PATIENT SAFETY AUTHORITY
An independent agency of the Commonwealth of Pennsylvania

Principles for Reliable Performance of Correct-Site Surgery

The following principles for reliable performance of correct-site surgery, identified by the Pennsylvania Patient Safety Authority during its Preventing Wrong-Site Surgery Project, should be consistently followed.

1. The correct site of the operation should be specified when the procedure is scheduled.
2. The correct operation and site should be noted on the record of the history and physical examination.
3. The correct operation and site should be specified on the informed consent.
4. Anyone reviewing the schedule, consent, history and physical examination, or reports documenting the diagnosis, should check for discrepancies among all those parts of the patient's record and reconcile any discrepancies with the surgeon when noted.
5. The surgeon should have supporting information uniquely found in the office records at the surgical facility on the day of surgery.
6. All information that should be used to support the correct patient, operation, and site, including the patient's or family's verbal understanding, should be verified by the nurse, anesthesia provider, and surgeon before the patient enters the operating room (OR).
7. All verbal verification should be done using questions that require an active response of specific information rather than a passive agreement.
8. Patient identification should always require two unique patient identifiers.
9. Any discrepancies in the information should be resolved by the surgeon, based on primary sources of information, before the patient enters the OR.
10. The site should be marked by a healthcare professional familiar with the facility's marking policy, with the accuracy confirmed both by all the relevant information and by an alert patient, or patient surrogate if the patient is a minor or mentally incapacitated; the site should be marked before the patient enters the OR.
11. The site should be marked by the provider's initials.
12. All information that should be used to support the correct patient, operation, and site, including the patient's or family's verbal understanding, should be verified by the circulating nurse upon taking the patient to the OR.
13. Separate formal time-outs should be done for separate procedures, including anesthetic blocks, with the person performing that procedure.
14. All noncritical activities should stop during the time-out.
15. The site mark should be visible and referenced in the prepped and draped field during the time-out.
16. Verification of information during the time-out should require an active communication of specific information, rather than a passive agreement, and be verified against the relevant documents.
17. All members of the operating team should verbally verify that their understanding matches the information in the relevant documents.
18. The surgeon should specifically encourage operating team members to speak up if concerned during the time-out.
19. Operating team members who have concerns should not agree to the information given in the time-out if their concerns have not been addressed.
20. Any concerns should be resolved by the surgeon, based on primary sources of information, to the satisfaction of all members of the operating team before proceeding.
21. Verification of spinal level, rib resection level, or ureter to be stented should require radiological confirmation, using a stable marker and readings by both a radiologist and the surgeon.

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For more information, visit http://www.patientsafetyauthority.org.

These principles accompany
Clarke JR. Quarterly update: what might be the impact of using evidence-based best practices for preventing wrong-site surgery? [online]. Pa Patient Saf Advis 2011 Sep [cited 2011 Nov 4]. http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/sep8(3)/Pages/109.aspx.

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