**Institution Name:** Directorate General of Quality Assurance Centre, MoH

**Document Title:** Policy & Procedure of Safe Surgery: Ensure correct patient, procedure and site for invasive/surgical procedures

### Approval Process

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<tr>
<th>Name</th>
<th>Title</th>
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<th>Signature</th>
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1. Purpose

To provide national guidelines for verification of correct site, correct procedure, and correct patient for invasive/surgical procedures(s).

2. Scope

National wide

3. Definitions

3.1 Emergency Situation:
A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention expected to result in:
3.1.1 Placing the health of the individual in serious jeopardy,
3.1.2 Serious impairment of body functions, or
3.1.3 Serious dysfunction of a body organ.

3.2 Time out:
A pause taken immediately before the start of any surgical or invasive procedure to conduct a final verification process.

4. Policy

4.1 It is the Ministry of health policy for safe surgery; all healthcare institutions should identify the correct patient, procedure and side/site before all invasive /operative procedures.

5. Procedure

5.1 Scheduling
5.1.1 The verification process for correct site procedure/surgery begins with scheduling.

5.1.2 The following information is required when scheduling an invasive/surgical procedure:

A. The correct spelling of the patient’s full name and tribe name for Omani patients (Given Name, Father Name and Grandfather Name).

B. Medical Record Number.

C. Procedure to be performed; and

D. Anatomical sites that have laterality, the word (s) right, left, or bilateral will be written out fully on the consent and all relevant documentation (e.g., procedure/operating room schedule).

5.2 Pre-procedure/Preoperative Verification

5.2.1 The healthcare professional will verify patient’s identity by asking the patient to state his or her full name, date of birth and procedure/ surgery to be performed.

5.2.2 The patient will be involved in the process with verbal and visual responses (e.g., stating name and pointing to correct site location).

5.2.3 The patient responses will be verified with hospital posted schedule, consent(s), radiographic films, site mark, and information in the medical record including history and physical examination.

5.2.4 Match the medical record number (MRN) with the patient Identification band (ID).

5.3 Site Mark:

5.3.1 When is a site mark required?

All patients having an invasive/surgical procedure that involves:

A. Laterality (right, left)
B. Multiple structures (e.g. fingers, toes, lesions); and/or

C. Multiple levels (e.g., spine)

5.3.2 Procedures exempt from site marking.

A. Tonsillectomy.

B. Hemorrhoidectomy.

C. Single organ cases (C-section).

D. Teeth (In the case of teeth, the operative tooth name will be documented in the patient record and marked on the dental radiographs/dental diagram).

E. Premature infants for whom the mark may cause a permanent tattoo.

F. Interventional cases for which the catheter/instrument site is not predetermined (cardiac catheterization, epidural/spinal analgesia/anesthesia).

G. If the site is a traumatic site (obvious surgical site).

H. Emergency Procedure – in critical emergencies at the discretion of the operating physician, a site mark may be omitted.

5.3.3 Procedures for Site Marking

A. Prior to marking the site(s), the physician performing the procedure/surgery verifies the patient’s identity, consent, medical record data including history and physical, and radiographs to confirm accuracy.

B. The physician performing the procedure/surgery asks the patient to state the procedure(s) and site(s)/side(s) of surgery as well as point of the site(s).

C. The site mark is completed before the patient enters the procedure/operating room. A site mark will be a line made at or
adjacent to the incision site, and must be visible after the patient is prepped and draped.

D. The physician performing the procedure will definitely mark the procedure site prior to induction of anesthesia, using an indelible, hypoallergenic, latex-free, skin marker. The marking should be clear.

E. Do not mark non-operative sites.

F. Once appropriate marking has been completed this must be documented in the medical record.

G. Patient Refusal for Site Marking – if a patient refuses to have the site marked, the patient’s physician will review with the patient the rational for site marking.

Patient refusal for site marking should be documented in the medical record.

5.3.3 Special Site Marking Requirements:

A. Multiple sides or sites:
B. If the procedure involves multiple sites/sides during the same operation. Each side and site must be marked.

C. Dental Surgery
   i. Teeth do not need to be marked.
   ii. The tooth number(s) or tooth/surgical site will be identified on the diagram or radiograph to be included as part of the medical record and site confirmation.
   iii. Radiographs will be checked for proper orientation and visually confirm correct teeth or tissue charted.
   iv. Skin integrity that is not intact: The skin mark will not be placed on an open wound or lesion.
D. In the case of multiple lesions: and when only some lesions are to be treated, the sites should be identified prior to the procedure itself.

