Quality and Patient Safety Directorate

Tús Áite do
Shábháilteacht Othar
Patient Safety First

National Policy and Procedure for Safe Surgery

College of Anaesthetists of Ireland

RCSI

Reader information

Directorate:	HSE Quality and Patient Safety
Title:	National Policy and Procedure for Safe Surgery
Document reference number:	QPSD-D-057-1
Version number:	V.1
Document developed by:	Quality and Patient Safety Directorate
Document approved by:	HSE Senior Management Team
Responsibility for implementation:	All Health Sector Employees
Publishing Date:	July 2013
Review Date:	July 2015
Revision Number:	n/a
Responsibility for Review and Audit	HSE Quality and Patient Safety Directorate

Table of contents

3

1.0   Policy statement

The Quality and Patient Safety Directorate, Health Service Executive in partnership with the National Clinical Programme for Anaesthesia, College of Anaesthetists and the National Clinical Programme for Surgery, the Royal College of Surgeons is committed to supporting services to ensure safer surgery; and that the correct procedure is performed on the correct patient and on the correct site all of the time. Every member of the healthcare team involved in the surgical patient pathway has a role to play in ensuring patient safety.

Safer surgery will be achieved by supporting strong organisational leadership to support safe practice and the development of systems and processes to prevent adverse incidents.

2.0   Purpose

The purpose of this document is to help ensure that patients undergoing surgical procedures do so safely. By providing guidance for safe practice throughout the surgical patient pathway and introducing key safety steps that can be incorporated into the operating theatre routine, the most common and avoidable risks associated with surgical error can be minimised. These critical safety steps are intended to support the development of a safety culture for operating departments and teams and endorse the principles of the World Health Organisation (WHO) Surgical Safety Check list.

The WHO initiative, Safe Surgery Saves Lives, which Ireland signed up to in 2008, aimed to identify a core set of safety standards that can be universally applied across countries and settings. A simple set of surgical safety standards were compiled into a one page checklist for use by healthcare professionals in delivering surgical care. The purpose of the checklist is to act as a reminder of the minimum safety checks and to facilitate focused communication between all members of the operating team.

There is no question that checklists are tools that have been shown to improve outcomes. Nevertheless, it must be remembered that checklists are suited to solving specific kinds of problems, but not others. Even in comparison to aviation, managing surgical patients involves an enormous amount of coordinated, time-pressured decision-making, and potential delays. Checklists are simple reminders of what to do, and unless they are coupled with attitude change and efforts to remove barriers to actually using them, they will have limited impact. Finally, if one begins to believe that safety is simple and that all it requires is a checklist, there is a danger of abandoning other important efforts to achieve safer, higher quality patient care. Perhaps, most important of all is team-working and an acceptance of corporate responsibility.

3.0   Scope

This policy and procedure applies to all patients being booked, admitted for and undergoing surgical procedures in the operating theatre. A separate policy and procedure will be applicable for patients undergoing other procedures such as gastro-intestinal endoscopy, and interventional and radiological procedures. This policy excludes minor surgical procedures which normally take place outside the theatre environment. This policy applies to all staff involved in the surgical patient pathway.

4.0   Legislation / Related Policies

HSE Code of Practice for Healthcare Records Management

HSE Code of Practice for Decontamination of Reusable Invasive Medical Devices (2007)

World Alliance for patient WHO Guidelines for Safe Surgery (2009)

Prevention of Intravascular Catheter-related Infection in Ireland HPSC (2009)

Guidelines for the administration of blood and blood components (2004)

A Guideline for the use of blood and blood components in the management of massive haemorrhage (2002)

Guidelines for Antimicrobial Stewardship in Hospitals in Ireland (2009)

National Consent Policy (2010)

Elective Surgery Model of Care (2011)

Acute Surgery Model of Care (2012)

HSE Clinical Governance Information Leaflet (2012)

An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework

An Bord Altranais (2002) Recording Clinical Practice Guidance to

Nurses and Midwives

5.0   Glossary of terms

Checklist Coordinator - Is a designated healthcare professional who guides the operating team through the questioning phases of the Surgical Safety Checklist by asking the checklist questions out loud and ticking that these have been answered. They also sign the checklist to indicate that the questions have been asked and answered. It is the responsibility of the operating team to identify and designate the checklist coordinator (usually the circulating nurse) but can be any clinician participating in the operation).

