ensure that all relevant documents are available prior to the commencement of the procedure.
 - Ensure the above have been reviewed and are consistent with each other and with the patients and team's expectations and understanding of the intended patient, procedure, site and implants if applicable.
 - Ensure missing information or discrepancies are addressed before commencement of the procedure.
 - The above should occur through all settings and interventions involved in the Pre procedure preparation of the patient, up to and including immediately prior to commencement of the procedure.
- √ ***Verification of patient identity is documented on the designated form: the Preoperative Patient Checklist; the Intra Operative Nursing Record (an example is provided in Appendix 1); or the Medical Imaging Procedure Sheet (an example is provided in Appendix 2); or the Procedure Verification Record (Appendix 3); or other document designed for this purpose.***
 - The Anaesthetist and Anaesthetic Assistant conduct a 'Time Out' for verification before administration of anaesthetic agents. This is particularly important when regional anaesthesia is being administered.
 - √ ***Pre- anaesthetic verification/time out is documented on the designated form: the Anaesthesia Record (Anaesthesia Record sheets must be modified to include a section for documenting this step); or the Procedure Verification Record (Appendix 3); or other document designed for this purpose.***

Step 4) Review Imaging Data, Equipment and Implants

- 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.
- Availability of correct equipment and/or implant(s) including size and type should be checked by two people before the procedure commences.
- √ ***Review of imaging data and checking of items is documented on the designated form: the Intra Operative Nursing Record (an example is provided in Appendix 1); or the Medical Imaging Procedure Sheet (an example is provided in Appendix 2); or the Procedure Verification Record (Appendix 3); or other document designed for this purpose.***

Step 5) Team “Time Out”

- Immediately prior to starting the procedure, all activity in the procedure room is stopped and all staff verbally conducts a final verification.
- 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).
- Verification 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 (review site marking)
 - Confirmation of imaging data and availability of any correct prostheses and/or any specialised equipment or requirements
- √ ***The result of the “Time Out” process must be documented on the designated form: the Intra Operative Nursing Record (an example is provided in Appendix 1); or the Medical Imaging Procedure Sheet (an example is provided in Appendix 2); or the Procedure Verification Record (Appendix 3); or other document designed for this purpose, and must be signed by the Proceduralist at the completion of the procedure.***

Success is totally reliant on active communication amongst all members of the procedure team. “Time Out” should be consistently initiated by a designated member of the team (team leader) and conducted in a “fail-safe” mode ie. the procedure should not be commenced until all questions or concerns are resolved.

In the event of a Wrong Patient, Wrong Procedure or Wrong Site 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 using an ‘open disclosure’ approach.

- An incident notification (IIMS) and Reportable Incident Brief (RIB) must be completed and an appropriate review undertaken. Procedures involving the wrong patient or body part are classified as Severity Assessment Code 1 'serious consequence'³.
- 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 (eg Network Clinical Safety and Quality Committee, Specialty Morbidity & Mortality meeting).

5.0 Monitoring, Evaluation and Review

Evaluation of the related Area Policy will occur 12 months following implementation.

The audit tool (Appendix 4) used to conduct the evaluation will measure compliance with the five steps involved in the patient verification process including:

- 1) Informed consent
- 2) Marking the procedure site
- 3) Patient Identification
- 4) Review of imaging data/implants and equipment
- 5) Team 'time out'

The Performance Indicator will be 100% compliance with Steps 1-5 listed above.

Following evaluation, a review of the Area Policy and model Procedure will be conducted and changes made where required.

6.0 Key words

Clinical Practices, Clinical Services, Clinical Service Provision, Clinical Quality Improvement, Operating Theatres, Surgery, Procedure

7.0 Definitions

Adverse event	An adverse event is an incident in which harm resulted to a person receiving healthcare ² .
Correct site	Correct site includes the correct side (ie. left or right) and the correct precise anatomical location (eg. anatomical location, specific vertebral body or finger).
“fail-safe” mode	A control function put in place to prevent failure of process and subsequent harm or an action taken to avoid an adverse event.
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 ³.

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.

