

Title:	Correct Patient, Correct Procedure and Correct Site Policy		
Policy Author(s)	Dr Stephen Badger, Consultant Vascular Surgeon Tel: 028 961 56394 Stephen.Badger@belfasttrust.hscni.net Shauna McKenna, Nursing Development Lead Tel: 028 961 51964 Shauna.Mckenna@belfasttrust.hscni.net		
Responsible Director:	Bernie Owens, Director of Unscheduled and Acute Care		
Policy Type: (tick as appropriate)	*Directorate Specific <input type="checkbox"/>	Clinical Trust Wide <input checked="" type="checkbox"/>	Non Clinical Trust Wide <input type="checkbox"/>
If policy type is confirmed as *Directorate Specific please list the name and date of the local Committee/Group that policy was approved			
Name:		Date:	
Approval process:	Standards and Guidelines Committee Executive Team Meeting	Approval date:	13/10/2020 11/11/2020
Operational Date:	November 2020	Review Date:	November 2025
Version No.	3.1	Supersedes	V3 – November 2020 – November 2025
Key Words:	Surgery, Procedure, Site, Correct, Operation		
Links to other policies	BHSCT Policy for the application of the WHO surgical safety checklist (2020) SG 05/13		

1.0 **INTRODUCTION / SUMMARY OF POLICY**

Surgery or procedures performed at the incorrect anatomical site are rare. However, they can be devastating for patients. Correct patient, correct procedures and correct site (CSP) refers to operating on the correct patient, the correct side of the patient and / or the correct anatomical location or level (such as the correct finger on the correct hand). This document outlines the national standard for pre-operative marking as outlined by the National Patient Safety Agency (NPSA, 2005) and provides a checklist for verification of marking for all surgical patients. This policy should be used in conjunction with the Trust Pre-operative checklist and the World Health Organisation (WHO) Peri-operative Checklist, Stop Before You Block (RA - UK, 2011) the Belfast Trust Protocol for Digital Amputation Marking, Appendix 1 and the Belfast Trust Neurosurgery Pre-Operative Marking Verification Checklist, Appendix 2

1.1 **Background**

Healthcare organisations in both the United Kingdom and North America have identified that communication breakdowns and failures of all types are a feature of many surgical events at the wrong site. The increasing complexity of healthcare systems is a contributory factor.

The *National Patient Safety Agency (NPSA)* and *Royal College of Surgeons of England (RCS)* have drawn up recommendations for surgical marking and a checklist to help staff rapidly confirm that steps to promote CSP have been taken. These are endorsed by a number of professional associations and Royal Colleges representing a cross section of surgical staff. The NPSA has devised a pre-operative marking checklist that provides a practical method for implementing the recommendations. It incorporates best practice for marking and subsequent checking of the mark, highlights the role of the surgeon and also other members of the operating theatre team in ensuring that patients receive the correct treatment.

1.2 **Purpose**

The purpose of this policy is clarify and inform a universally acceptable method within the Belfast Health and Social Care Trust (BHSCT) in order to ensure that patients undergoing a surgical, medical, anaesthetic, radiology or oncology procedure will have their surgery or invasive procedure site marked appropriately and accurately. It will:

- Describe the principles by which the Trust will ensure that surgical interventions or invasive investigative procedures are performed on the correct patient at the correct site.
- Ensure that patient safety is maintained through the consistent practices of pre-operative marking and verification checks.
- Ensure that pre-operative site marking and verification checks are undertaken and completed for all surgical interventions or invasive investigative procedures performed under local and/or general anaesthetic, including those carried out in other settings.

- Ensure that any procedure performed on the patient reflects what has been consented to and that the procedure/treatment has been performed on the patient's correct site and correct side.

This policy also provides assurance to the Medical Director that the risk of wrong site surgery is minimised.

1.3 Objectives

To provide guidance to staff on:

- Checks needed before marking site.
- How to mark site correctly.
- When to mark site.
- Who is to mark site.
- Exemptions to site marking.
- Specialty specific instructions.

2.0 SCOPE OF THE POLICY

This policy is of interest to surgeons, anaesthetists, nurses, ODP's and ward staff who are responsible for identification and/or marking of a patient's surgical or invasive investigative procedure site.

3.0 ROLES AND RESPONSIBILITIES

3.1 Medical Director

The Medical Director has ultimate responsibility for ensuring that appropriate processes are in place for the safe management of surgical or invasive investigative procedures, including preoperative marking.