Competent deputy (surgeon): A surgeon, either trainee or deputy who is;

1) is competent to perform the operation or a significant part thereof, or is an experienced first assistant, and
2) has been clearly designated to act as deputy by the consultant surgeon in charge of the case

Operating team

In this policy the operating team is understood to comprise of the surgeons, anaesthetists, nurses, midwives, healthcare assistants or other operating room personnel involved in the surgery.

Safe Surgery Checklist - Is a tool designed to bring together best practice about safety checks within the theatre environment.

Sign In -   The period before induction of anaesthesia.

Sign Out -   The period immediately after wound closure, before dressings are applied

Time Out -   The period before skin incision

6.0   Roles and responsibilities

The CEO/GM, in collaboration with the Lead Clinical Director and the Clinical Director/ Lead for Peri-Operative Care and Director of Nursing/Midwifery are accountable for ensuring that this policy and procedure is adopted and implemented throughout their organisation. This National Policy and Procedure for Safe Surgery should form part of the care provided to all patients undergoing a surgical procedure within the operating theatre environment in their organisation.

All healthcare staff who are involved in any aspect of a patient's surgical care pathway should receive education in the application of this policy and procedure.

It is the responsibility of all healthcare staff who are involved in any aspect of a patient's surgical care pathway (outpatient visit, booking for surgery, compilation of the theatre lists, admission, peri and post operative care) to support this policy within the scope of their work practice.

This National Policy and Procedure for Safe Surgery may be adapted for local implementation but <u>must</u> contain the critical safety steps as outlined within this document and associated checklist. General hospitals should apply this policy, procedure and checklist across all specialities. Hospitals with a single dedicated speciality e.g. Maternity hospitals, Orthopaedic hospitals, ENT and Eye hospitals etc, may add additional specific criteria for their own use.

The policy and procedure should be available in all care settings where surgery is planned to take place.

7.0   Procedure

7. 1   Guidance for achieving safe practice when planning a surgical procedure for a patient

The decision to plan and book a surgical procedure often occurs in the out-patient department. To ensure safe surgery is planned at this point the following steps should be adhered to:

- All of the patient's relevant healthcare records, X-ray films, diagnostics and original reports must be available for review by the consultant or nominated competent deputy to plan and book a surgical procedure, and to complete the informed consent process.

- Verification of the patient's name, date of birth, health care record number (HCRN) against relevant document must be completed.

- The planned procedure must be clearly documented in the healthcare record (including IT systems). The record of the scheduled procedure should state
  (a) The exact procedure, exact side/site/level/digit,
  (b) Left/Right should be written in full, abbreviations must not be used.

- Information regarding the procedure must be provided to the patient/parent/ guardian. A record of this conversation should be recorded in the healthcare record.

- Where a patient is scheduled for a procedure outside of the hospital setting in which the procedure will be performed (e.g. within the context of a hospital network), a detailed letter or proforma containing all of the above information must be forwarded to the hospital in which the procedure is being carried out for inclusion in the patient's healthcare record.

- Records relating to the planned procedure (healthcare record and relevant hospital documentation for scheduling the patient for theatre) must be completed before the next patient consultation commences.

- In the absence of a clear record of the planned procedure in the healthcare record at a pre-admission clinic or on admission to a ward area, the patient must be referred to the consultant in charge of the patient's care or their nominated competent deputy for review, before they are prepared for surgery. An adequate time frame dependent on the clinical need, must exist between the decision to operate and the transfer to the operating theatre department to allow for preoperative preparation.

7.1.1   Informed consent

To ensure the informed consent process is completed in a safe manner the following steps should be adhered to:

- o The patient must be provided with sufficient information in a comprehensible manner about the nature, purpose, benefits and risks of the planned procedure.

