Possible Integration of Actions to Satisfy Joint Commission Universal Protocol and WHO Surgical Safety Checklist

Joint Commission Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ | World Health Organization (WHO) Surgical Safety Checklist | Pennsylvania Patient Safety Authority expanded advice for the implementation of the Universal Protocol | Possible modifications of the WHO Surgical Safety Checklist

	A. Preoperative Preparation	B. Preoperative Verification	C. Site Marking	D. Before Anesthesia	E. Before Incision	F. Time-Out	G. Intraoperative Verification (for spinal levels, rib levels, and ureters)	H. Postoperative Verification
1	Include the correct operation and site on the schedule.	Verify that all relevant information (history and physical, consent, critical diagnostic test results and images) is available and all documents agree about the correct patient, procedure, and site.	Mark the site, as indicated, before any procedure is performed. [SAME AS D2]	Verify that the patient's identity and understanding agree with all the other relevant information. [SAME AS B3]	Introduce all team members to each other. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	Conduct a time-out immediately before starting any invasive procedure but after reconciling any preexisting discrepancies in the information. [ALSO SEE D8]	Require an intraoperative imaging study.	Verify the specimen label, including the patient's name, with a read-back.
2	Include the correct operation and site on the history and physical.	Include the schedule in the relevant information to be verified and reconciled.	Verify the mark with the patient's understanding.	Mark the site, as indicated, before any procedure is performed. [SAME AS C1]	Get ultimate agreement from all members of the procedure team regarding the patient's identity, the procedure, and the site during the time-out. [SAME AS F5] [SHOULD BE DONE JUST BEFORE MAKING THE INCISION]	Conduct the time-out according to a standard format (script) with a designated leader.	Get independent verification by the surgeon and a radiologist.	The surgeon should verify the information identifying the specimen, including site, using active communication.
3	Include the correct operation and site on the consent.	Verify that the patient's identity and understanding agrees with all the other relevant information. [SAME AS D1]	Verify the mark with all the relevant information.	Complete a check of the anesthesia machine and medications.	Confirm if antibiotics prophylaxis was given to the patient within 60 minutes before the incision. [SHOULD BE DONE JUST BEFORE MAKING THE INCISION]	Involve all active members of the team doing the procedure in the time-out, including, typically, the surgeon/proceduralist, the anesthesia provider, the circulating nurse, and the surgical technologist.		Clear all patient labels from the OR before the next patient arrives.
4	Reconcile any discrepancies when noted.	Identify the patient by requiring active responses for two identifiers.	The mark should be made by someone who will see it in the prepped and draped field during the time-out.	Verify that the pulse oximeter is present and functioning.	Discuss critical or unusual steps. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	All relevant members of the team doing the procedure should ACTIVELY communicate during the time out (Joint Commission quote, with Authority emphasis).		The nurse should confirm the name of the procedure.
5		Have the preoperative verification done independently by the preoperative nurse, anesthesia professional, operating surgeon, and operating room (OR) circulating nurse.	The operating surgeon should confirm the accuracy of the site marking.	Confirm any known patient allergies. [SHOULD BE DONE AT THE INITIAL ENCOUNTER]	Estimate how long the case should take. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	Get ultimate agreement from all members of the procedure team regarding the patient's identity, the procedure, and the site during the time-out. [SAME AS E2]		The nurse should confirm that the instruments, sponges, and needles are accounted for.
6		Reconciliation of any discrepancies should be done by the surgeon, using primary source information.	Make a mark that is consistent throughout the organization.	Assess the patient for the risk of a difficult airway and aspiration. [SHOULD BE DONE AT THE INITIAL ENCOUNTER] [RELATED TO E7]	Discuss the anticipated blood loss (and resources). [RELATED TO B8, D7] [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	Do a separate time-out for each separate procedure and involve those doing that procedure. [RELATED TO D8]		Discuss and initiate follow-up on any equipment problems.
7		Verify all relevant information with the patient and reconcile all discrepancies before entering the OR.	Place the mark at or near the proposed incision site.	Assess the patient for the risk of >500 ml blood loss and start two IVs if true. [RELATED TO B8, E6] [LOGICALLY BEFORE B8?]	Discuss anesthetic concerns. [RELATED TO D6] [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	Reference the site marking, visible in prepped and draped field, during the time-out.		Discuss recovery and postoperative management concerns for the patient.
8		Confirm that required blood products, implants, devices, and special equipment are available and designated for the patient. [RELATED TO D7(blood), E6(blood), E9(special equipment)] [LOGICALLY AFTER D7?]	Use a pen whose mark will not wash off with the prep.	Conduct a time-out immediately before starting any localized anesthetic block. [SIMILAR TO F1] [RELATED TO F6]	Confirm the sterility of all sterile equipment and supplies. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	Verify the active communication of specific information from each member of the procedure team, using the information in relevant documents, during the time-out.		
9					Confirm that special equipment is available and functioning. [RELATED TO B8] [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]	The surgeon/proceduralist should expicilty empower team members to speak if concerned and address any concerns expressed.		
10					Display essential images. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR]			
11					The anesthesia professional and surgeon should assess the fire risk of the planned procedure and modify the plan if the risk is high. [SHOULD BE DONE AS SOON AS FEASIBLE IN THE OR AND CERTAINLY BEFORE DRAPING THE SURGICAL FIELD]			