E. Bedside procedures (e.g., chest tube insertion, etc.)

i. If the person performing the procedure leaves the bedside at any point, the site/side must be marked prior to the procedure.

ii. However, if the person performing the procedure is in continuous attendance from the time the diagnosis is made until the procedure begins and performs the following:
   a. Identifies the patient and confirms all data, including consent, history and physical, and radiographs, then.
   b. He/she may perform the procedure without marking the site.

5.3.4 Removal of the Site Mark
At the end of the case, staff should attempt to remove the site mark in the event that the patient will be having a subsequent surgical/invasive procedure.

5.4 Pre-operative checklist:
The pre-operative checklist is used to ensure that all pre-operative criteria are met for each patient before undergoing a surgical procedure and patient information are communicated correctly when transfer to Operating Room. (P&P of Safe Surgery, Preoperative communication MOH-DGQAC/006/Vers 1.0).

5.5 TIME OUT in the procedure/operating room/bedside/treatment room

5.5.1 The patient enters the procedure/operating room and the nurse/radiographer/healthcare professional will confirm: Identity of the patient, Procedure, and Site.

5.5.2 The physician performing the procedure/surgery is responsible for reading and interpreting the radiographic films to be used during the procedure and confirming that the films have been placed correctly for the correct patient.
5.5.3 A verbal time out or pause must be done in the location where the procedure is to be performed, immediately before the start of the case by the entire procedure/surgical team. The patient does not have to be awake during time out.

5.5.4 Even when there is only one person doing the procedure, a brief pause to confirm the correct patient, procedure and site is required. Site marking must be visible at the time out.

5.5.5 The time out requires confirmation of:
A. Correct patient,
B. Correct side/site
C. Correct procedure
D. Correct patient position
E. Correct radiographs, and
F. Correct implants and equipment
G. VTE (Venous Thrombo Emblism) prophylaxis
H. Surgical site infection bundle
I. In addition to any anticipated critical events.

5.5.6 Time out will be documented in the medical record, documentation includes all the above items mentioned under (5.5.5).

5.5.7 In Emergency: time out or pause should be conducted unless there is more risk than benefit to the patient.

5.5.8 In Bedside procedures: A time out must still occur with all parties involved in the procedure prior to the start of the procedure and must be documented in the medical record.
5.6 **Before any team member or the patient leaves the operating room:**

5.6.1 Nurse verbally confirms with the team:

   A. The name of the procedure is documented.

   B. Instruments, swabs and sharps counts are complete

   C. All specimens been labeled (including patient identification)

5.6.2 All team should clarify:

   A. Any equipment problems identified that need to be assessed.

   B. Key concerns for recovery and management of the patient.

5.7 **Procedure for Managing Discrepancies**

5.7.1 Any discrepancies in data should be clarified with the physician.

5.7.2 If the patient is a minor, incompetent or sedated; has a language barrier; or is a trauma/emergency victim, accurate communication may be impeded. In such cases, the family’s interpreter, or legal guardian should complete the identifiers and verify site mark (P&P of Informed Consent – MOH/DGQAC/005/Vers. 1.0)

5.7.3 If any of the above guidelines cannot be followed, the attending physician must write a detailed explanation of the extenuating circumstances in the medical record.

5.7.4 When the same patient has two or more procedures: If the person performing the procedure changes, another time-out needs to be performed before starting each procedure.

5.7.5 A discrepancy at any point must stop the case from proceeding until resolved.

5.7.6 All team members and patient (if possible) must agree on the resolution(s) to the identified discrepancy.
5.7.7 The discrepancy and resolution must be documented by the physician, registered nurse, radiology technician or other appropriate healthcare professional involved in the case.

6. Responsibility

6.1 All healthcare professional will verify patient’s identity by asking the patient to state his or her full name, date of birth and procedure/surgery to be performed.

6.2 The physician performing the procedure/surgery is responsible for site marking.

6.3 The physician performing the procedure/surgery is responsible to verify the patient’s identity, consent, medical record data including history & physical, and radiographs to confirm accuracy before site marking.