- o Formal consent must be obtained by the consultant surgeon or nominated competent deputy and signed legibly.

- o Relevant X-ray films, diagnostics and original reports must be available and reviewed by the consultant or nominated competent deputy to complete the informed consent process.

- o Consent may be obtained during the OPD visit as this setting allows the surgeon time to respond to the patient's questions and provide adequate information to the patient. The consent for the procedure should be checked on admission by a member of the operating team, to make sure that the patient has no questions or concerns and still consents to proceed. Consent is valid for 3 months (please refer to the national consent policy for further details).

- o The procedure must be clearly specified on the consent form and include the side/site/level/digit spelt out as "Left", "Right" or "Bilateral"

- o **If the consent is altered or illegible a new consent form must be completed and signed by all parties.**

7.2   In hospital pre-operative patient preparation

7.2.1 Pre-operative verification process work-up
To ensure safe surgery the following steps are required:

- The patient's name, address, date of birth, and planned procedure should be verified with the patient/parent/guardian/advocate during each stage of the admission process (nursing/midwifery admission, medical admission and informed consent/confirmation)

- All of the patient's relevant healthcare records, X-ray films, diagnostics and original reports must be available for review by the consultant or nominated competent deputy during pre-operative preparations

- The planned procedure must be clearly documented in the healthcare record. Absence of this information must be referred to the consultant surgeon in charge of the patient's care.

- Any queries in relation to the planned procedure including side/site/level/digit must be escalated to the consultant surgeon in charge of the patient's care before the patient leaves the ward area for surgery.

- All relevant preoperative preparation related to the planned surgery should be undertaken to ensure safe surgery e.g. fasting, blood group or cross match etc.

7.2.2 Pre-operative site marking

The patient's identity, planned procedure, side/site/level/digit should be verified with the patient/ parent/ guardian prior to site marking. Site marking must be performed by the consultant surgeon in charge of the patient's care or nominated competent deputy, who will be performing/ assisting in the operation and be present for the "Time Out" process. Relevant X-ray films, diagnostics and original reports must be available and reviewed by the consultant or nominated competent deputy prior to site marking. The site must be marked with indelible ink *in the presence of a parent or guardian if applicable* prior to the patient being transferred to the Operating Theatre Environment. (Please see Appendix 3 for guidance on pre-operative site marking).

7.2.3 Admission to operating theatre

The operating theatre nurse/midwife confirms with the ward nurse/midwife that the patient is prepared for surgery according to hospital policy using a pre-operative checklist.

7.3 Safe Surgery Checklist

The Safe Surgery Checklist (Appendix 1) divides the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure.

- **"Sign In"** is the first phase. It is the period before induction of anaesthesia.

- **"Time Out"** is the second phase before skin incision

- **"Sign Out"** is the third phase and is the period immediately after wound closure*

*This phase must be completed prior to the patient being removed/transferred from the Operating theatre.

The operating team cannot proceed to the next stage of the operation until the relevant phase of the checklist has been completed satisfactorily e.g., if the "Sign In" check has not been completed, induction of anaesthesia cannot be commenced.

7.3.1 Appointment of a checklist coordinator

o At the start of each case a checklist coordinator needs to be identified. This can be any member of the healthcare team.
o At each phase the checklist coordinator asks the checklist questions out loud to the operating team present and records that these have been answered. They also sign the checklist to indicate that the checks have been carried out.

7.3.2 Phase 1: "Sign In" (before induction of anaesthesia)

The surgeon (or competent deputy) will be present for "Sign In" to ensure confirmation of correct site, anticipated blood loss, allergies or other complicating patient factors. In the case of procedures performed under local anaesthetic, "not applicable" can be recorded in the relevant section.

Confirmation of Identity

Verbally confirm with the patient or advocate his or her identity, the type of procedure planned, the site of surgery and that informed consent for surgery has been given. In the case of children a parent/guardian/advocate can provide confirmation.

Verification of site marking

If applicable verbally verify that the operation site has been marked correctly checking site marked with the patient, against the consent form, operating theatre list and the healthcare record.

