Delivering a **Healthy WA**

Correct Patient, Correct Procedure and Correct Site Policy and Guidelines for Western Australian Health Services

Department of Health

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A. Background

System failures, human error and problems with medical devices and medications can all lead to potentially preventable clinical incidents in a health care facility. A clinical incident is defined as:

> *'an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint'.*[1]

In the context of this document, a 'person' includes a patient, client or visitor. Clinical incidents include:

- near misses – incidents that may have, but did not cause harm; and
- adverse events - an incident in which harm resulted to a person. Harm includes death, disease, injury, suffering and/or disability.[1]

Surgical, medical, anaesthetic, radiology or oncology procedures performed on the wrong body part, wrong side of the body, wrong patient or at the wrong level of the correctly identified anatomical site[2] are preventable adverse events.

(i). The International Evidence

International and Australian literature suggests that the incidence and cost of wrong site surgery is significant, not only to the patient and clinician involved, but also to the health care system.

In 1997 the American Academy of Orthopaedic Surgeons (AAOS) established a Taskforce to determine the incidence of wrong site surgery and to develop and implement initiatives to prevent its occurrence. The Taskforce reviewed data from twenty-two medical insurance organisations covering 110,000 physicians.[3] Three hundred and thirty-one wrong site surgery claims were identified; 225 were related to orthopaedic procedures. Only 2% of the total claims were attributed to wrong site surgery, however, of these, 84% resulted in payments to the plaintiff.[4]

In another American study that ran from January 1995 to March 2001, the Joint Commission on the Accreditation of Healthcare Organisations (JCAHO) reviewed voluntary reports of 1,152 Sentinel Events. Sentinel Events are rare events that lead to catastrophic patient outcomes. Wrong site surgery accounted for 10% (114) of these Sentinel Event reports and included procedures in neurosurgery, urology, orthopaedics and vascular surgery.[5] However, a subsequent review has found that the JCAHO results may have been under reported by a factor of up to 20 times.[6]

In New Zealand, the Accident Compensation Corporation (ACC) received 28 claims for wrong site surgery between 1992 and March 2003. These claims amount to 2% of their reported medical errors. Orthopaedics accounted for 32% of wrong site claims, Dental 28% and Gynaecology 12%. Ear Nose and Throat, General Practice, Ophthalmology and Radiology accounted for 16% of all wrong site claims.[2] The main causes of wrong site procedures identified by the ACC were: misinterpreting a referral or radiology report (20%); identification of the wrong site during surgery (16%), marking of the wrong side of the patient before surgery (16%), and breakdown in communication between members of the surgical team (8%).

(ii). The Australian Evidence

In Australia, many States and Territories are collecting and reporting data on procedures carried out on the wrong patient or body part as part of their sentinel event reporting procedures. In New South Wales 13 such sentinel events were reported in 2003/04 and 14 were reported in 2004/2005.[7] Victoria has been collecting and reporting data on wrong site surgery as part of its Sentinel Events Program since 2001. In 2001/2002 nine sentinel events reported to the Victorian Department of Human Services involved procedures carried out on the wrong patient or body part. Sixteen sentinel events reported in 2002/2003, 14 sentinel events in 2003/2004[8] and 25 sentinel events in 2004/2005 involved procedures on the wrong patient or body part.[9]

(iii). The Western Australian Evidence

In Western Australia, the Department of Health has collected and analysed sentinel event data since October 2003, when the WA Sentinel Event Policy was introduced into the WA health system.[10] Between October 2003 and June 2005, 11 sentinel events involving procedures on the wrong patient or wrong body part were reported to the Chief Medical Officer at the WA Department of Health.[11] Four sentinel events involving procedures on the wrong patient, wrong body part or wrong procedure were reported to the Chief Medical Officer between 1 July 2005 and 30 June 2006.[12]

(iv). The International Response

In highly regulated industries such as the Aviation industry, airlines and pilots are required to adhere to mandated safety standards, which are enforced by agencies like the Federal Aviation Administration (USA) and Civil Aviation Safety Authority (Australia).

One component of the safety standards used by the Aviation industry are detailed procedures and checklists that pilots must follow during a flight. In the health care industry, Governments and professional organisations have adapted the verification procedures and checklists used by pilots to develop a series of processes and checklists to assist health practitioners to ensure correct patient, correct site, and correct procedure surgery.