8.0 References

1. NSW Health PD2005_380 Correct Patient, Correct Procedure and Correct Site Model Policy
2. NSW Health PD2005_406 Consent to Medical Treatment – Patient Information
3. NSW Health PD2006_030 Incident Management Policy

9.0 Appendices

- Appendix 1 Intra Operative Nursing Record – example
- Appendix 2 Medical Imaging Procedure Sheet – example
- Appendix 3 Procedure Verification Record
- Appendix 4 Teleform Clinical Audit Tool – Correct Patient, Correct Procedure, Correct Site

Appendix 1 – Intra Operative Nursing Record (Example)

INTRA OPERATIVE NURSING RECORD

(Tick appropriate remark or fill in details)

ALLERGIES:

PATIENT POSITION: Prone Supine Lithotomy Right lateral Left lateral

Traction Legs Wedge Handtable Bean Bags

SCDs Yellow Frits Other (Please indicate): _____

Positioning aids used Yes No Pressure areas protected Yes No Gel Pad

CATHERISATION: Yes No

Residual Indwelling

2 way 3 way Size _____ (Please indicate)

Silicone Latex

Batch No: _____

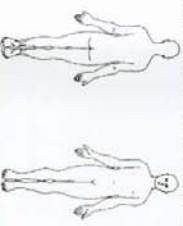
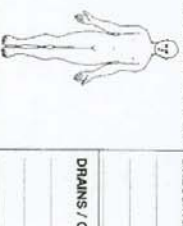
PREP SOLUTION:

Povidone - Iodine

Chlorhexidine + cetrimide

Other (Please indicate): _____

Dehairy used Yes No (If data used indicate site on diagram)

North Coast Area Health Service

-TIME OUT- (PD 2005, 380)

Checklist poster steps observed.

Time Out: Yes / No _____

At Time: Hts _____

Procedural team stops & verifies _____

Correct patient (circle outcome): Yes / No - if no - do not proceed _____

Correct Site has been marked (circle outcome): Yes / No (if no - why not?) _____

Procedure to be performed verified by team (circle outcome): Yes / No _____

Availability of correct Implant / prosthesis confirmed (circle outcome): Yes / No / N/A _____

Signature of person documenting: _____

TOURNIQUET: Site 1 _____ Time on _____ off _____ hrs

Pressure: _____ Time on _____ off _____ hrs

Site 2 _____ Time on _____ off _____ hrs

Pressure: _____ Time on _____ off _____ hrs

IRRIGATIONS / ADDITIVES: (Please indicate type, dose & amount)

WOUND INFILTRATION: _____

DRESSINGS: (Please indicate)

DRAINS / GAUZES / ETC left in situ

SPECIMENS: FRESH FORMALIN

COMMENTS:

STERIS: OPERATOR ID: _____

SERIAL: _____

CYCLE COUNT: _____

INDICATOR CHANGE: YES / NO _____

NORTH COAST AREA HEALTH SERVICE HOSPITAL

OPERATING ROOM NURSES' REPORT

DATE: _____ OR NO: _____

ANESTHETIST ①: _____ ANESTHETIST ②: _____

ASSISTANT ①: _____ ASSISTANT ②: _____

INSTRUMENT R/V ①: _____ INSTRUMENT NURSE ①: _____ SCOUT R/VEN: _____ RELIEF SCOUT ①: _____

INSTRUMENT R/V ②: _____ INSTRUMENT NURSE ②: _____ OPERATION START: _____ OPERATION FINISH: _____ RELIEF SCOUT ②: _____

TIME IN UNIT: _____ ANAESTHETIC START: _____ OPERATION START: _____ OPERATION FINISH: _____ TIME OUT OR: _____

OPERATION PERFORMED:

PROSTHESIS USED:

COUNT ITEMS	First Count	Added during Operation	Total	Second Count	Added	Total	FINAL COUNT
Raytec							
Sponges							
Forceps							
Gauze strips							
Tapes / loops							
Bulldogs							
Towel clips							
Scalpel blades							
Ordinary needles							
Atraumatic needles							
Haemostats							

INITIAL TO INDICATE CORRECT FINAL CHECK OF OTHER INSTRUMENTS

SURGEON INFORMED THAT ABOVE COUNTS CORRECT _____

Signature of Surgeon: _____ Instrument Nurse ①: _____ Instrument Nurse ②: _____ Scout Nurse: _____