6.4 In Time out, the physician performing the procedure/surgery is responsible for reading and interpreting the radiographic films to be used during the procedure and confirming that the films have been placed correctly for the correct patient.
7. **Document History and Version Control**

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<th>Review Date</th>
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<td>01</td>
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<td>Minister of Health</td>
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8. **Related Documents:**

8.1 P&P of Patient Identification (MOH/DGQAC/004/Vers 1.0).

8.2 P&P of Informed Consent (MOH/DGQAC/005/Vers 1.0).

8.3 P&P of Safe Surgery, Pre-Operative Communication (MOH/DGQAC/006/Vers 1.0).

9. **Attachments:** Safe Surgery Checklist
10. References:

<table>
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<tr>
<th>Title of book/journal/articles/Website</th>
<th>Author</th>
<th>Year of publication</th>
<th>Page</th>
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<tr>
<td>Ensuring Correct Surgery. Available at: <a href="http://www.patientsafety.gov/CorrectSurgDir.DOC">http://www.patientsafety.gov/CorrectSurgDir.DOC</a></td>
<td>Department of Veteran’s Affairs National Centre for Patient Safety</td>
<td>2006</td>
<td></td>
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<td>Implementation expectations for the universal protocol for preventing wrong site, wrong procedure, and wrong person surgery.</td>
<td>The Joint Commission</td>
<td>2003</td>
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<td>Universal Protocol for preventing wrong site, wrong procedure, wrong person surgery.</td>
<td>The Joint Commission</td>
<td>2003</td>
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<td>Implementation Guidelines for Ensuring Correct Patient, Correct Side and Correct Site Surgery</td>
<td>Royal Australasian College of Surgeons</td>
<td>2004</td>
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<td>Safe patient, Safe procedure</td>
<td>K.A. Abulmajid</td>
<td>2012</td>
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<td><a href="http://www.aorn.org/about/positions/correctsite.htm">www.aorn.org/about/positions/correctsite.htm</a></td>
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<td>Patient Safety alert 06</td>
<td>NPSA</td>
<td>2005</td>
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## Safe Surgery Checklist

### SIGN IN (To be read out loud)

**Before induction of Anesthesia**
- Pre-operative checklist is reviewed, completed and signed:
  - No
  - Yes
- Has the patient confirmed his/her identity, site, procedure and consent?
  - No
  - Yes
- Is the surgical site marked?
  - No
  - Yes
  - Not applicable
- Is the anesthesia machine and medication check complete?
  - No
  - Yes
- Pre anesthesia assessment including ASA scoring and difficult airway/aspiration risk is completed:
  - No
  - Yes
- Monitoring equipment is checked and functioning:
  - No
  - Yes
- Risk of >500 ml blood loss (7ml/kg in children) is assessed:
  - No
  - Yes
- Two Intra venous access in place and functioning
  - No
  - Yes

**Responsibility Name**

**Signature:**

### TIME OUT (To be read out loud)

**Before start of surgical intervention**
- for example, skin incision

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<th>Question</th>
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<th>Yes</th>
<th>Not applicable</th>
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<tr>
<td>Have all team members introduced themselves by name and role?</td>
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<tr>
<td>Surgeon, Anesthetists and Registered Practitioner verbally confirm:</td>
<td></td>
<td></td>
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<tr>
<td>- What is the patient’s name?</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>- What procedure, site and position are planned?</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Anticipated critical events explained by Surgeon:</td>
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<td></td>
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<tr>
<td>- How much blood loss is anticipated?</td>
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<td>- Any specific equipment requirements or special investigations?</td>
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<tr>
<td>- Any critical or unexpected steps to know about?</td>
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<tr>
<td>Anticipated critical events explained by Anesthetist:</td>
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<tr>
<td>- Are there any patient specific concerns?</td>
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<td>- What is the patient’s ASA grade?</td>
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<td>- Any specific level of support are required</td>
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<td>Anticipated critical events explained by Nurse:</td>
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<td>- Sterility of the instruments confirmed (including indicator results)?</td>
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<td>- Are there any equipment/instruments issues or concerns?</td>
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<td>Has the surgical site infection (SSI) bundle been undertaken?</td>
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<tr>
<td>- Antibiotic prophylaxis within last 60 minutes</td>
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<td>- Patient warming</td>
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<td>- Hair removal</td>
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<tr>
<td>- Glycemic control</td>
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<tr>
<td>Has VTE prophylaxis been undertaken?</td>
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<tr>
<td>Is essential imaging displayed?</td>
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<tr>
<td>Surgical Implants in place?</td>
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### SIGN OUT (To be read out loud)

**Before any member of the team leaves the operating room**

- Nurse verbally confirms with the team:
  - The name of the procedure been recorded?
    - No
    - Yes
  - Instruments, swabs and sharps counts are complete
    - No
    - Yes
    - Not applicable
  - All specimens been labelled (including patient identification)?
    - No
    - Yes
    - Not applicable

**Surgeon, Anesthetist and Nurse:**
- Have any equipment problems been identified that need to be assessed?
- What are the key concerns for recovery and management of this patient?

### Patient Information

**Name:**

**MRN:**

**Date:**

MRF 006