Patient Safety Authority

Facility name:

Date:

Wrong-Site Surgery Prevention Observational Monitoring Tool

Perform 10 unannounced observations of operating room (OR) cases, preferably orthopedic with laterality, spinal, eye, and other procedures on extremities. Exclude cardiac and upper abdominal surgeries. **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. Document time in minutes where indicated.

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 procedure was on OR schedule (including site, level, side, digit)										
Exact description of procedure was on consent (including site, level, side, digit)										
Consent was completed (including exact procedure, all required signatures, dates)										
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 at least two providers										
Verification included OR schedule										
Verification included 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
Duration for the surgeon to complete the verification process and marking process *(enter minutes)*										
OR staff member marking the site used his or her initials										
Site marking occurred after reconciliation of all documents (schedule, consent, H&P)										
Site marking occurred before administration of sedative and/or anesthesia										
Site marking included discussion with patient										
Site marking was visible after patient was positioned, prepped, and draped										
Site marking was confirmed by intraoperative imaging, if for vertebrae, ribs, or ureters										

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
Duration to complete the time-out *(enter minutes)*										
A separate time-out was conducted prior to regional or local anesthesia, if applicable										
The final time-out was conducted after patient was positioned, prepped, and draped										
All documents (schedule, consent, H&P) were verified during time-out										
Diagnostic, radiology, and pathology results were verified during time-out										
Surgeon was engaged during time-out—all work stopped and verbal acknowledgement occurred										
Anesthesia provider was engaged during time-out—all work except ventilation stopped and verbal acknowledgement occurred										
Nurses were engaged during time-out—all work stopped and verbal acknowledgement occurred										
Surgeon encouraged the entire surgical team to speak up if there were any concerns										

OR Turnover	Case #1	Case #2	Case #3	Case #4	Case #5	Case #6	Case #7	Case #8	Case #9	Case #10
All patient information and specimens were removed from the OR before the next patient arrived										

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.	Case #1	Case #2	Case #3	Case #4	Case #5	Case #6	Case #7	Case #8	Case #9	Case #10
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.										

Adapted with permission from the Health Care Improvement Foundation