In 1994 the Canadian Orthopaedic Association developed a position paper and education program *'Operate Through Your Initials'* to reduce the incidence of wrong site surgery.[13] This was followed by the American Academy of Orthopaedic Surgeons (1998)[14] and the American College of Surgeons (2002)[15] who have endorsed programs encouraging health care organisations and surgeons to develop guidelines and processes to ensure correct patient, correct site, and correct procedure surgery.

More recently, JCAHO[16] and the Veterans Affairs National Centre for Patient Safety (VA NCPS)[17] in the United States have issued separate guidelines for preventing surgery on the wrong site, wrong procedure and wrong person.

(v). The Australian Response

In April 2004, Australian Health Ministers endorsed a recommendation from the Australian Council for Safety and Quality in Health Care requiring *'all public hospitals to report all sentinel events either to the State department or to an agreed third party'*.[18] Procedures involving the wrong patient or wrong body part are one of the eight nationally agreed reportable sentinel events.

In addition, Australian Health Ministers approved the Australian Council for Safety and Quality in Health Care's (ACSQHC's) *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol*.[19] Australian Health Ministers also agreed at this meeting that all State and Territory jurisdictions would ensure that:

> *'all public hospitals adopt the five step right patient, right site, right procedure protocol for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures'.*[18]

The protocol is consistent with the Royal Australasian College of Surgeons' (RACS) *Correct Side and Correct Site Surgery Guidelines*[20] and was adapted from material produced by the Veterans Affairs National Centre for Patient Safety (VA NCPS) in the United States.[17]

(vi). The Western Australian Response

In March 2005, the Western Australian Council for Safety and Quality in Health Care ('the Council') and Office of Safety and Quality in Health Care (OSQH) released the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services*. This policy was based on extensive work undertaken by the Royal Australasian College of Surgeons,[20,21] the VA NCPS and the Joint Commission on Accreditation of Healthcare Organisations (JCAHO)[16] in the USA and the New South Wales Department of Health's Quality and Safety Branch.[22]

In November 2005, the Council reviewed the implementation of the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* by WA hospitals/health services and recommended that:

> *'all surgical, medical, radiology, oncology and endoscopy specialties in WA public hospitals should adopt the five-step process outlined in the correct patient, correct site, correct procedure guidelines to reduce the risk of wrong site treatment or procedural interventions in all surgical and medical procedures'.*

B. The revised and updated correct patient, correct site and correct procedure policy and guidelines

T*he Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services*, released in March 2005 by the Western Australian Council for Safety and Quality in Health Care and Office of Safety and Quality in Health Care has been revised and reissued. The updated Policy and Guidelines supersedes Operational Circular OP 1933/05.

(i). Scope of Policy

The revised and reissued *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* applies to all surgical, anaesthetic and medical procedures that potentially expose patients to harm, including diagnostic procedures and those procedures performed in settings other than the operating room.

This policy is not designed to answer technical issues about whether the chosen treatment/procedure is appropriate for the patient's clinical condition. Rather, the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* is designed to ensure that any procedure performed on a patient reflects what has been consented to, and that the procedure/ treatment has been performed on the patient's correct site and correct side.

(ii). Key Principles

The key principles of the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* are that:

- wrong patient, wrong procedure and wrong site incidents can and must be prevented;
- all team members are responsible for ensuring that the correct treatment or procedure is performed on the correct patient and at the correct site, however, the person in charge of the clinical team carries overall responsibility;
- active involvement and effective communication between the patient and all members of the surgical or medical team is required to ensure that the correct treatment or procedure is performed on the correct patient and at the correct site;
- the patient (or authorised representative) should be involved in identifying and indelibly marking the correct site. Where the patient has been asked or has chosen to mark the site of the surgery/procedure, the senior member of the clinical team must verify that the site has been marked in accordance with the consent form; and
- two or more members of the clinical team are required to confirm that the imaging data used for confirming the side and site of the procedure are correct and properly labelled.

(iii). Roles and responsibilities for ensuring that the site of the surgery or invasive procedure has been correctly identified and marked

(a). Hospitals/Health Services

A hospital/health service will, consistent with its obligation to take reasonable care, minimise the occurrence of wrong patient, wrong procedure, and wrong site incidents.

The Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services represent the minimum standard of care that is expected from all WA clinicians and hospitals/health services.

It is recommended that WA hospitals/health services implement the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines in toto*. However, the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* may be tailored to suit clinical and administrative conditions at the local level.