Known allergy status

Checklist coordinator asks the anaesthetist and patient (if appropriate) whether the patient has a known allergy and if so identify what it is.

Risk of large blood loss

Checklist coordinator asks the surgeon if there is an expectation of a large blood loss during the procedure. If it is anticipated that the patient is at a risk of a large blood loss and transfusion of blood or blood products are required, then confirm that the blood products are available in theatre.

Venous Thromboembolic (VTE) Prophylaxis

Checklist coordinator and surgeon verify if VTE prophylaxis has been undertaken if applicable.

ASA Physical Status Classification System

ASA Physical Status 1 - A normal healthy patient

ASA Physical Status 2 - A patient with mild systemic disease

ASA Physical Status 3 - A patient with severe systemic disease

ASA Physical Status 4 - A patient with severe systemic disease that is a constant threat to life

ASA Physical Status 5 - A moribund patient who is not expected to survive without the operation

ASA Physical Status 6 - A declared brain-dead patient whose organs are being removed for donor purposes

These definitions appear in each annual edition of the ASA Relative Value Guide.®

At this point the first phase of surgical safety checklist is completed, the checklist should be signed to indicate the questions were asked and answered and the team may proceed with anaesthetic induction.

7.3.3   Phase 2: "Time Out" (before skin incision)

A pause is to be taken by the team before skin incision[1] in order to confirm that several essential safety checks are undertaken. These checks involve every member of the operating team. The patient must be in the final position before "Time Out". This check could be completed prior to skin preparation and draping. The consultant or operating surgeon who will be performing the skin incision <u>must</u> be present for the "Time Out".

Confirmation that new team members have been introduced to all of the team

All members of the operating team understand who each member is and their role in the operating room. Teams already familiar with each other can confirm that everyone knows each other, but new members of staff (or those rotated into the operating theatre since the last operation) should be asked to introduce themselves including students or other personnel.

---

[1] Before skin incision is the recommended time to complete the "Time Out" based on the WHO recommendations, however, if individual organisations wish to perform the "Time Out" prior to skin preparation and draping the patient this may be adapted locally.

Verification of patient's name, date of birth, HCRN, procedure and where the incision will be made

The checklist coordinator verifies to the operating team the name of the patient, date of birth, healthcare record number, the surgery to be performed, consent and the site of surgery using available documentation and visually checking the site. For example, the checklist coordinator might announce, *"Before we make the skin incision"* and then continue, *"Does everyone agree that this is patient x undergoing a right inguinal hernia repair?"* The surgeon, anaesthetist and scrub nurse/midwife should explicitly and individually confirm agreement.

Patient positioning

The checklist coordinator verifies to the operating team that the patient is positioned correctly. The aim of the correct surgical position is to provide optimal visualisation of, and access to the surgical site that causes the least physiological compromise of the patient, while also protecting the skin, joints and nerves.

Display and checking of essential imaging

The checklist coordinator asks the surgeon if imaging is needed for the case. If so, the coordinator verbally confirms that the essential imaging is in the room and prominently displayed/checked for use during the operation. If imaging is needed but not available, it should be obtained. The surgeon will decide whether to proceed without the imaging if it is necessary but unavailable. In such a circumstance the checklist box should be left blank. If imaging is not necessary, the "not applicable" box should be checked.

Antibiotic prophylaxis

The checklist coordinator asks out loud whether prophylactic antibiotics were given during the previous 60 minutes. If prophylactic antibiotics have not been administered it should be considered prior to incision. The team member responsible for administering antibiotics, should provide verbal confirmation. If prophylactic antibiotics are not considered appropriate, the "*not applicable*" box should be checked once the team verbally confirms this.

Patient specific concerns: Anaesthetist

The checklist coordinator asks the anaesthetic team to review any patient-specific concerns.

It is understood that many operations do not entail particularly critical risks or concerns that must be shared with the team. In such cases, the anaesthetist can simply say, *"I have no special concern regarding this case."*

Patient specific concerns: Surgeon

The checklist coordinator asks the surgeon whether there are any critical or non routine steps anticipated in relation to the surgery.