3.2 Lead Clinicians

Clinical Directors and Clinical Leads in each specialty have responsibility for ensuring their surgeons mark patients accordingly and carry out the instructions within this policy.

3.3 Operating Surgeon / Clinician (or deputy)

It is the responsibility of the operating surgeon / clinician performing the procedure or their nominated deputy to mark the operative site in accordance with this policy (nominated deputy must- be present during procedure).

It is recognised that there will be instances relating to emergency admissions, when patients will be marked by a member of the surgical team who will not be the operating surgeon, but who will be responsible for obtaining consent for the procedure.

3.4 Anaesthetists

Anaesthetists are responsible for checking the surgical site marking and the correct site and side before insertion of a regional block anaesthetic.

The anaesthetist and anaesthetic assistant must be involved in the sign in if administration of anaesthetic is required. This will include the checking of site marks. All anaesthetists should do a 'Stop before you block' prior to any regional anaesthetic technique.

3.5 The Operating Theatre Team

The operating theatre team has joint responsibility for ensuring that the WHO Checklist is completed prior to surgery and as part of this, that the correct site and in particular the side has been identified prior to commencement of surgery.

3.5.1 Operating anaesthetist

For procedures performed under general or regional anaesthesia, the anaesthetist and anaesthetic assistant must be present for sign in.

3.5.2 Operating surgeon

For procedures not involving an anaesthetist, the operator and an assistant should perform the sign in. The operating surgeon is responsible for ensuring that the WHO safer surgery checklist 'time out' (or appropriate adaptation) is completed prior to the surgery commencing and that this is documented appropriately.

3.5.3 Operating Scrub nurse

The scrub nurse assigned to the case is responsible for ensuring that the WHO safer surgery checklist 'sign out' is completed prior to the patient leaving the theatre and that this is documented appropriately.

4.0 CONSULTATION

Circulated to lead clinicians and senior management within all relevant departments. Circulated to Standards and Guidelines Committee

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Dissemination

The policy will be disseminated to all surgeons, anaesthetists, lead clinicians, clinical directors, service managers and all registered nurses and support staff both within ward and the peri-operative environment.

5.2 Resources

Training of all surgeons and junior doctors must be carried out at their induction and specifically at local induction, covering the WHO checklist and guidelines for surgical site marking. This will be provided by the designated clinical teams providing new employee induction for surgical teams. This will be directed by clinical leads.

5.3 Policy Principles

5.3.1 Preoperative Skin Marking

The patient should be marked at the time of consent. This of course will not be the case in the event that the patient has consented for surgery at a clinic appointment. The confirmation of consent is completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance. The healthcare professional is required to confirm that s/he has no further questions and wishes the procedure to go ahead.

The patient's surgical site is to be marked before the patient is moved to the location where the procedure will be performed. The patient will be involved, awake and aware and this should preferably occur before any prescribed pre-medication is administered. Documentation of completion of marking must be included in the patient's medical notes before the patient can be transferred to the operating department or procedure room. 'Left' or 'Right' must be written in full on all documentation.

If the preoperative site is unavailable for marking because of dressings, bandages, POP, the site should be marked as close as possible to the operative site.

The mark is to be an arrow pointing to the site of the operative procedure as close as possible to the incision site.

The mark is to be made with an indelible, permanent black marker pen and should be sufficient to remain visible after skin preparation and draping and, if practicable, be in the exposed operative field. In areas where the marked side may be hidden by drapes, the corresponding arm must be marked as an additional measure to indicate correct side.

Where patient may be turned during the procedure, there should be at least two marks, so that the correct site/side is clearly marked at all times during the procedure.

The site for all procedures that involve incisions or insertion of instruments must be marked, taking into consideration surface, spine level, specific digit or lesion to be operated on.

For procedures involving laterality of organs, but where the decision or approach may be from the mid-line or natural orifice, the site must be marked and a note made of the laterality.

All site markings must be made in conjunction with checks made on the patient's diagnostic imaging results i.e. X-rays, scans, electronic imaging or other appropriate test results, ensuring these match the patient's medical notes and identity band. Where imaging data is used to confirm the side and site of a procedure is correct, this must be confirmed by two or more members of the clinical team who should also check that the radiographic images are properly labelled.