Relief Scout ①: _____ TIME: _____

Relief Scout ②: _____ TIME: _____

PO: _____

Appendix 2 – Medical Imaging Procedure Sheet (Example)

LISMORE HOSPITAL MEDICAL IMAGING Procedure Sheet	MRN: SURNAME: GIVEN NAMES: D.O.B./AGE (Affix Sticker)	SEX
Procedure requested..... Request form..... Consent:..... Allergies..... Previous Contrast..... Proceduralist..... Radiographer..... Registered Nurse (1)..... Registered Nurse (2).....	<p style="text-align: center;">TIME OUT</p> Checklist poster steps observed. Time Out: Yes/No At Time: Hrs Procedural team stops & verifies Correct patient (circle outcome): Yes / No – if no — do not proceed. Correct Site has been marked (circle outcome): Yes / No (if no — why not?) Procedure to be performed verified by team (circle outcome): Yes / No Availability of correct implant/prosthesis confirmed (circle outcome): Yes / No Not applicable Person documenting: Signature..... Print Name.....	M E D I C A L I M A G I N G
Procedure:		
Anaesthetic.....		
Contrast Agents;.....Amount:.....mls		
Entry site.....Catheter/sheath size.....		
Time removed.....Transfer to ward time.....		
Registered Nurse..... <div style="display: flex; justify-content: space-between;"> Signature Print name Date </div>		
Instructions to Ward; 1. Stay in bed until.....2. Observations and puncture/wound site as per protocol.		
Provisional report (Typed report to follow);.....		
Proceduralist..... <div style="display: flex; justify-content: space-between;"> Signature Print name Date </div>		

North Coast Area Health Service

Appendix 3 – Procedure Verification Record

NB This form can be used in the absence of other purpose designed documents.

North Coast Area Health Service PROCEDURE VERIFICATION CHECKLIST UNIT/DEPT:	Affix Patient Label
Signed Consent Form Sighted	Signature: _____
Procedure Site Marked	Signature: _____
Pre Anaesthetic Verification	Signature: _____
‘TIME OUT’ CHECKLIST <p>Team ‘Time Out’ conducted at: _____ Hrs</p> <p>The Procedure Team has verified:</p> <p>Correct Patient YES / NO <i>(if NO do not proceed)</i></p> <p>Correct Procedure YES / NO <i>(if NO do not proceed)</i></p> <p>Correct Site marked YES / NO / NA <i>(if NO state reason?)</i></p> <p>Imaging data reviewed and correct YES / NO / NA <i>(if NO do not proceed)</i></p> <p>Availability of correct equipment/implant(s) YES / NO / NA <i>(if NO do not proceed)</i></p> <p>Any Comments:</p> <p>Person documenting signature: _____</p>	
Proceduralist signature: _____ Date: _____	

Appendix 4

Teleform Clinical Audit Tool – Correct Patient, Correct Procedure, Correct Site

Site:	<input type="checkbox"/> Ballina	<input type="checkbox"/> Dorrigo	<input type="checkbox"/> Mullimbimby	Ward	<input type="checkbox"/> Theatre	Audit completed by	<input type="text"/>												
	<input type="checkbox"/> Bellingen	<input type="checkbox"/> Grafton	<input type="checkbox"/> Murwillimbah		<input type="checkbox"/> Radiology		Designation	<input type="text"/>											
	<input type="checkbox"/> Bonalbo	<input type="checkbox"/> Kempsey	<input type="checkbox"/> Nimbin		<input type="checkbox"/> Emergency	NR = Not Recorded		Signature	<input type="text"/>										
	<input type="checkbox"/> Byron	<input type="checkbox"/> Kyogle	<input type="checkbox"/> Tweed		<input type="checkbox"/> ICU					<input type="text"/>									
	<input type="checkbox"/> Casino	<input type="checkbox"/> Lismore	<input type="checkbox"/> Urbenville		<input type="checkbox"/> General			<input type="text"/>											
	<input type="checkbox"/> Coffs	<input type="checkbox"/> Macksville	<input type="checkbox"/> Wauchope					<input type="text"/>											
	<input type="checkbox"/> Coraki	<input type="checkbox"/> Maclean	<input type="checkbox"/> Port Macquarie					<input type="text"/>											