A discussion of "critical or non-routine steps" is intended, at a minimum, to inform all team members of any steps that may put the patient at risk of injury or other major morbidity. This is also a chance to review steps that might require special equipment, implants or preparations.

If the intended operation does not entail particularly critical risks or concerns that must be shared with the team, the surgeon can simply say, "*I have no special concerns regarding this case.*"

Patient specific concerns: Nursing/Midwifery team

The checklist coordinator asks the nursing/midwifery team if there are any patient specific concerns e.g., hypothermia, pressure ulcers.

This is an opportunity to discuss any safety concerns the scrub or circulating nurse/midwife may have, particularly not addressed by the surgeon and anaesthetic team. If there is no particular concern, the scrub nurse/midwife can simply say, *"I have no special concerns regarding this case."*

Equipment issues

The checklist coordinator asks the operating team if there are any specific equipment issues for this case e.g., tourniquet, unavailable equipment etc. If equipment is needed it should be obtained immediately.

At this point the second phase (Time Out) of the checklist is completed, the checklist should be signed to indicate the questions were asked and answered and the team may proceed with the operation.

7.3.4 Phase 3: "Sign Out" (immediately after wound closure)

This part of the checklist is to be completed immediately after wound closure and again requires participation from all members of the operating team. The aim is to facilitate the transfer of important information to the care teams responsible for the patient post operatively.

Confirmation of procedure performed

Since the procedure may have changed or expanded during the course of an operation, the checklist coordinator confirms with the operating team exactly what procedure was performed. This can be done as a question, "*What procedure was performed*?" or as a confirmation, "*We performed X procedure, correct*?"

Completion of instrument, sponge and needle counts

The checklist coordinator verbally confirms the completeness of final instrument, sponge and needle counts. If counts are not appropriately reconciled, the operating team should be alerted so that appropriate steps can be taken (such as examining the drapes, rubbish, wound or, if required, obtaining an x-ray).

Identification and labelling of specimens

The checklist coordinator should confirm the correct labelling of any pathological specimen obtained during the procedure by reading out loud the patient's name, hospital number the specimen description and any orientating marking stitches e.g. if there is left/right distinction if appropriate and any other marking sutures.

Patient specific post–op concerns

The operating team review the postoperative recovery and management plan, focusing in particular on intra-operative or anaesthetic issues that might affect the patient's post operative care. Events that present a specific risk to the patient during recovery and that may not be evident to all involved are especially pertinent.

With this final step, the Safe Surgery Checklist is completed. The completed checklist must be signed to confirm that questions were asked and answered. The completed checklist is filed in the patient's healthcare record.

8.0   Implementation

Implementation of this policy and procedure will be supported through the National Clinical Programme for Anaesthesia and the National Clinical Programme for Surgery.

It is recognised that some hospitals already have systems for safe surgery in place; these organisations are required to ensure that their processes meet the minimum requirements outlined in this document.

9.0   Revision and audit

The content of this National Policy and Procedure and Safe Surgery document will be reviewed every two years or earlier, if indicated. Hospitals will need to review their own locally adapted safe surgery policies and procedures as well as auditing local implementation. This will be supported by the national safe surgery audit tool. Hospitals should audit compliance with this policy annually.

Any surgical adverse events due to non-compliance with this Policy and Procedure should be reported via the hospitals incident management process, reviewed and the findings reported to the next Clinical Governance Committee.

10   References

Beesley, J. Correct Site Surgery. British Journal Of Perioperative Nursing. 2005;15(9): 362-364.

Edwards, P. Promoting Correct Site Surgery. Journal Of Perioperative Practice. 2006;16 (2):80-86.

Edwards, P. Ensuring Correct Site Surgery. Journal Of Perioperative Practice. 2008; 18(4):168-171.

Haynes A et al. Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 2009; 360:491-499

Patient Safety First. The 'How to' Guide for Reducing Harm in Perioperative Care'. United Kingdom 2009.

NICE Clinical Guideline 92 (2010): Venous thromboembolism: reducing the risk

World Health Organisation. Safe Surgery Saves Lives Implementation Manual Surgical Safety Checklist. Geneva, 2009.