Area Health Services will implement regular audits to verify that:

- local hospital/health service policies and procedures for preventing wrong site interventions comply with the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services*;
- hospital/health service staff comply with the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* and/or locally endorsed policies and procedures;
- the five-step process outlined in the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* are implemented and utilised in all surgical, anaesthetic, medical, radiology, oncology, endoscopy and telemedicine specialties;
- invasive procedures performed on the wrong patient or wrong site are reported as sentinel event to the Chief Medical Officer, Department of Health within seven (7) working days of the incident occurring, and the investigation findings are submitted to the Department of Health within forty-five (45) working days of initial notification;[23]
- hospital/health service staff participate in approved and relevant specialty morbidity and mortality audits (eg the WA Audit of Surgical Mortality); and
- deaths reportable under the *Coroner's Act 1996* are reported to the Coroner.

(b). Hospital/Health Service Staff

Hospital/health service staff, including clinical teams, have an obligation to *'comply with all lawful regulations and administrative instructions made or issued for the officer's guidance in the performance of their duties, or governing the terms and conditions of the officer's employment'*.[24]

As part of their administrative obligations, hospital/health service staff have an operational responsibility to comply with the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services*.

(iv). Other Relevant Policies

The *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* should be read and used in conjunction with the following Department of Health polices and guidelines:

- Department of Health (2006): *Sentinel Event Policy* (2nd Edition);[23]
- Department of Health (2006): *Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System (AIMS)*;[25]
- Department of Health (2005): *Clinical Risk Management Guidelines for the Western Australian Health System;*[26]
- Department of Health (2006): *Communication in Times of Stress: Procedural Guidelines for Practicing Open Disclosure in WA Health System*;[27] and
- Department of Health (2006): *Consent to Treatment Policy for the Western Australian Health System*.[28]

C. Five stages of the 'correct patient, correct site and correct procedure' policy

The five key steps to the *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* are outlined below.

A checklist must be used by members of the clinical team to document the completion of each step of the five-step verification process. The checklist should be stored on the Theatre Management System or in the patient's medical record. A sample checklist is provided at Attachment C.

Step 1: Ensure that valid informed consent has been obtained

The Department of Health has issued a new *Consent to Treatment Policy for the Western Australian Health System*.[28] This policy updates and replaces the Department of Health's 2000 *Guidelines for Health Practitioners: Patient Consent to Treatment and Disclosure of Material Risk* (OP 1347/00)[29] and related operational circular on *Documenting Patient Consent to Treatment and Disclosure of Material Risks by Health Practitioners* (OP 1857/04).[30]

The *Consent Policy for the Western Australian Health System* outlines the process and requirements that are to be followed by all clinicians when obtaining consent to treatment from patients in WA public hospitals. Compliance with the *Consent to Treatment Policy for the Western Australian Health System* is mandatory.

As a matter of policy, no surgical operation, medical, anaesthetic, radiology or oncology procedures may be performed without the consent of the patient, if the patient is a competent adult.

A copy of the full *Consent Policy for the Western Australian Health System* and associated consent forms is available from the Office of Safety and Quality in Health Care website at: http://www.health.wa.gov.au/safetyandquality/

Step 2: Confirm the patient's identity

The *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* recognises that the patient is an integral member of the team undertaking the verification process.

When the patient is being prepared for their treatment/procedure, it is recommended that a 'team time-out' is taken, and that the patient is involved in the initial stages of the five-step verification process. The 'time-out' may be undertaken in the patient's room or the waiting room, if the patient is an outpatient.

Process

Prior to the patient receiving any medication that could affect his/her cognitive function, a member of the clinical team will take 'time-out' to confirm the following details with the patient:

- the patient's full name and date of birth; (the patient should be asked to state not confirm these details);

- the type of treatment/procedure being performed;
- the reason for the treatment/procedure; and
- the side and site of the treatment/procedure.

Staff must check the patient's responses against the patient's identification band, consent form and other information provided in the patient's medical record. The completion of this **Step** must be recorded on a checklist (Attachment C), which should be completed at the end of each stage of the five-step verification process and stored in Theatre Management System or in the patient's medical record.

If a patient is transferred between different locations within a hospital, is incapable of personally participating in the verification process and has no authorised representative present, a member of staff from the preceding location (e.g. ward or Emergency Department) must act as the patient's representative during the verification process.

If a patient is unable to participate in the final verification step due to lack of mental competence or due to language barriers, another appropriate adult or approved interpreter should be asked to assist in the communication process. Details of the discussions and the names of the participants must be recorded in the patient's medical record.

It is recognised that some patients (e.g. renal dialysis patients and patients receiving chemotherapy) do not wear name bands that can be checked prior to a procedure. In addition, many patients, for example oncology patients, undergo multiple procedures during a single hospital visit (e.g. oncology day patients not only have chemotherapy administered but also have invasive procedures performed such as bone marrow aspirations, lumbar punctures with intrathecal injections etc).

