

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 bring copies of supporting information uniquely found in the office records to the surgical facility 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.
11. 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.
12. Separate formal time-outs should be done for separate procedures, including anesthetic blocks, with the person performing that procedure.
13. The site mark should be visible and referenced in the prepped and draped field during the time-out.
14. 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.
15. All members of the operating team should verbally verify that their understanding matches the information in the relevant documents.
16. The surgeon should specifically encourage operating team members to speak up if concerned during the time-out.
17. Operating team members who have concerns should not agree to the information given in the time-out if their concerns have not been addressed.
18. 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.
19. Verification of spinal or rib level should require radiological confirmation, using a stable marker and readings by both a radiologist and the surgeon.
20. All paperwork and labels for a patient in an OR should be cleared before the next patient arrives.
21. Information identifying surgical specimens should be verified with the surgeon via active communication of specific information, rather than a passive agreement.

More information is available online at <http://www.patientsafetyauthority.org>.

**These principles accompany
Improvement in preventing wrong-site surgery! Traction or transient?
Pa Patient Saf Advis [online] 2009 Sep [cited 2009 Sep 16].**

Available from Internet:

[http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6\(3\)/Pages/104.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6(3)/Pages/104.aspx).