

PROCEDURAL SAFETY CHECKLIST WITH OR WITHOUT SEDATION

PATIENT INFORMATION

Date: ___/___/___ Location: _____ Procedure: _____

**PRIOR TO SEDATION / INDUCTION
SIGN-IN / BRIEFING**

COMPLETED PRIOR TO PROCEDURE / SEDATION

PATIENT / SEDATION PROVIDER / REGISTERED NURSE / SURGEON / PROCEDURALIST / CLINICAL TEAM MEMBER

- Confirm with patient:
 - ✓ Name, Date of Birth
 - ✓ Procedure and if applicable
 - ✓ Site / Side / Level / Marking Confirmed
 - ✓ Laterality Right ___ Left ___
 - ✓ Allergies
- All consents are present, accurate, signed
- Radiologic films/reports available as needed
- Confirm any special equipment / supplies / implants are present
- Risk of blood loss addressed

FOR CASES RECEIVING SEDATION ONLY

**For sedation administered by non-anesthesia personnel:
Physician confirms case reviewed for anesthesia consultation.**

**For sedation administered by Anesthesia Dept personnel.
Care of the patient is governed by the Department of Anesthesia policy and procedure manual.**

RN/Clinical Team
Member Signature: _____

STOP Time: _____

**IMMEDIATELY PRIOR TO PROCEDURE / INCISION
TIME OUT / HUDDLE**

NURSE / CLINICAL TEAM MEMBER

- Ready for the time out?
- Assure that all team members introduce themselves.
- Announces “sterility confirmed.”

SURGEON / PROCEDURALIST

• “We are all here to work together for patient safety. All team members should speak up with any concerns before, during, and after the procedure.”

Confirm:

- Patient I.D. (Name, Date of Birth)
- Medical Record Number
- Procedure to be performed
- Verify position.
- All supplies, equipment and implants expected to be needed are present
- Need for and availability of blood products, if applicable
- Confirm for high risk (as listed on back of form) site-specific procedures that relevant images were reviewed together by two (2) appropriately credentialed practitioners and documented.
- “I verify that all relevant pathology reports, diagnostic and/or imaging studies are available and correctly oriented and labeled.”
- Diagnostic/imaging studies have the correct name and orientation, if applicable
- Confirm the anticipated intraoperative critical pauses.

**CONFIRMING TEAM MEMBER
(Sedation Provider or RN or Clinical Team Member)**

- Confirm site / side / level is marked and is **visible**, if applicable
- “Procedure confirmed by consent” making sure that the consent matches description of procedure just given by Provider
- Fire risk assessment addressed
- Allergies
- Team member announces “confirmed” (available diagnostic/imaging studies have the correct name and orientation)

REGISTERED NURSE / CLINICAL TEAM MEMBER

- Does anyone have any patient-specific concerns that have not been addressed?
- “We have independently and collectively identified the patient and have resolved any discrepancies”
- Team announces “confirmed”

RN/Clinical Team
Member Signature: _____

STOP Time: _____

**INTRAOPERATIVE CRITICAL PAUSES
IMPLANTS AND HANDOFF OF PATHOLOGY**

**AT TIME OF IMPLANTATION
REGISTERED NURSE**

- Implants will not be opened until verbally and visually confirmed by the surgeon/proceduralist.
- Confirm at time of implantation:
 - ✓ Implant Name
 - ✓ Laterality, if assigned
 - ✓ Size
 - ✓ Sterility and tissue indicators on package
 - ✓ Expiration dates of implant and necessary reconstitutions

**AT TIME OF LAST PATHOLOGY HANDOFF FROM STERILE FIELD
REGISTERED NURSE**

Confirms with team:

- That all specimens were reconciled including parked specimens (*number of specimens, proper labeling, method of fixation and pathology form completed by the procedural team*).

**PRIOR TO SURGEON / PROCEDURALIST LEAVING
PROCEDURE ROOM
SIGN-OUT / DEBRIEFING**

REGISTERED NURSE / CLINICAL TEAM MEMBER

- Are we ready for the debrief?

Confirms with team:

- The procedure to be recorded
- Wound Class (if applicable)
- Confirm with team members any equipment, instrument and/or supply issues that need to be addressed
- Instrument, sponge and needle counts done per policy, if applicable
- All specimens and pathology have been reconciled and signed by Procedural team.
- All guidewires removed intact, if applicable

SEDATION PROVIDER / SURGEON / PROCEDURALIST

- Confirm estimated blood loss or Quantitative blood loss (if applicable)
- Confirm disposition of the patient and any key concerns for recovery and management of the patient

RN/Clinical Team
Member Signature: _____

STOP Time: _____

PATIENT INFORMATION

Additional “Time Out”:

(Verbalize name of patient, site, side, implants as applicable, and procedure) not applicable

- 1. For regional nerve block by Anesthesiologist (2 disciplines perform “time out”)
- 2. Invasive procedure performed prior to the primary surgical procedure
- 3. When a new surgeon arrives and is assuming primary responsibility for the case
- 4. When the patient/operative site is re-draped
- 5. Spinal surgery: after intraoperative imaging to confirm the exact level/site

RN Signature: _____ Name (Print): _____ Time: _____

Surgeon Name: _____ Anesthesiologist Name: _____ Reason: _____

RN Signature: _____ Name (Print): _____ Time: _____

Surgeon Name: _____ Anesthesiologist Name: _____ Reason: _____

RN Signature: _____ Name (Print): _____ Time: _____

Surgeon Name: _____ Anesthesiologist Name: _____ Reason: _____

High Risk Procedures include but are not limited to the following:

- Amputation of limb or portion of a limb
- Craniotomy
- Pneumonectomy
- Nephrectomy
- Adrenalectomy
- Spine
- Enucleation of eye