Hospitals/health services must therefore implement appropriate processes to ensure that these patients will be adequately identified and managed, particularly if they are unable to give their name or do not speak sufficient English to understand what is happening.

Step 3: Mark the site of the surgery or invasive procedure

The site of the surgery or invasive procedure should ideally be marked by the person performing the surgical or interventional procedure.[1] A hospital/health service may permit the task of marking the site of the surgery or invasive procedure to be delegated to another health practitioner. Any health practitioner delegated to mark the site of the surgery or invasive procedure must be sufficiently competent and knowledgeable about the patient's case to be able to undertake this task.

If at any time a health practitioner is concerned that the incorrect side/site is being prepared for surgery or invasive procedure, or if they feel uncomfortable or too inexperienced to undertake the verification task, they should immediately voice their concerns. There must be no criticism of health practitioners raising concerns, even if these concerns prove to be unfounded.

Where the patient refuses marking, this must be documented in the patient's medical records and alternative strategies must be employed to prevent the procedure being performed on the wrong site.

The doctor in charge of the patient retains overall responsibility for ensuring that the site of the surgery/invasive procedure has been correctly identified and marked, and that the surgery/invasive

procedure is performed on the correct side and at the correct site. The senior medical practitioner may be held responsible, where the site of the procedure was not marked or the task was not properly carried out, and results in the procedure being performed on the wrong site.

Process

When marking the site of the surgery or invasive procedure, care should be taken to ensure that the patient is not injured or compromised. Therefore:

- the intended site of incision or site of insertion must be unambiguously marked. Multiple operation/procedure sites must be individually marked (do not mark non-procedure sites);
- all cases involving laterality, multiple structures (e.g. fingers, toes or lesions) or levels (eg spine) must be clearly marked;
- the mark must be visible and sufficiently permanent so as to remain visible following skin preparation and draping. Site marking should be done with an indelible marker, wherever practical;
- marking of the operative site should be done in such a way as to ensure that when a patient is turned or placed in a prone position, the site of the surgery or procedure is still clearly visible to members of the clinical team;
- marking must take place when the patient is awake and before the patient enters the procedure room. Except in an emergency, the patient should not enter the procedure room until this has been completed;
- “Left” or “Right” should be written in full on all documentation. Any abbreviations and symbols used should be endorsed and published by the hospital/health service. The method of marking should also be consistent throughout the hospital/health service; and
- where imaging data is used during the marking process, members of the clinical team must confirm that the images are properly labelled and are for the correct patient.

In order to reduce the occurrence of hospital-acquired infections such as Methicillin-Resistant Staphylococcus Aureus (MRSA) and Epidemic MRSA (EMRSA) in WA hospitals/health services, it is recommended that hospitals/health services use single-use marker pens to mark the site of the surgery or invasive procedure.

Once appropriate marking has been completed, the patient’s medical record should be properly documented.

Possible Exceptions

Exceptions to the requirement for operative sites to be clearly marked may include:

- interventional cases for which the catheter or instrument site is not pre-determined (e.g. cardiac catheterisation, epidural or spinal analgesia or anaesthesia, etc);
- procedures performed on midline organs such as the umbilical, perineal, or anal areas (an obvious exception here is the level of the spinal cord which requires an operation);
- endoscopic or other procedures performed through the mouth or anus;
- single organ cases such as caesarean section, midline sternotomy, laparoscopy, laparotomy or urethtrotomy;

- where the procedure site cannot be marked (e.g. teeth). Relevant radiographs or other scans must, if possible, be marked to indicate the operative site. Where this is not possible, a diagram clearly indicating the site and side must be prepared and entered into the patient's medical record;
- where marking of premature infants may cause permanent tattoos;
- where the operative site is a traumatic site (obvious surgical site);
- where intra-procedure imaging for localisation (e.g. radiological, MRI, stereotaxis) will be used; and
- where the urgency of surgery precludes marking.[1,17,21]

Where the site of the surgery is not marked for urological procedures involving the ureter, clinicians should develop and implement agreed processes and procedures to prevent errors such as the wrong ureter being instrumented.