Other sites that may require marking are those necessary for some other aspect of care that directly relates to the planned, proposed procedure – i.e. dual/multiple surgical sites, stoma sites.

5.3.2 Who Marks the site?

The person who is responsible for making the mark on the patient is the Operating Surgeon / Clinician who will be performing the procedure, or the delegated deputy who must also be present during subsequent procedure.

Where a patient will require a stoma as a result of a planned, elective procedure, the stoma site may be marked by the stoma nurse specialist pre-operatively in collaboration with the surgical team.

5.3.3 Exceptions to Site Marking

All endoscopies without planned intentional, invasive procedures are considered exempt from surgical site marking. Also, such sites where there is no predetermined site of surgical access, (e.g cardiac catheterisation, spinal analgesia, epidural) and other minimally invasive procedures, would be considered exempt.

There may also be exemption instances where the laterality of surgery needs to be confirmed following examination under anaesthetic (EUA) or exploration.

Procedures that have a midline approach for specific named treatments intended for a single specific organ i.e. caesarean section, hysterectomy or thyroidectomy, can also be exempted from site marking.

It is acknowledged that there is no practical or reliable way of marking teeth or mucous membranes; especially in the case of teeth planned for extraction. A review of the dental records and radiographs with the tooth/teeth must be undertaken and their anatomical numbers for extraction clearly marked on these records and radiographs.

Other areas/patients where it is anatomically and technically difficult to mark the operative site include areas such as the perineum, friable skin around the site and with neonates or premature infants.

For obvious wounds or lesions, site marking is not applicable if that wound or lesion is the site of surgical intervention. However, if there are multiple wounds or lesions and only some of them are to be treated and this decision is pre-determined, then these sites must be marked as soon as possible after the decision has been made for surgery.

For any sites not marked, the proposed operation/procedure must be reviewed to verify patient and procedure at the 'Time Out' part of the WHO Safety Checklist. This must be undertaken in conjunction with a review of all relevant documentation, including: the patient's notes; appropriate charts; diagnostic imaging (correctly oriented); and a 'double person' check of all

information. The procedure must not commence without this review having occurred.

Lifesaving surgery should not be delayed due to lack of pre-operative marking. Compliance with WHO policy is essential under these circumstances.

5.3.4 Specialty specific instructions - (Not otherwise covered above)

1. Spinal Surgery

For spinal surgery, a 2-stage marking process will be used. Firstly, before the patient goes to the operating theatre, the general level of the procedure is marked pre-operatively: cervical, thoracic or lumbar. The surgical site is appropriately marked to show either an anterior or posterior approach with right or left sides being clearly indicated. Secondly, during the operation itself, the exact interspace(s) or levels are demonstrated using standard intra-operative radiographic marking technique.

2. Ophthalmic Surgery

For single eye surgery, a small mark should be made on the temple above and pointing to the correct eye for treatment. The exception is for planned bilateral procedures on both eyes (such as bilateral squint surgery), but the laterality of such procedures should be well documented.

The marking of a child's head/face must be assessed at the time of pre-assessment by the surgeon. In general, a mark should always be made, and it is usually straightforward to mark a child's face without distressing the child if done in a sensitive manner. If no mark is made, then the procedures referred to at 4.3.7 must be adhered to.

3. Bilateral Treatment

Whilst this policy focuses on laterality, specific anatomical sites, levels and areas, surgeons must consider that it is possible to perform the wrong bilateral procedure(s). Therefore site marking for bilateral, identical, procedures is not required. If no mark is made, then the procedures referred to at 4.3.7 must be adhered to.

4. ENT Surgery

There may be occasions where marking the patient's skin to 'point' to the correct site for surgery may be inappropriate e.g. bilateral tonsillectomy/adenoidectomy, laryngectomy. In these cases 4.3.3 / 4.3.4 / 4.3.7 apply. For ENT surgical sites where a skin incision is made on a specific side i.e. surgery on the external pinna and tympanotomy and surgical side/site to take the graft, these should be marked with an arrow accordingly.

5. Neuro Surgery

For Neurosurgery a mark should be made on the side of the forehead or the back of the neck (below the hairline) for posterior approaches. The marking should take place on the ward with imaging, notes and patient consent available and should adhere to the requirements of paragraphs 4.1 – Making

the Mark. Wherever possible, the patient/carer should be involved in discussion to confirm the operative side. In an emergency situation these principles should be adhered to wherever possible.