World Health Organisation. WHO Guidelines for Safe Surgery. Geneva, 2009.

11   List of appendices

Appendix 1 - Safe Surgery Checklist

Appendix 2 - Site marking verification checklist

Appendix 3 - Guidance for pre-operative site marking

Appendix 4 - National safe surgery policy and procedure: audit plan

Appendix 5 – Members of National Working Group

Safe Surgery Checklist

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Date of Procedure ___ / ___ / ___

"SIGN IN" (to be read out loud)

Before Induction of Anaesthesia
Anaesthetist/Surgeon/Nurse/Midwife

☐ **Has the patient confirmed his/her identity, site, procedure, and consent?**
☐ Yes ☐ Confirmed with Advocate/Parent/Guardian

☐ **Is the site marked? (check verification overleaf)**
Check with surgeon if problem
☐ Yes ☐ Not applicable

☐ **Has the anaesthetic machine been checked?**
☐ Yes ☐ No

☐ **Does the patient have a known allergy?**
☐ No ☐ Yes

☐ **Risk of large blood loss (check with surgeon)**
☐ No ☐ Yes

☐ **If yes, Blood Products immediately available?**
☐ Yes ☐ No ☐ Not applicable

☐ **Has VTE prophylaxis been undertaken (check with surgeon)?**
☐ Yes ☐ Not applicable

What is the patient's ASA Grade?
1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐ E. ☐

Signature to confirm "Sign In" questions were asked and answered:
_____ Time: ___ : ___

"TIME OUT" (to be read out loud)

Before Skin Incision
Anaesthetist/Surgeon/Scrub & Circulating Nurse/Midwife

☐ **Confirm that new team members have been introduced to all of the team?**

☐ **Verify the patient's name, DOB, MRN number, procedure and visually check where the incision will be made.**

☐ **Verify the patient is positioned correctly**

☐ **Is essential imaging displayed and is it consistent with procedure?**
☐ Yes ☐ Not applicable

☐ **Has antibiotic prophylaxis been given within the last 60 minutes?**
☐ Yes ☐ Not applicable

☐ **Verify if there are any patient-specific concerns?**

☐ **Verify if there are any equipment issues?**

Signature to confirm "Time Out" questions were asked and answered:
_____ Time: ___ : ___

"SIGN OUT" (to be read out loud)

Before dressings are applied
Anaesthetist/Surgeon/Nurse/Midwife

Checklist Co-ordinator verbally confirms:
☐ **The name of the procedure**

☐ **Completion of instrument, sponge and needle counts**
☐ Yes ☐ Not applicable

☐ **Specimen identified and labelled (read specimen labels aloud, including patient name and hospital number)**
☐ Yes ☐ Not applicable

To Surgeon, Anaesthetist and Nurse/Midwife
Any patient specific post-op concerns?
☐ Anaesthetist
☐ Surgeon
☐ Nurse/Midwife

Signature to confirm "Sign out" questions were asked and answered:
_____ Time: ___ : ___

Patient Details (Addressograph label)
Name:

Healthcare Record Number:
Date of Birth:

Appendix 2: Site marking verification checklist

Pre-operative Marking Verification

Patient Details (Addressograph label)
Name:

Healthcare Record Number:
Date of Birth:

Procedure Name:

The operating surgeon, or nominated deputy, who will be present in the theatre at the time of the patient's procedure, signs to confirm that site marked and identity checked.

- **Check the patient's identity – Name, Date of Birth, Address, Medical Record Number**

- **Check Consent form indicates correct procedure and side**

- **Mark the side and site with indelible ink**

Doctor Name (PRINT):

Doctor Signature:

MCRN:

Date:

Time:

Bleep no.:

Mobile no (if used):

Appendix 3: Guidance for pre-operative site marking

The role of marking to promote correct site surgery

Pre-operative marking has a significant role in promoting correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level (such as the correct finger on the correct hand). This procedure is essential for all patients attending for surgical procedures (with the exception of those procedures mentioned in Exceptional Cases, outlined below)

How to mark

A single use indelible marker pen should be used. The site mark should be legible and unambiguous. The mark should be an arrow that extends to or near to the incision site with the exception of cases where a smaller mark is required, e.g., in Ophthalmic/Facial surgery where a small dot may be used. It is desirable that the mark should remain visible after the application of theatre drapes.