It is strongly recommended that extra precautionary measures are also taken when preparing a patient for eye surgery. Where possible, the eye should be marked in the ward by the ophthalmologist. Other recommended in-house risk management strategies include: labelling eye drops "left eye" or "right eye" as appropriate, on the bottle; the pre-op nursing record having a tick-box section verifying that the type of procedure and correct side has been fully stated on the consent form and also marked on the patient; an operating theatre policy document containing the elements of the said policy; and a "team time-out" prompt being included in the "prep" dish of all bowl sets, which is then handed to the surgeon with every prepping solution.

The *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* recognises that the above list of possible exemptions may not cover the full range of surgical and medical procedures undertaken in all WA hospitals. Therefore, the hospital/health service executive, in consultation with relevant clinicians and Learned Colleges, may modify this policy and expand the list of exempted procedures to suit clinical and administrative conditions at the local level.

As a minimum, where this Policy has been modified to suit local clinical conditions, it is expected that hospitals/health services will implement appropriate audit procedures to verify that clinical teams are following the mandated procedures.

Step 4: Take a final 'team time-out' in the operating theatre, treatment or examination area.

When the patient arrives in the operating theatre or treatment room, all members of the clinical team (e.g. proceduralist, anaesthetist, nurse) should participate in a final 'team time-out'.

The final 'team time-out' should be consistently initiated by a designated member of the clinical team. The success of the 'team time-out' process is totally reliant on active communication amongst all members of the clinical team.

It is up to the individual clinicians, in consultation with their respective hospitals/health services, to determine whether or not the patient should be anaesthetised before or after the final 'team time-out' has been completed.

Process

Prior to the procedure beginning, all members of the clinical team must participate in a final 'team time-out' and independently verify the following details:

- the presence of the correct patient;
- the correct type of procedure to be performed;
- that the correct procedure site has been marked; and
- availability of the correct prostheses and/or any specialised equipment.

The final 'team time-out' procedure must be conducted in the room where the procedure will be done, immediately before starting the procedure. All participating clinicians (e.g. proceduralist, anaesthetist, nurse) must stop and conduct the final verification.

A member of the clinical team should be delegated to document and sign ***Part 4*** of the checklist (Attachment C) demonstrating the completion of the 'team time-out' process.

The occurrence and result of the 'team time-out' process must be documented. Ideally, where the 'team time-out' process is recorded on the Theatre Management System, a copy of these records should also be stored on the patient's medical record.

Step 5: Ensure the correct and appropriate documents and diagnostic images are available

Clinical errors caused by poor quality documentation or improperly labelled diagnostic images are a real vulnerability in the *correct patient, correct site and correct procedure* process.

Clinicians and hospitals/health services alike have a responsibility to develop and implement policies and procedures to mitigate against this vulnerability. They may do this by ensuring that the relevant documents have been reviewed and are consistent with each other and with the patient's and clinical team's expectations and understanding of the proposed procedure or treatment.

When imaging data is used to confirm the site of the procedure, two or more members of the clinical team must ensure, prior to the commencement of the procedure, that all the relevant documents including x-rays, imaging reports, pathology reports and other clinically relevant material are for the correct patient, are properly labelled and properly presented.

Where there are discrepancies in information or disagreements in verification, the procedure should be delayed until the issues are resolved. This decision should be in keeping with the degree of urgency of the procedure. The justification for proceeding in the presence of such discrepancies must be documented in the patient's medical record and an incident report completed.

Written confirmation of this step should be documented in the patient's medical record.

D. Verification of the correct patient, correct procedure and correct site checking process

The correct patient, correct procedure and correct site checking process should occur at all stages of the treatment process, including:

- at the time the procedure is scheduled;
- at the time of giving consent;
- at the time of admission into the facility;
- any time the responsibility for care of the patient is transferred between clinical teams and/or hospitals/health services;
- during preparation of the patient for their procedure;
- on entry to the procedure suite; and
- before entering the room in which the procedure will occur, or as soon as practicable after entering the procedural room, but prior to the commencement of the anaesthetic.[22]

E. What should occur if discrepancies are identified at any stage of the five-step Correct Patient, Correct Procedure, Correct Site verification process?

In the event that there is a discrepancy identified at any stage of the five-step correct patient, correct procedure, correct site verification process, or there is disagreement regarding the planned treatment/intervention, the commencement of the procedure/intervention must be delayed until verification is confirmed.

(a) Where sedation, neuroleptic or anaesthesia medication have not been administered

If a patient has not been administered any sedation, neuroleptic or anaesthesia medication that may alter his/her mental state, and the verification can be conducted safely in the operating theatre/ treatment room, the surgeon/interventionist should undertake the verification process with the patient. This action must be recorded in the patient's medical record.

