Gap Analysis and Action Plan to Prevent Wrong-Site Surgery

Wrong-Site Surgery Evidence-Based Principles	Goal(s) of Principles	Measurement Standard(s)	Observation(s)	Action Plan to Comply with Evidence-Based Principle	Identified Barriers to Compliance
TO BE COMPLETED BEFORE THE PATIENT ARRIVES ON THE DAY OF SURGERY					
1. The correct site of the operation should be specified when the procedure is scheduled.	Schedule, history and physical, and consent are complete and correct, and all such documents are consistent prior to the day of surgery or prior to the patient's arrival in the preoperative holding area, if the procedure is not elective.	100% of documents are present, complete, correct, and in agreement on initial verification when the patient arrives in the preoperative holding area on the day of surgery.			
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 any related reports or other information should check for discrepancies among all parts of the patient's record, and reconcile any discrepancies with the surgeon when noted.					

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TO BE COMPLETED IN THE PREOPERATIVE HOLDING AREA					
5. The surgeon should have supporting information uniquely found in the clinical records at the surgical facility on the day of surgery.	The physician doing the procedure should properly verify the information and properly mark the site prior to the patient entering the operating room (OR).	A. 100% compliance by the physician doing the procedure with verifying and reconciling the patient's understanding, the schedule, the consent, the history and physical examination, and any other relevant information.			
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 OR.		B. 100% compliance by the physician doing the procedure with marking the site so that the initials can be seen in the prepped and draped field.			
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.					

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TO BE COMPLETED IN THE OR					
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.	1. All members of the OR team give primary attention to the time-out and participate with active-voice responses. 2. 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.	A. 100% compliance by the surgeon, the anesthesia professional, the circulating nurse, and the surgical technologist with an active-voice response to questions or statements in the time-out script directed to each of them. B. 100% compliance by the physician doing the procedure with pointing out the site mark in the prepped and draped field.			
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.					

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TO BE COMPLETED IN THE OR IMMEDIATELY BEFORE THE PROCEDURE BEGINS					
18. The surgeon should specifically encourage operating team members to speak up if concerned during the time-out.	Members of the OR team know 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.	A. The facility has a policy that allows any member of the operating team to stop the procedure if he or she feels that his or her concerns have not been addressed. B. 100% compliance by the physician doing the procedure with actively empowering the other members of the operating team 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.					
NOTIFY RADIOLOGY IN ADVANCE OF SITE CONFIRMATION REQUESTS					
21. Verification of spinal level, rib resection level, or ureter stented should require radiological confirmation, using a stable marker and reading by both a radiologist or other qualified physician and the surgeon.	When intraoperative verification by an imaging study is indicated, the properly executed intraoperative imaging study is read by both a radiologist or other qualified physician and the surgeon to verify the correct anatomic location before doing the procedure.	Spinal level and rib resection: 100% of imaging studies have documentation that two physicians verified the anatomic site before the procedure is done. Ureteral stents: 100% of cases performed under fluoroscopy with good intraoperative verification.			

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

This tool accompanies
Arnold TV. Quarterly update on wrong-site surgery: eleven years of data collection and analysis. Pa Patient Saf Advis [online] 2015 Sep [cited 2015 Sep 16]. http://patientsafety.pa.gov/ADVISORIES/Pages/201509_119.aspx