	Patient MRN	Step 1: Informed Consent	Step 2: Procedure Site Marked	Step 3: Patient Identification	Step 4: Review of Imaging data/implants and equipment	Step 5: Team 'Time Out'
1	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
2	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
3	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
4	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
5	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
6	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
7	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
8	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
9	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R
10	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Incomplete	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R <input type="checkbox"/> N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/R

Comments

Rules (Derived from Correct Patient, Correct Procedure and Correct Site Clinical Procedure)

Step 1 - Informed Consent

- Valid consent is obtained for the procedure (PD20058_406)
- The Consent form must include; Patients full name and date of birth, name of procedure, procedures site (this should directly identify the body part involved), reason for procedure and laterality.
- No abbreviations are used
- **THE SIGNED CONSENT FORM IS HELD IN THE PATIENT'S MEDICAL RECORD**

Step 2 - Marking the Procedure Site

- The site is 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 made using surgical skin markers
 - The mark is visible and sufficiently permanent so as to remain visible following skin preparation and draping
 - At a minimum mark all cases involving laterality, multiple structures (fingers, toes or lesions) or levels (spine)
 - Marking should occur before the patient enters the procedure room (except in an emergency, the patient should not enter the procedure room until this has been completed)
- **Do not mark non-procedure sites**
- **ONCE APPROPRIATE MARKING HAS BEEN COMPLETED THIS MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD**

Marking Exemptions (eg. Not applicable)

- To avoid confusion if a procedure requires a regional anaesthetic then only the procedure site should be marked
- Interventional cases of which the catheter/instrument site is not predetermined (eg. Cardiac Catheterisation, Epidural/Spine Analgesia/ Anaesthesia etc)
- Where the 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 a traumatic site (obvious surgical site)
- When intra-procedure imaging for localisation (eg. Radiological, MRI, Stereotaxis) will be used
- Where the patient refuses marking (this must be documented in the medical records)

Step 3 - Patient Identification

- Verification of the correct person, procedure and site is conducted:
 - 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
 - Before entering the room in which the procedure will occur, or as soon as practicable after entering the procedure room but prior to the commencement of the anaesthetic (this may be the anaesthetic bay)
- **VERIFICATION OF PATIENT IDENTITY IS DOCUMENTED ON THE DESIGNATED FORM: THE PREOPERATIVE PATIENT CHECKLIST; THE INTRA OPERATIVE NURSING RECORD OR THE MEDICAL IMAGING PROCEDURE SHEET OR THE PROCEDURE VERIFICATION RECORD OR OTHER DOCUMENT DESIGNED FOR THIS PURPOSE**

Step 4 - Review Imaging Data, Equipment and Implants

- 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
- Availability of correct equipment and/or implant(s) including size and type should be checked by two people before the procedure commences
- **REVIEW OF IMAGING DATA AND CHECKING OF ITEMS IS DOCUMENTED ON THE DESIGNATED FORM; THE INTRA OPERATIVE NURSING RECORD OR THE MEDICAL IMAGING PROCEDURE SHEET OR THE PROCEDURE VERIFICATION RECORD OR OTHER DOCUMENT DESIGNED FOR THIS PURPOSE**

Step 5 - Team "Time Out"

- Immediately prior to starting the procedure, all activity in the procedure room is stopped and staff verbally conduct a final verification
- This must be conducted in the room where the procedure will be done, immediately before starting the procedure (this will occur after the patient has been anaesthetised)
- Verification 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 (review site marking)
 - Confirmation of imaging data and availability of any correct prostheses and/or any specialised equipment or requirements
- **THE RESULT OF THE "TIME OUT" PROCESS MUST BE DOCUMENTED ON THE DESIGNATED FORM; THE INTRA OPERATIVE NURSING RECORD OR THE MEDICAL IMAGING PROCEDURE SHEET OR THE PROCEDURE VERIFICATION RECORD OR OTHER DOCUMENT DESIGNATED FOR THIS PURPOSE, AND MUST BE SIGNED BY THE PROCEDURALIST AT THE COMPLETION OF THE PROCEDURE.**