Time out **must** take place in theatre before final positioning, head pins inserted or incision made confirming the correct patient, proposed procedure and the correct side with reference to imaging, clinical records, consent form and operating list. These checks should be signed by the operating surgeon, who takes ultimate responsibility for ensuring surgery on the correct side, or designated member of team.

Stereotactic and Image Guided Surgery: Despite the use of stereotaxy, the possibility exists for the wrong sided approaches to be used. The recommendation concludes that where this remains a possibility, the patient is marked preoperatively as for other non-image guided operations. (Neurosurgery Pre-Operative Marking Verification Checklist, Appendix 2)

5.3.5 Exceptions:

The surgical site or side should always be marked unless there is an overwhelming reason not to do so which should be clearly marked in the notes.

Emergency surgery where a delay will be detrimental.

1. Digital Surgery

Each and every digit to be operated on must have an individual arrow pointing to and as close as possible to the respective digit. In cases where both the palmar and volar surfaces of a digit are to be operated on, both should be marked.

2. Anaesthetic Local/Block Procedure

Immediately before the insertion of a regional anaesthetic, the anaesthetist and anaesthetic assistant must simultaneously check the surgical site marking and the site and side of the block (Stop Before You Block).

3. Prior to patient transfer to theatre/procedure room

On review of the operating/procedure list the ward nurse will be able to identify if pre-operative marking is required. The surgical site mark should be checked with the patient at the first nursing pre-operative check on the ward and against reliable documentation (including medical notes, consent form, x-rays) to confirm it is (a) correctly located, and (b) still legible, using the Pre-operative Checklist and documented in the nursing care pathway.

The ward nurse will visually check that a mark is present where this is appropriate. This will be done in conjunction with completing the Adult Pre-Operative Checklist Care- Pathway.

Should the surgical procedure not require a mark, this will be documented in the care pathway as 'not applicable'

If discrepancies are identified at ward level, eg the patient has not been marked or the mark is not visible, then this should be addressed with the surgical team before the patient is transferred to theatre.

Theatre Sign-In

Checking should occur at each transfer of the patient's care; the first – prior to leaving the ward, the second check at handover to theatre area and third prior to commencement of surgery. The anaesthetist and the anaesthetic nurse/ODP should verify the correct site and consent as part of the WHO Safer Surgery Checklist 'sign-in' prior to induction of anaesthesia. If this has not happened, the surgeon must be informed, who may choose to mark the patient in the anaesthetic room. The patient must not be anaesthetised until marking has been undertaken.

Theatre Time-Out

All team members should be involved in checking that mark is correct and for the correct procedure at **Time Out** before start of surgical intervention using the **WHO Surgical Safety Checklist**. 'Time Out' must be performed immediately before the start of the surgery/procedure. The clinical team must verify the following details:

- The presence of the correct patient
- The correct procedure to be performed
- That the correct procedural site has been marked or agreed method of indicating site.

A copy of each patient's WHO checklist will be filed in their medical notes.

6.0 MONITORING AND REVIEW

Key Performance Indicators	Responsible Leads	Evidence	Reviewed by/ frequency	Lead responsible for any required actions
100% of surgical sites will be marked correctly	Operating Surgeon or appointed deputy	WHO documentation	Weekly	Surgical Clinical Director with Advice from Standards and Guidelines
100% compliance of WHO documentation	Lead Nurse Operating Theatre	Form spot checks and weekly audit	Weekly	Service Manager Standards and Guidelines

Audit of compliance with the WHO surgical checklist, which includes site marking, will be in the form spot checks and the weekly audits as outlined in the WHO Surgical Safety Checklist Policy.