Where to mark

Surgical operations involving side (laterality e.g. brain), upper/lower and/or paired organs (e.g. kidney), multiple structures (fingers, toes, lesions) or multiple levels (e.g. spine) should be marked at or near the intended incision. For digits on the hand or foot the mark should extend to the correct specific digit on the anterior, posterior or both. For surgery of the spine, pre-operative skin marking is required to indicate laterality, when appropriate.

Who Marks

Marking must be undertaken by the Consultant Surgeon in charge of the patient or Nominated Competent Deputy who will be performing/assisting at the surgery and present for the "Time Out" process.

Involving the patient/parent/guardian

The process of pre-operative marking of the intended site should involve the patient as appropriate. Any concerns regarding the correct procedure and/or correct site/side must be conveyed to the Consultant Surgeon or nominated Competent Deputy in charge and recorded in the healthcare record.

Marking time and place

The surgical site mark should be marked on the ward or day care unit/holding bay area prior to the patients transfer to the operating theatre.

Verification of Marking

The surgical site mark should subsequently be checked against the healthcare documentation and relevant x-rays and diagnostic reports to confirm it is correctly located, and visible.

These checks should be verbally confirmed on transfer to theatre and end with a final verification, as part of the Safe Surgery Checklist, prior to commencement of surgery. The operating team members (Surgeon, Anaesthetist and Scrub/Circulating Nurse/Midwife) should be involved in checking pre-operative marking during the Surgical Pause.

Circumstances where marking may not be appropriate

It is recognised that in some situations it may not be appropriate or possible for surgical site marking. Examples include:

- Premature infants cannot be marked in any circumstances due to risk of permanent marking

- Single organ cases, which do not involve laterality, such as Cardiac cases, Appendectomy

- Life threatening emergency when any delay in initiating the surgery would compromise the safety or outcome of the patient.

- When movement of a patient to create a marking would compromise the safety or outcome of the procedure, e.g., movement of a patient with an unstable spine fracture.

- Situations in which the primary pathology itself is plainly visible (single laceration)

- Dental cases, where the operative tooth number or name(s) can be indicated on documentation or the operative tooth (teeth) including laterality can be marked on the dental radiographs or dental diagram.

- Situations where the surgical site needs to be identified under radiology screening in the theatre e.g. neurosurgery, spinal surgery

Refusal of patient to site marking

Should the patient refuse to allow site marking to take place the following procedure will apply:

- The surgeon will inform the patient /parent/guardian of the risks of their decision.

- The surgeon will document the patient's refusal and subsequent discussion in the patient's healthcare record.

- The verification and "Time Out" will proceed as normal.

AUDIT TOOL SAFE SURGERY CHECKLIST
Appendix 4: National Safe Surgery Policy and Procedure: Audit plan

Objectives of the audit:
1. To identify if the Surgical Safety Checklist is completed appropriately
2. To identify if there were any incidents related to non-compliance with the National Policy and Procedure for Safe Surgery

Methodology:

Audit 1:   Retrospective healthcare records audit

1. A retrospective audit of a random selection of patient charts identified from the theatre register.
2. The sample should be small enough to allow for speedy data collection but large enough to be representative.
3. A separate data collection form should be completed for each patient.
4. This form should be identified using a respondent number rather than the patient's healthcare record number for data protection.
5. Analysis should identify % compliance for each of the criteria

Audit 2:   Observational audit of the checklist being utilised

1. An observational audit of the checklist being utilised by the operating team can be conducted using questions 8-36 of the audit tool.
2. A member of the operating team should be assigned to complete this.

