Wrong-Site Surgery Prevention Compliance Monitoring Tool

Within two weeks, perform 10 unannounced observations of nonemergent operating room (OR) cases, preferrably orthopedic with laterality, spinal, eye, or other procedures on extremities. Exclude cardiac and upper abdominal surgeries. **For each blank box**, indicate: *Yes* if the action was completed, *No* if the action was not completed, or *N/A* if not applicable.

Facility name:

Date:

	Case #1	Case #2	Case #3	Case #4	Case #5	Case #6	Case #7	Case #8	Case #9	Case #10
The schedule, history and physical, and consent are complete and correct, and all such documents are consistent prior to the day of surgery.										
The schedule, history and physical, and consent are present, complete, correct, and in agreement on initial verification when the patient arrives in the preoperative holding area on the day of surgery.										
The physician doing the procedure properly verifies the information and properly marks the site prior to the patient entering the OR.										
The physician doing the procedure verifies and reconciles the patient's understanding, the schedule, the history and physical, the consent, and any other relevant information prior to the patient entering the OR.										
The physician doing the procedure marks the site, if indicated by the procedure, with the physician's initials prior to the patient entering the OR.										
All members of the OR team give primary attention to the time-out and participate with active-voice responses.										
The surgeon, the anesthesia professional, the circulating nurse, and the surgical technologist each respond with active voices to questions or statements in the time-out script directed to each of them.										
The physician doing the procedure points out the site mark in the prepped and draped field to the other members of the OR team during the time-out.										
If the presence of a mark is indicated by the procedure, the initials can be seen in the prepped and draped field and the physician doing the procedure points out the site mark in the prepped and draped field.										
Members of the OR team are told that they can speak up during the time-out if they have concerns and that those concerns will be addressed in the best interest of the patient.										
The physician doing the procedure actively empowers the other members of the operating team to speak up if concerned during the time-out.										
If a member of the operating team stops the procedure because he or she has concerns, those concerns are addressed.										
When intraoperative verification by an imaging study is indicated, the properly executed intraoperative imaging study is read by the OR surgeon and, if possible, by a radiologist or other qualified physician to verify the correct anatomic location before doing the procedure.										
If intraoperative verification by an imaging study is indicated, the physicians document that the imaging studies verify that the anatomic site is correct before the procedure is done.										

For more information, visit http://www.patientsafety.pa.gov
This tool accompanies: What keeps facilities from implementing best practices to prevent wrong-site surgery? Barriers and strategies for overcoming them.
Pa Patient Saf Advis [online] 2012 Nov 20 [cited 2012 Nov 20].
http://patientsafety.pa.gov/ADVISORIES/Pages/2012sup1_01.aspx