(b) Where sedation, neuroleptic or anaesthesia medication have been administered

Where a patient has been administered sedation, neuroleptic or anaesthesia medication that may alter his/her mental state or who may be otherwise incompetent, the surgeon or interventionist must determine the urgency of the case. If the procedure is not urgent, it should be rescheduled until such time that the patient regains his/her mental faculties and the verification can be completed. This action must be recorded in the patient's medical record and an appropriate process undertaken to inform the patient of the reasons for the delay/postponement in treatment. The procedure/ intervention must be rescheduled as soon as practicable.

(c) Emergency Situations

If the surgeon/interventionist deems the surgery/procedure urgent he/she must document their action and rationale in the patient's medical record. In addition, the surgeon interventionist must notify the relevant Clinical Nurse Manager and the Medical Director and relevant hospital/health service Administrators of all incidences where the five-step correct patient, correct procedure and correct site verification process has not been completed. Such notification will be supported with a relevant entry in the patient's medical record.

F. Required action in the event of a wrong patient, wrong procedure or wrong site incident

Procedures involving the wrong patient, wrong site or wrong procedure, are a reportable sentinel event. It is a Department of Health requirement that a sentinel event reporting form is completed and forwarded to the Department of Health within seven (7) working days of the wrong patient, wrong procedure or wrong site incident occurring. Please refer to the Department of Health's Sentinel Event Policy,[23] for more information on the sentinel event reporting and investigation process.

Where a wrong patient, wrong procedure or wrong site incident has resulted in harm or discomfort to a patient while receiving treatment at a hospital, an appropriate representative from the organisation will use, where possible, an approved Open Disclosure process to provide information about the incident to the patient and/or family. Please refer to the Department of Health's policy on Open Disclosure[27] for further guidance.

G. Conclusion

The *Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA Health Services* have been developed to provide a standardised approach for health professionals in WA hospitals/health services to prepare patients for surgical, anaesthetic, medical, radiology and oncology procedures. Further advice, information and assistance can be obtained by contacting, the relevant Learned College such as the Royal Australasian College of Surgeons, or:

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Attachment A. — Definitions

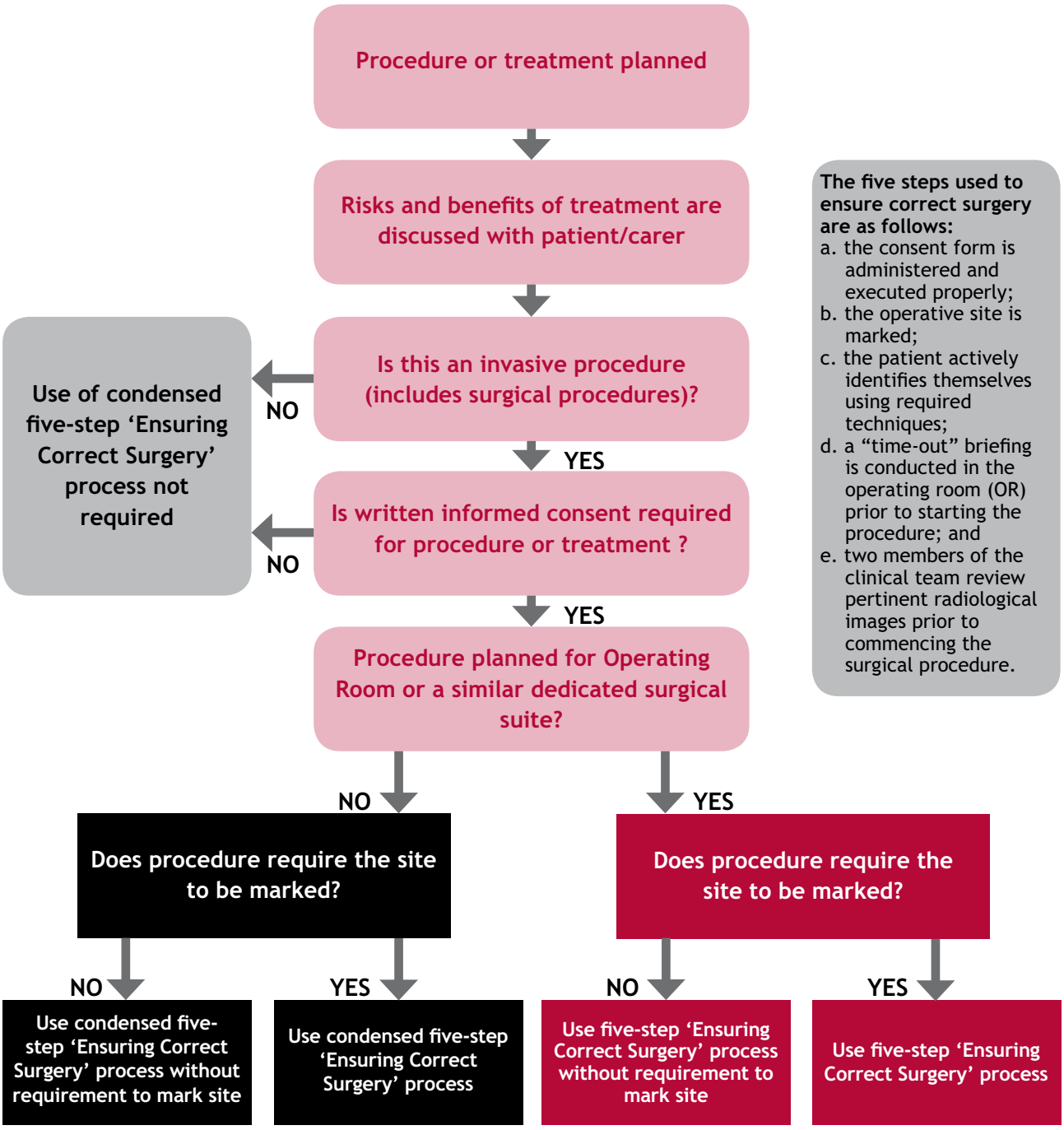
Adverse event	An injury or complication which resulted in death, …disability or prolongation of hospital stay and was caused by the health care received rather than by the disease from which the patient suffered.[1]
Clinical team	The clinical team includes all health professionals participating in the delivery of care at all stages of the surgery/procedure.
Clinician	Clinicians include doctors, nurses and allied health professionals.
Correct Procedure	Does not relate to technical issues around whether the chosen treatment/ procedure was appropriate for the patient's clinical condition. Rather, 'Correct Procedure' relates to whether or not the treatment/procedure was the same procedure that the patient has consented to, and has been performed on the correct site and correct side.
Incident	An incident is an event or circumstance which could have, or did, lead to unintended and or unnecessary harm (death, disease, injury, suffering and or disability) to a person, and/or a complaint, loss or damage.[25]
Informed consent	A doctor's legal obligation to provide patients with appropriate information about the proposed treatment or procedural intervention, including any inherent benefits or material risks to the patient.[28]
Interventional procedure	A procedure involving any invasive contact with a patient. Examples include surgical operations, endoscopy, dentistry and certain radiological procedures.
Material risks	**Material risk:** as defined by *Rogers v Whittaker* (1992) 175 CLR 479, means "a risk which, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it".[28]
Doctor	Any person registered by the Medical Board of WA in accordance with the *Medical Act 1894*.
Near Miss	Incidents that did not cause harm.[25]
Open Disclosure	The open discussion of incidents that result in harm to a patient while receiving health care. The elements of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent recurrence.[27,31]
Person performing the procedure	This is either the Surgeon/proceduralist or his/her delegate who is performing or assisting in the surgery or procedure.
Sentinel Event	Sentinel events are rare events that lead to catastrophic patient outcomes. The Australian Council of Safety and Quality and the Department of Health (WA) have endorsed a national list of sentinel events:[23] ■ Procedures involving the wrong patient or body part. ■ Suicide of a patient in an inpatient unit. Under the Mental Health Act, Mental Health services are also required to report to the Chief Psychiatrist episodes of unexpected death. See Operational Circular OP 2061/06.

Sentinel Event (cont.)	■ Retained instruments or other material after surgery requiring re-operation or further surgical procedure. ■ Intravascular gas embolism resulting in death or neurological damage. ■ Haemolytic blood transfusion reaction resulting from ABO incompatibility. ■ Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs. ■ Maternal death or serious morbidity associated with labour or delivery. ■ Infant discharged to wrong family or infant abduction. ■ Unexpected death or serious disability reasonably believed to be preventable. Assessment should be based on clinical judgement, circumstances and context of the incident. **Serious Incidents and Deaths Reportable to the Chief Psychiatrist** Under the *Mental Health Act 1996*, 'matters to be reported to the Chief Psychiatrist apply in regard to serious incidents and deaths, which occur in mental health services throughout Western Australia':[32] **(a). Deaths** The Chief Psychiatrist is to be informed as a matter of priority, of any death of a patient while under the care of any mental health service. This applies to voluntary and involuntary inpatients and patients cared for in the community. See Operational Circular OP 2061/06 for details on information that needs to be provided to the Chief Psychiatrist. **(b). Serious Incidents** The Chief Psychiatrist is also to be notified as a matter of priority, of any serious incident and associated issue that may reflect on the standards of mental health care in WA. The reporting will include advice as to the potential for media or public implications in regard to the incident or associated issue. Serious incidents may include, but are not confined to the following examples: (a) serious assaults on or by staff, other patients or visitors; (b) alleged sexual assault on or by staff, other patients or visitors; (c) serious medication error in regard to a mental health patient, which may require review; (d) absconding of any forensic patient; (e) absconding of any detained involuntary patient at serious risk of self-harm or harm to others;