7.0 EVIDENCE BASE/REFERENCES

1. National Patient Safety Agency (NPSA) – Patient safety alert 06 – Correct side surgery – making your surgery safer (2005)
2. Regional Anaesthesia United Kingdom (2011) Stop Before You Block Campaign. NHS England. Safe Anaesthesia Liaison Group.
3. National Patient Safety Agency (NPSA). Patient Safety Alert – WHO Surgical Safety Checklist (2009). NPSA/2009/PSA002/U1
4. National Patient Safety Agency (NPSA). Seven Steps to Patient Safety (2004)
5. Royal United Hospital Bath – Surgical Site Marking Protocols and Policy
6. National Patient Safety Agency (NPSA). Rapid Response Report – Avoiding Wrong Side Burrholes/Craniotomy (2008). NPSA/2008/RRR009
7. Withers Orthopaedic Theatres – Surgical Site Marking- Local Protocol NO:46
8. Department of Health. The “never events” list 2011/12: Policy Framework for use in the NHS (2011)
9. Royal Belfast Health and Social Care Trust – Policy for the Application of the WHO Surgical Safety Checklist
10. Society of British Neurological Surgeons (2015)
11. National Patient Safety Agency (NPSA) – Rapid Response Report (Nov 2008)

8.0 APPENDICES

Appendix 1 Belfast Vascular and Endovascular Surgery Department, Digital Marking Trust Protocol

Appendix 2 Neurosurgery Pre-Operative Marking Verification Checklist (Approved via BHSCT Standards and Guidelines Committee May 2008)

9.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this [link](#).

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact
Minor impact
No impact

Wording within this section must not be removed

10.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalitiescreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved
A full data protection impact assessment is required
A full data protection impact assessment is not required

Wording within this section must not be removed.

11.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address

Wording within this section must not be removed.

12.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Stephen Badger

13/10/2020

Date: _____

Policy Author



11/11/2020

Date: _____

Director

Belfast Vascular and Endovascular Surgery Department

Protocol for digital amputation marking

Background

Within vascular surgery a large number of digital amputations are carried out and we are conscious of the possibility of wrong site surgery. Following review of the relevant literature and appropriate benchmarking, the following recommendations have been made to help reduce the possibility of wrong site surgery in digital amputation patients.

This protocol must be used in conjunction with the below policies

- Policy to be followed when obtaining consent for examination, treatment or care in adults and children.
- Correct Patient, Correct Site and Correct Procedure Policy.
- Policy for the Application of the WHO Surgical Safety Checklist

Recommended care pathway of digital amputation patients:

1. The foot should be reviewed on the morning of surgery and the digit(s) confirmed with other members of the team present, as well as with the patient.
2. If the case is cancelled and re-scheduled to the following day, the same examination and confirmation should occur the following morning, as it may be a different operating surgeon.
3. The digit(s) should be marked as close to the digit as possible, so that it continues to be visible after theatre skin prep and draping. Preferably it should be on the dorsum of the foot and involve both verbal description and appropriate arrows to the effected toe(s).
4. The foot should be numbered 1st toe – Big/Great toe. 2nd Toe – long toe. 3rd Toe – middle toe. 4th toe – Ring toe. 5th Toe – Little/Pinkie toe.
5. The hand should be numbered 1st digit – Thumb. 2nd digit – Index. 3rd digit – Middle. 4th digit – Ring. 5th digit – Little.
6. Should this deviate from the initial plan an explanation should be provided and subsequently detailed on the operation note.

Appendix 2

PRE-OPERATIVE MARKING VERIFICATION CHECKLIST

Patients name:	Date:	
Hospital No/DOB:	Intended procedure	
Addressograph label		
	Responsibility	Signature to confirm check completed:
<u>Check 1</u> <ul style="list-style-type: none"> Check the patients identify Check reliable documentation and/or images to ascertain intended surgical site Mark the intended site with an arrow using an indelible pen 	The operating surgeon or nominated deputy, who will be present in the theatre at the time of the patient's procedure.	Signed: Print name:
<u>Check 2</u> <ul style="list-style-type: none"> Prior to leaving ward/day care area the mark is inspected and confirmed against the patient's supporting documentation Relevant imaging studies accompany patient or are available in operating theatre or suite 	Ward or day care staff	Signed: Print name:
<u>Check 3</u> <ul style="list-style-type: none"> In the anaesthetic room and prior to anaesthesia, the mark is inspected and checked against the patient's supporting documentation Re-check imaging studies accompany patient or are available in operating theatre or suite The availability of the correct implant (if applicable) 	Operating surgeon or a senior member of the team	Signed: Print name:
<u>Check 4</u> The surgical, anaesthetic and theatre team involved in the intended operative procedure prior to commencement of surgery should pause for verbal briefing to confirm: Presence of the correct patient <ul style="list-style-type: none"> Marking of correct site Procedure to be preformed 	Theatre staff directly involved in the intended operative procedure	Signed: Print name:

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