Facility name:

Date:

# Wrong-Site Anesthesia Prevention Observational Monitoring Tool

Perform 10 unannounced observations of regional or local blocks in the operating room (OR), preferably orthopedic cases with laterality, eye cases, and other procedures on extremities.
**For each blank box, indicate:** *Yes* if element/action was completed as described, *No* if element/action was not completed as described, or *N/A* if not applicable.

| **Scheduling/Consent (a standardized form is suggested)** | CASE #1 | CASE #2 | CASE #3 | CASE #4 | CASE #5 | CASE #6 | CASE #7 | CASE #8 | CASE #9 | CASE #10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Exact description of surgical procedure was on OR schedule (including site, side, digit) | | | | | | | | | | |
| Exact description of surgical procedure was on surgical consent (including site, side, digit) | | | | | | | | | | |
| Anesthesia consent was completed (including exact anesthesia procedure, site, side, digit) | | | | | | | | | | |
| **Preoperative Verification (a standardized checklist is suggested)** | CASE #1 | CASE #2 | CASE #3 | CASE #4 | CASE #5 | CASE #6 | CASE #7 | CASE #8 | CASE #9 | CASE #10 |
| Verification and documentation were completed independently by anesthesia provider | | | | | | | | | | |
| Verification included OR schedule | | | | | | | | | | |
| Verification included surgical consent | | | | | | | | | | |
| Verification included anesthesia consent | | | | | | | | | | |
| Verification included history and physical (H&P) | | | | | | | | | | |
| Verification included patient's understanding of the procedure | | | | | | | | | | |
| **Site Marking** | CASE #1 | CASE #2 | CASE #3 | CASE #4 | CASE #5 | CASE #6 | CASE #7 | CASE #8 | CASE #9 | CASE #10 |
| Site marking occurred before administration of anesthesia | | | | | | | | | | |
| Site marking was referenced by anesthesia provider before administration of anesthesia | | | | | | | | | | |
| Site marking was visible after patient was positioned, prepped, and draped for anesthesia | | | | | | | | | | |

PATIENT SAFETY AUTHORITY
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| Time-Out (a standardized tool is suggested) | CASE #1 | CASE #2 | CASE #3 | CASE #4 | CASE #5 | CASE #6 | CASE #7 | CASE #8 | CASE #9 | CASE #10 |
|---|---|---|---|---|---|---|---|---|---|---|
| A separate time-out was conducted prior to regional or local anesthesia | | | | | | | | | | |
| The anesthesia time-out was conducted after patient was positioned, prepped, and draped | | | | | | | | | | |
| All documents (schedule, both consents, H&P) were verified during time-out | | | | | | | | | | |
| Anesthesia provider was engaged during time-out—all work stopped and verbal acknowledgement occurred | | | | | | | | | | |
| Nurses were engaged during time-out—all work stopped and verbal acknowledgement occurred | | | | | | | | | | |
| Anesthesiologist encouraged the entire team to speak up if there were any concerns | | | | | | | | | | |

***Adapted with permission from the Health Care Improvement Foundation and modified for anesthesia procedures.***

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