Audit 3:   Review of incident report forms

1. A review of all incidents reported in relation to non-compliance with the National Policy and Procedure for Safe Surgery should be completed

Reporting:

1. Results should be shared with Operating Theatre Manager and Staff, Clinical Lead for Surgery/Obstetrics/Dental as appropriate, hospital Clinical Governance Committee.

2. An action plan outlining the actions to be taken to address areas of non-compliance should be documented, with assigned responsibility and dates for completion.

3. An annual report on compliance with the National Policy and Procedure for Safe Surgery should be written, including evidence from the audits and adverse incident reporting.

Audit tool Safe Surgery Checklist

Respondent number:_____

Consent

1	Is the consent form available in the Healthcare Record (HCR)?	Yes		No	
2	Is the consent form legible?	Yes		No	
3	Is the consent form signed by a Doctor who was present during the surgery?	Yes		No	
4	No abbreviations used on the consent form?	Yes		No	

Surgical Safety Checklist

5	Is there an addressograph on the checklist?	Yes		No	
6	Is the date of the operation recorded on the checklist?	Yes			
7	Was the checklist filed with the theatre documentation in the HCR?	Yes		No	

"SIGN IN"

Were each of the following checks completed?

8	Patient confirmed identity, site, procedure and consent	Yes		No	
9	Surgical site marked/ not applicable	Yes		No	
10	Anaesthetic checklist completed	Yes		No	
11	Known allergies checked	Yes		No	
12	Blood loss risk documented	Yes		No	
13	VTE Prophylaxis check	Yes		No	
14	ASA grade checked	Yes		No	
15	Sign In section signed	Yes		No	
16	Sign In section timed	Yes		No	

"TIME OUT"

Were each of the following checks completed?

17	All team members introduced themselves	Yes		No	
18	Verbal confirmation of patients name, procedure and incision site	Yes		No	
19	Verification that patient positioned correctly	Yes		No	
20	Essential imaging displayed/ not applicable	Yes		No	
21	Antibiotic prophylaxis / not applicable	Yes		No	
22	Patient specific concerns: Surgeon	Yes		No	
23	Patient specific concerns: Anaesthetist	Yes		No	
24	Patient specific concerns: Nursing /Midwifery Team	Yes		No	
25	Equipment issues: Surgeon	Yes		No	
26	Equipment issues: Nursing/ Midwifery Team	Yes		No	
27	Time Out section signed	Yes		No	

28	Time Out section timed	Yes		No	

"SIGN OUT"

Were each of the following checks completed?

29	Name of procedure confirmed	Yes		No	
30	Completion of instrument, sponge and needle count	Yes		No	
31	Specimen labelling	Yes		No	
32	Patient specific post-op concerns: Surgeon	Yes		No	
33	Patient specific post-op concerns: Anaesthetist	Yes		No	
34	Patient specific post-op concerns: Nurse /Midwife	Yes		No	
35	Sign Out section signed	Yes		No	
36	Sign Out section timed	Yes		No	

APPENDIX 5

NATIONAL SAFE SURGERY POLICY WORKING GROUP MEMBERS

Ms. Maria Lordan Dunphy, (Chairperson), Asst. National Director HSE, ISD
National Oversight, Quality and Patient Safety

Mr. Eddie Byrne, Director of Nursing, Acute Hosps Services Section, Cavan General Hospital

Dr. Mary Brown, Consultant in Public Health Medicine HSE, Quality & Patient Safety,

Dr. Bairbre Golden, Anaesthetic Lead, National Clinical Programme in Anaesthesia, National College of Anaesthetists of Ireland

Prof. Frank Keane, Clinical Lead for Surgical Programmes, Royal College of Surgeons of Ireland

Ms. Anne Marie Kiernan, Clinical Risk Manager, Our Lady's Children's Hospital, Crumlin

Mr. Paul McCormick, Consultant Surgeon, St James' Hospital, Dublin 8

Ms. Judy McEntee, Director Nurse Manager, Beaumont Hospital, Dublin 9

Ms. Grace Reidy, Asst Director of Nursing, Cork University Hospital, Cork

Ms. Gillian Whyte, Clinical Audit Project Facilitator, Cavan General Hospital