Sentinel Event (cont.)	(f) serious misuse or mistake of a function performed under the MHA; (g) activity of any government or non-government organisation which is contrary to functions under the MHA; (h) serious or significant criminal activity, which occurs either in the community or a mental health facility, reported at a mental health facility, and which may receive attention by the media or the police service; (i) any incident which by its nature or persons involved may receive.
Treatment	Treatment includes any medical or surgical management, care, therapy, test or procedure.
Wrong-site procedure	A procedure performed on the wrong area of the body of a patient or on the wrong patient. This can occur at any procedure but is more likely in patients undergoing orthopaedic, spinal, urological, ophthalmic, ENT and dental procedures.[3,4,5]

Attachment B – Correct Patient, Correct Site and Correct Procedure Algorithm[17]

Algorithm for assuring correct invasive procedures in all clinical settings



Note:
1. The following sites of invasive procedures are not required to be marked:
   a. endoscopic and other procedures through the mouth or anus and,
   b. oral surgery and other sites that would require marking a mucous membrane.
2. For sites that are awkward or potentially embarrassing to mark, such as the perineum, a special purpose wristband may be used to indicate the site. In these cases the site and the procedure must be written on the wristband.
3. If the provider is in the presence of the patient from the time of signature consent to the time of the procedure the site does not need to be marked.

Attachment C: Pre-operative/pre-treatment verification checklist[33,34]

Affix Hospital Identification Here	Surname	UMRN	
	Given names	DOB	SEX
	Address		
	Suburb		Postcode

Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

_____

_____

	Responsible Team Member	Signature of staff member confirming completion of process
Check 1 1. Confirm completion of the Informed Consent process 2. Confirm the patient's identity 3. Check patient's medical record, consent form and/ or images to ascertain intended site of treatment/ surgery	■ The surgeon/doctor performing the procedure; ■ Admitting Nurse; ■ Ward Nurse; or ■ Out-Patient Clinic Nurse	**Print name:** **Signature:**
Check 2. Prior to leaving the ward/Out-patient waiting area: ■ Confirm the patient's identity and treatment/ procedure to be performed; ■ Ensure that the intended site of treatment or surgery has been correctly marked using an indelible pen ■ Review the patient's medical record and other supporting documentation and confirm that the site of the treatment or surgery has been correctly marked; ■ Ensure that relevant diagnostic images are present to accompany the patient to the operating theatre or treatment room.	■ Surgeon/proceduralist or delegated Ward/out-patient Nurse ■ Ward/out-patient Nurse; or Theatre Check-in Nurse, who will be present in the theatre at the time of the patient's procedure	**Print name:** **Signature:**
Check 3 Prior to commencement of treatment and/or anaesthesia ■ Confirm the patient's identity ■ Inspect the site marked on the patient and check it against the patient's medical record and other supporting documentation ■ Re-check images that accompanied patient or are available in operating theatre or treatment room ■ Ensure the availability of the correct implant (if applicable)	■ Anesthetist ■ Surgeon/Proceduralist or a senior member of the treating/ surgical team.	**Print name:** **Signature:** **Print name:** **Signature:**
Check 4 Prior to commencement of the surgery or treatment procedure, the surgical or medical team should pause for a 'team time-out' to confirm: ■ Presence of the correct patient ■ Marking of the correct site ■ Correct procedure to be performed ■ Availability of the correct implant (if applicable)	■ Proceduralist/Surgeon or a designated member of the treating/surgical team.	**Print name:** **Signature:**

In the event that there is a discrepancy identified at any stage of the five-step Correct Patient, Correct Procedure, Correct Site verification process, or there is disagreement regarding the planned treatment/intervention, the commencement of the procedure/intervention must be delayed until verification is confirmed.

MR 30.5 PRE-OPERATIVE/TREATMENT VERIFCATION CHECKLIST

Notes: