

# Patient Safety Alert

File Number: 17/18- 01

June 15, 2017

## **CORRECT PATIENT IDENTIFICATION PRIOR TO ANY CARE INTERACTION**

Ensuring correct patient identification prior to any episode of care is fundamental to the delivery of safe health care. Using person-specific identifiers to confirm that patients receive the service or procedure intended for them can prevent harmful events such as administering the wrong medication or blood product to a patient, or performing the wrong surgery or diagnostic test on a patient.

In February 2017, a similar Patient Safety Alert (16/17 – 04) was issued, specifically related to the identification of patients prior to blood transfusion. Failure to correctly identify patients prior to any intervention continues to result in harm to patients.

### **RECOMMENDATIONS**

**The Ministry of Health recommends all regional health authorities and health care organizations:**

- **Have a process in place to ensure correct patient identification prior to performing any care or procedure. The process will require at least two person-specific identifiers are used to confirm the patient receives the service or procedure intended for them.**
- **Ensure the process is in accordance with applicable standards from *Accreditation Canada*, and that staff are trained and comply with the process.**
- **Encourage patients and their families to be active participants in correct identification of the person and procedure. Organizations should encourage patients to discuss concerns about their care with staff prior to any procedure or investigation.**

### **Supporting Documents:**

1. Accreditation Canada Required Organizational Practices 2017 (v2) – Client Identification.
2. Patient Safety Solutions Volume 1, Solution 2/May 2007. The Joint Commission, The Joint Commission International, and The World Health Organization.  
<http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf>

3. Association of Surgical Technologists – Standards of Practice for Patient Identification, Correct Surgery Site and Correct Surgical Procedure.  
[http://www.ast.org/uploadedFiles/Main\\_Site/Content/About\\_Us/Standard%20Patient%20Identification,%20Correct%20Site%20Surgery,%20Correct%20Surgical%20Procedure.pdf](http://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/Standard%20Patient%20Identification,%20Correct%20Site%20Surgery,%20Correct%20Surgical%20Procedure.pdf)

### Background of Critical Incidents

Critical incident #1 - A patient booked for left cataract surgery received the wrong intraocular lens during the surgery. At the time of surgery, there were two charts in use for each patient – one belonging to the health region, and one belonging to the surgeon's office. The error was recognized by the surgeon when the surgeon's office chart for the next patient scheduled for surgery could not be located. The patient who received the wrong intraocular lens received a second surgery to remove the incorrect lens and implant the correct one.

Critical incident #2 - A staff member in ambulatory care called out the first name of a patient into a waiting room full of patients awaiting a medical procedure. A patient with that first name came into the treatment area where the wrong procedure was performed on the patient. The patient's name band was not checked, nor was there confirmation of the last name prior to the procedure. There was no sedation or anesthetic administered prior to the procedure. The error was identified following the procedure. The two patients that were scheduled for different medical procedures shared the same first name, but not the last.

### Contributory Factors and Analysis

In critical incident #1, the Surgical Safety Checklist was completed, but checked against information from only the health region chart. The surgeon's office chart was also used in the operating room, however this chart did not undergo identification and verification with the patient's name band. The wrong lens was implanted during the surgery when the surgeon's office chart belonging to a different patient was used for reference.

In critical incident #2, the last name of the patient was not called out and the patient did not question the procedure performed. The patient identification should have been verified at the point of care.

---

Patient safety alerts may be issued by the Ministry of Health following the review of at least one critical incident reported to the Ministry. A critical incident is defined as a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority, Saskatchewan Cancer Agency or health care organization.

The purpose of a patient safety alert is to recommend actions that will improve the safety of patients who may be cared for under similar circumstances. Recommendations are intended to support the development of best practices and to act as a framework for improvement and can be adapted to fit the needs of the health service organization. When possible, policies or initiatives that have been developed by RHAs or the Saskatchewan Cancer Agency will be shared, to encourage adoption of similar policies or actions.

# REQUIRED ORGANIZATIONAL PRACTICES 2017 (v2)

## CLIENT IDENTIFICATION

*This ROP is found in most service-based sets of standards, see table on page 71.*

**Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.**

---

### GUIDELINES

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depend on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

---

### TESTS FOR COMPLIANCE

Major At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.

---

### REFERENCE MATERIAL

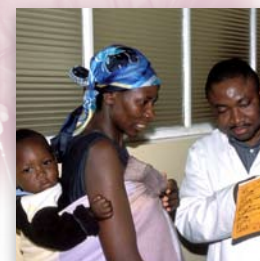
- Allworth, S., Lapse, P., Kelly, J (2008). Technology Solutions to Patient Misidentification - Report of Review. Australian Commission on Safety and Quality in Health Care. Sydney, Australia. [www.safetyandquality.gov.au/wp-content/uploads/2012/01/19794-TechnologyReview1.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/19794-TechnologyReview1.pdf)
- World health Organization (2007). Patient Identification. Patient Safety Solutions. [www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf](http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf)



# Patient Identification

Patient Safety Solutions

| volume 1, solution 2 | May 2007



## ► STATEMENT OF PROBLEM AND IMPACT:

Throughout the health-care industry, the failure to correctly identify patients continues to result in medication errors, transfusion errors, testing errors, wrong person procedures, and the discharge of infants to the wrong families. Between November 2003 and July 2005, the United Kingdom National Patient Safety Agency reported 236 incidents and near misses related to missing wristbands or wristbands with incorrect information (1). Patient misidentification was cited in more than 100 individual root cause analyses by the United States Department of Veterans Affairs (VA) National Center for Patient Safety from January 2000 to March 2003 (2). Fortunately, available interventions and strategies can significantly reduce the risk of patient misidentification.

## ► ASSOCIATED ISSUES:

The major areas where patient misidentification can occur include drug administration, phlebotomy, blood transfusions, and surgical interventions. The trend towards limiting working hours for clinical team members leads to an increased number of team members caring for each patient, thereby increasing the likelihood of hand-over and other communication problems (3). Because patient misidentification is identified as a root cause of many errors, the Joint Commission, in the United States of America, listed improving patient identification accuracy as the first of its National Patient Safety Goals introduced in 2003, and this continues to be an accreditation requirement (4). While in some countries wristbands are traditionally used for identifying hospitalized patients, missing bands or incorrect information limit the efficacy of this system. Colour coding of wristbands facilitates rapid visual recognition of specific issues, but the lack of a standardized coding system has led to errors by staff who provide care at multiple facilities (5).

There are newer technologies which can improve patient identification, for example, bar coding. Some of these have proved to be cost-effective (6-11).

Regardless of the technology or approach used for accurately identifying patients, careful planning for the processes of care will ensure proper patient identification prior to any medical intervention and provide safer care with significantly fewer errors.

## ► SUGGESTED ACTIONS:

The following strategies should be considered by WHO Member States.

1. Ensure that health-care organizations have systems in place that:
  - a. Emphasize the primary responsibility of health-care workers to check the identity of patients and match the correct patients with the correct care (e.g. laboratory results, specimens, procedures) before that care is administered.
  - b. Encourage the use of at least two identifiers (e.g. name and date of birth) to verify a patient's identity upon admission or transfer to another hospital or other care setting and prior to the administration of care. Neither of these identifiers should be the patient's room number.
  - c. Standardize the approaches to patient identification among different facilities within a health-care system. For example, use of white ID bands on which a standardized pattern or marker and specific information (e.g. name and date of birth) could be written, or implementation of biometric technologies.

- d. Provide clear protocols for identifying patients who lack identification and for distinguishing the identity of patients with the same name. Non-verbal approaches for identifying comatose or confused patients should be developed and used.
  - e. Encourage patients to participate in all stages of the process.
  - f. Encourage the labeling of containers used for blood and other specimens in the presence of the patient.
  - g. Provide clear protocols for maintaining patient sample identities throughout pre-analytical, analytical, and post-analytical processes.
  - h. Provide clear protocols for questioning laboratory results or other test findings when they are not consistent with the patient's clinical history.
  - i. Provide for repeated checking and review in order to prevent automated multiplication of a computer entry error.
2. Incorporate training on procedures for checking/verifying a patient's identity into the orientation and continuing professional development for health-care workers.
  3. Educate patients on the importance and relevance of correct patient identification in a positive fashion that also respects concerns for privacy.

---

#### ▶ LOOKING FORWARD:

- ▶ Consider implementation of automated systems (e.g. electronic order entry, bar coding, radiofrequency identification, biometrics) to decrease the potential for identification errors, where feasible.

---

#### ▶ STRENGTH OF EVIDENCE:

- ▶ Expert consensus and reports of significant error reduction from individual facilities after implementing revised patient identification processes.

---

#### ▶ APPLICABILITY:

- ▶ In all health-care settings.

---

#### ▶ OPPORTUNITIES FOR PATIENT AND FAMILY INVOLVEMENT:

- ▶ Educate patients about the risks related to patient misidentification.
- ▶ Ask patients or their family members to verify identifying information to confirm that it is correct.
- ▶ Ask patients to identify themselves before receiving any

medication and prior to any diagnostic or therapeutic interventions.

- ▶ Encourage patients and their families or surrogates to be active participants in identification, to express concerns about safety and potential errors, and to ask questions about the correctness of their care.

---

#### ▶ POTENTIAL BARRIERS:

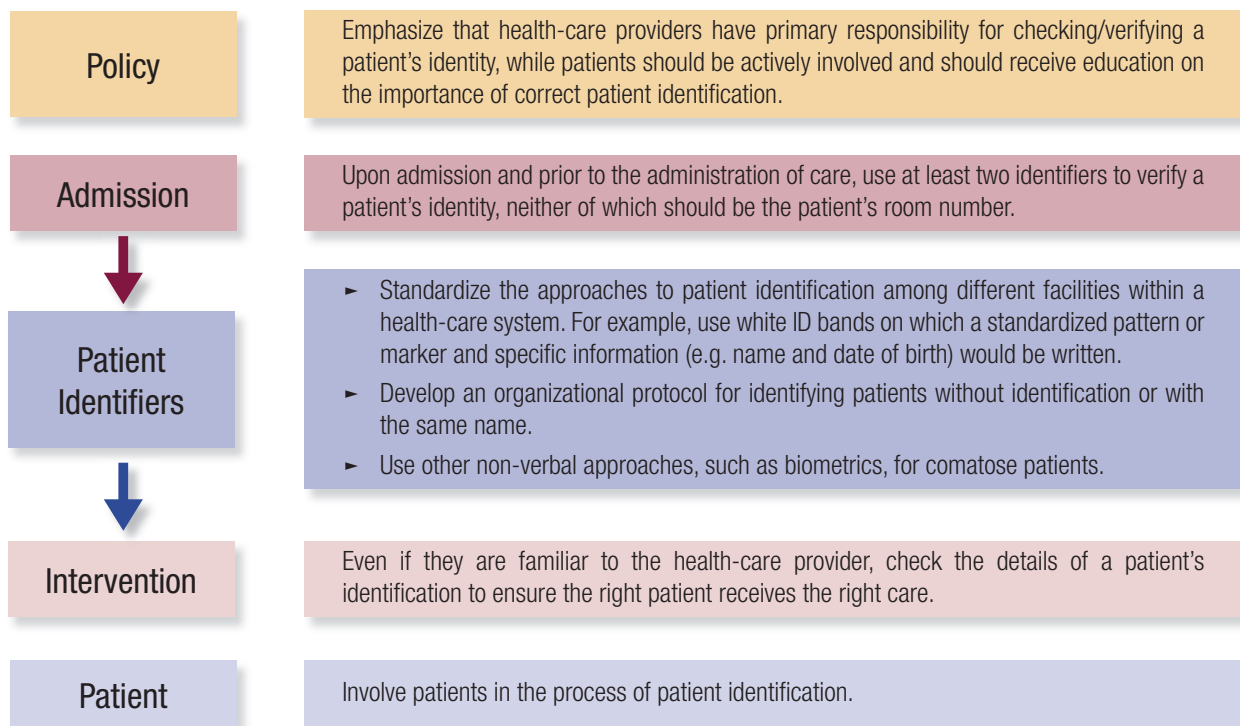
- ▶ Difficulty in achieving individual behaviour change to comply with recommendations, including the use of short cuts and workarounds.
- ▶ Process variation among organizations within a geographic area.
- ▶ Process variation where there may be regional facilities staffed by the same practitioners (for example, colour-coded wrist bands with different meanings in different organizations).
- ▶ Costs associated with potential technical solutions.
- ▶ Integration of technology within and across organizations.
- ▶ Perception by health-care providers that relationship with the patient is compromised by repeated verification of patient identity.
- ▶ Technological solutions that fail to consider the reality of clinical care settings.
- ▶ Increase in staff workload and time spent away from patient care.
- ▶ Typing and entry errors when registering patients on computerized systems.
- ▶ Cultural issues, including:
  - ▶ *Stigma associated with wearing an identification band.*
  - ▶ *High risk of patient misidentification due to name structure, close similarity of names, and inaccuracies in birth dates for elderly patients.*
  - ▶ *Patients using health cards belonging to other individuals, in order to access services.*
  - ▶ *Clothing that conceals identity.*
  - ▶ *Lack of familiarity with local names for increasing number of foreign health-care workers.*
- ▶ Insufficient generally accepted research, data, and economic rationale regarding cost-benefit analysis or return on investment (ROI) for implementing these recommendations.

## ► RISKS FOR UNINTENDED CONSEQUENCES:

- Not assessing the basic processes for care while becoming preoccupied with technical and non-technical devices or solutions.
- Reliance on technical solutions without adapting the workflow process related to the new support systems.
- Reliance on imperfect technical solutions as if they were perfect.

- Elimination of human checking processes when automated systems are implemented.
- Rapid replication of errors in linked computer systems masking patient identification errors.
- Possible compromising of patient confidentiality and privacy by standardized identification systems.

## EXAMPLE OF Patient Identification



*This example is not necessarily appropriate for all health-care settings.*



---

## ► REFERENCES:

1. Wristbands for hospital inpatients improves safety. National Patient Safety Agency, Safer practice notice 11, 22 November 2005. [http://www.npsa.nhs.uk/site/media/documents/1440\\_Safer\\_Patient\\_Identification\\_SPN.pdf](http://www.npsa.nhs.uk/site/media/documents/1440_Safer_Patient_Identification_SPN.pdf)
2. Mannos D. NCPS patient misidentification study: a summary of root cause analyses. VA NCPS Topics in Patient Safety. Washington, DC, United States Department of Veterans Affairs, June–July 2003 ([http://www.va.gov/ncps/TIPS/Docs/TIPS\\_Jul03.doc](http://www.va.gov/ncps/TIPS/Docs/TIPS_Jul03.doc), accessed 11 June 2006).
3. Thomas P, Evans C. An identity crisis? Aspects of patient misidentification. *Clinical Risk*, 2004, 10:18–22.
4. 2006 National Patient Safety Goals. Oakbrook Terrace, IL; Joint Commission, 2006 (<http://www.jcpatientsafety.org/show.asp?durki=10293&site=164&return=10289>, accessed 11 June 2006).
5. Use of color-coded patient wristbands creates unnecessary risk. Patient Safety Advisory Supplement, Vol. 2, Sup. 2. Harrisburg, Pennsylvania Patient Safety Authority, 14 December 2005 ([http://www.psa.state.pa.us/psa/lib/psa/advisories/v2\\_s2\\_sup\\_\\_advisory\\_dec\\_14\\_2005.pdf](http://www.psa.state.pa.us/psa/lib/psa/advisories/v2_s2_sup__advisory_dec_14_2005.pdf), accessed 11 June 2006).
6. Edozien L. Correct patient, correct site, correct procedure. *Safer Health Care*, 27 July 2005. [http://www.saferhealthcare.org.uk/NR/rdonlyres/6D89DBA8-4414-4092-9CF0-62BEBB80F8D8/0/shc\\_patientidentification.pdf](http://www.saferhealthcare.org.uk/NR/rdonlyres/6D89DBA8-4414-4092-9CF0-62BEBB80F8D8/0/shc_patientidentification.pdf).
7. Right patient—right care. Improving patient safety through better manual and technology-based systems for identification and matching of patients and their care. London, National Patient Safety Agency, 2004 ([http://www.npsa.nhs.uk/site/media/documents/781\\_Right%20patient%20right%20care%20final%20report.pdf](http://www.npsa.nhs.uk/site/media/documents/781_Right%20patient%20right%20care%20final%20report.pdf), accessed 11 June 2006).
8. Dighe A et al. Massachusetts General Hospital—bar coded patient wristband initiative: a CPM initiative. IHI National Forum storyboard presentation, December 2004; Safety Improvement Reports. *saferhealthcare*, 2005 (<http://www.saferhealthcare.org.uk/IHI/Topics/IntheRealWorld/PatientIdentification/ImprovementReports/MassachusettsGeneralHospital.htm>, accessed 1 April 2007).
9. Wright AA et al. Bar coding for patient safety. *New England Journal of Medicine*, 2005, 354:329–331.
10. Emerging technology: hospitals turn to RFID. *HealthLeaders*, August 2005 [http://www.healthleaders-media.com/print.cfm?content\\_id=71598&parent=106](http://www.healthleaders-media.com/print.cfm?content_id=71598&parent=106).
11. Secure identification: the smart card revolution in health care. *The Silicon Trust*, 4 June 2003 ([http://www.silicon-trust.com/trends/tr\\_healthcare.html](http://www.silicon-trust.com/trends/tr_healthcare.html), accessed 1 April 2007).

---

## ► OTHER SELECTED RESOURCES:

1. Greenly M: *Helping Hippocrates: a cross-functional approach to patient identification*. *Joint Commission Journal on Quality and Patient Safety*, 32:463–469, August 2006.
2. McDonald CJ. Computerization can create safety hazards: a bar-coding near miss. *Annals of Internal Medicine*, 2006, 144:510–516.
3. National Quality Forum (NQF) Safe Practices for Better Health Care: [http://www.qualityforum.org/projects/completed/safe\\_practices/](http://www.qualityforum.org/projects/completed/safe_practices/)
4. Poon EG et al. Medication dispensing errors and potential adverse drug events before and after. *Annals of Internal Medicine*, 2006, 145:426–434.

### © World Health Organization 2007

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: [permissions@who.int](mailto:permissions@who.int)).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

This publication contains the collective views of the WHO Collaborating Centre for Patient Safety Solutions and its International Steering Committee and does not necessarily represent the decisions or the stated policy of the World Health Organization.



## **Standards of Practice for Patient Identification, Correct Surgery Site and Correct Surgical Procedure**

### **Introduction**

The following Standards of Practice were researched and written by the AST Education and Professional Standards Committee and have been approved by the AST Board of Directors. They are effective October 27, 2006.

AST developed the following Standards of Practice to provide support to healthcare facilities in the reinforcement of proper surgical patient identification, and confirmation of the correct surgery site and procedure in the perioperative setting. The purpose of the Standards is to provide an outline that the surgical team in the perioperative setting can use to develop and implement policies and procedures for surgical patient identification, and confirmation of the correct surgery site and procedure. However, AST refers healthcare providers to The Joint Commission statements in the document *National Patient Safety Goals* for definitive guidance on improving the accuracy of patient identification, correct surgery site and procedure, and developing and implementing policies and procedures. The Standards are presented with the understanding that it is the responsibility of the healthcare facility to develop, approve and establish policies and procedures for identification of the surgical patient, and confirmation of the correct surgery site and procedure according to established healthcare facility protocols.

### **Rationale**

The following are Practices related to the proper identification of the surgical patient, verification of the correct surgery site and surgical procedure by the surgical team. There are many instances when patient misidentification, wrong site surgery and wrong patient can occur, including invasive procedures, medication administration, transfusion of blood products, and matching pathology specimens to the correct patient.<sup>6</sup> The Practices are meant to contribute to the efforts of patient safety and reduce the risks of patient errors.

### **Standard of Practice I**

**The patient should have at least two corroborating patient identifiers as evidence to confirm identity.**

1. The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Additionally, the use of two patient identifiers is necessary in the instances of a name patient alert because two (or more patients) have the same name that can be spelled the same, close to being spelled the same and/or pronounced the same. Examples of acceptable patient identifiers include<sup>9</sup>:



- A. Name
  - B. Assigned identification number
  - C. Telephone number
  - D. Date of birth
  - E. Social security number
  - F. Address
  - G. Photograph
2. The patient's room number should not be used as a patient identifier; room numbers are not person-specific identifiers, since patients can be moved from room to room.<sup>9</sup>

### **Standard of Practice II**

#### **All patients undergoing a surgical procedure should wear an identifying marker.**

1. Identification markers on the patient will prevent wrong patient surgery.
2. Identification markers on the patient will prevent wrong-procedure and wrong-site surgery.
3. Identification markers can include the following:
  - A. Wristband as identification bracelet
  - B. Wristband with unique bar-coded patient identifier
  - C. Radio frequency identification (RFID) marker<sup>3</sup>
4. Healthcare facilities should still be aware that the reliance on wristbands for identification of the correct patient has, obviously, not eliminated the problem of patient misidentification. Surgical technologists should still follow all other patient identification policies to prevent an error. Surgical technologists should be aware of the six most common types of wristband errors as an aid in foreseeing the hazards associated with wearing a wristband<sup>6</sup>:
  - A. Wristband is not present
  - B. Wrong wristband, ie another patient's wristband
  - C. Presence of more than one wristband, and conflicting information is written on both.
  - D. Partially missing information on the wristband
  - E. Erroneous information on the wristband
  - F. Written information on wristband is illegible
  - G. Patient's name is written the same, written close to the same, and/or pronounced the same as another patient's name
5. Surgical technologists should avoid removing the wristband.
  - A. The wristband should be placed on the wrist of the non-operative/non-affected side of the body.
  - B. If the wristband must be removed, it is recommended that it be placed with the patient chart in order to be immediately replaced on the wrist at the end of the procedure, or a new wristband is obtained and placed with the patient chart for immediate placement on the wrist.

### **Standard of Practice III**

#### **All patients undergoing a surgical procedure must be properly identified by the surgical team members prior to transporting the patient to the surgery department.**

1. All surgical team members should recognize that performing an invasive procedure on the wrong patient is a possibility that always exists.<sup>2</sup> No healthcare facility, small or large, is immune from human errors, poor communication and lack of teamwork.<sup>12</sup> To reduce patient identification errors is not accomplished by trying to perfect human performance, but rather by improving the system where healthcare providers work. The human condition can't be changed, but the conditions under which people work can be changed.<sup>11</sup> The following recommendations are intended to reduce the risk of performing an invasive procedure or surgery on the wrong patient.
  - A. The following are recommended times for verification of patient identity and surgical procedures:
    - (1) When the surgery is scheduled
    - (2) When the patient is admitted to the healthcare facility
    - (3) Anytime the patient is transferred to another caregiver
    - (4) Prior to sedation
    - (5) Prior to the patients entry into the operating room
  - B. The following are recommendations for the identification of the conscious, competent patient prior to the start of the surgical procedure<sup>1</sup>:
    - (1) The surgical technologist should address the patient using his/her full name and introduce himself/herself, including job title or position. This will aid in lessening the anxiety of the patient.
    - (2) Patient should be asked to say his/her name, the surgical procedure to be performed, and location of the operation.
    - (3) The patient's name and hospital-assigned identification number on the surgery schedule and transfer slip should correspond with the information on the patient's wristband.
    - (4) The information on the patient's wristband should correspond with the information in the patient's chart.
    - (5) Verify that the procedure listed and described on the informed consent in the patient's chart is the same procedure that the patient verbally stated.
    - (6) Confirm that the correct procedure is on the operating room schedule.
  - C. The following are recommendations for the identification of the mentally incapacitated patient<sup>1</sup>:
    - (1) Verify that the correct patient is being taken to the operating room by asking a family member or designated representative the patient's name.
    - (2) Verify the information on the patient's wristband is the same as the information in the patient's chart.
    - (3) The patient's name and hospital-assigned identification number on the surgery schedule and transfer slip should correspond with the information on the patient's wrist band.

- (4) Verify that the procedure listed and described on the informed consent in the patient's chart is the same procedure listed on the surgery schedule.
  - (5) Confirm with the family member or designated representative the procedure that is expected to be performed, as well as location of the operation and verify this matches up with the informed consent.
- D. The following are recommendations for the identification of a minor patient<sup>1</sup>:
- (1) Complete the recommendations for an alert, oriented patient.
  - (2) Confirm the minor patient's name with the parent or legal guardian, the procedure to be performed and location of the operation.
- E. If, at any point, the verification process fails to confirm the correct patient, correct procedure and/or correct site, the surgeon should be notified and no action taken in transporting the patient into the operating room until the verification is accurate.

#### **Standard of Practice IV**

#### **Verifying the correct surgical procedure and site is the responsibility of the surgical team members.**

1. Methods of proper confirmation of the surgical procedure and surgical site identification should include, but are not limited to, the following:
  - A. Oral confirmation
  - B. Patient identification marker
  - C. Surgery schedule
  - D. Patient chart (ie signed consent for surgery, history and physical)
2. The physician should initial the correct surgical site on the patient, if applicable.
3. It is recommended that the surgical site be "marked" to identify the intended site of skin incision or insertion, ie trocars. Marking the site unambiguously contributes to the safety of the patient by avoiding wrong site surgery.
4. Recommendations for marking the surgical site include<sup>8</sup>:
  - A. No marks of any type should be made on the nonoperative site.
  - B. Use clear unambiguous marks, such as "Yes" or a line marking the proposed skin incision.
  - C. The healthcare facility should establish a policy for indicating the type of mark and method of marking to promote continuity among the various departments of the facility.
  - D. Site marking must take place with the patient conscious, alert and oriented, and the patient indicating the surgery site.
  - E. Use a permanent marker in which the mark will remain visible after the skin prep is performed.
  - F. The mark must be visible after the sterile surgical drapes have been placed.

### Standard of Practice V

**Prior to the start of any surgical procedure, a “time out” should be completed to verify the correct patient, correct surgical procedure, and correct surgical site.**

1. In the preoperative holding area, the surgical team members should ask the patient to state (not confirm) the following (Veterans Administration National Center for Patient Safety).
  - A. Name
  - B. Social Security number or date of birth
  - C. Correct procedure
  - D. Site of surgical procedure
  - E. Patient’s responses should be reconciled against the marked site, patient’s hospital identification wristband, and informed consent.
2. A time-out should serve as a final verification of correct patient, correct procedure, and correct site.
3. A time-out should be performed according to hospital policy.
4. If verification does not occur, the procedure should not occur.
5. With the patient positioned, draped and anesthetized on the OR table, and just before the skin incision is made, “time out” is conducted as a final verbal confirmation of the correct patient, surgical procedure, surgical site, and when applicable, implants (The Joint Commission, 2003).
  - A. The surgical technologist can request a time out if none of the other surgical team members requested it to be completed.

### Competency Statements

Competency Statements	Measurable Criteria
<p>1. Certified Surgical Technologists (CSTs) have the knowledge and proper skills to assist in patient identification, and confirmation of correct surgery site and procedure in a manner that promotes patient safety.</p> <p>2. The CST is qualified to communicate to the surgical team members the confirmation of the correct patient, surgery site and procedure, or communicating a failure during the verification process.</p>	<p>1. Educational standards as established by the <i>Core Curriculum for Surgical Technology</i><sup>5</sup></p> <p>2. The subject of correct patient identification and confirmation of the correct surgery site and procedure is included in the didactic studies as a surgical technology student. Additionally, the studies include the proper documentation of correct patient identification, surgery site and procedure.</p> <p>3. Students demonstrate knowledge of correct patient identification, surgery site and procedure in the lab/mock OR setting and during clinical rotation.</p> <p>4. As practitioners, CSTs perform correct patient identification, and confirmation of</p>



	<p>the correct surgery site and procedure implementing patient safety policies. Healthcare facilities whose protocols and policies allow, CSTs can complete the intraoperative record to include the information pertaining to correct patient identification, surgery site and procedure.</p> <p>5. CSTs complete continuing education to remain current in their knowledge of correct patient identification, surgery site and procedure including annual review of the policies of the healthcare facility.</p>
--	--

### References

1. Beyea SC. *Perioperative Nursing Data Set*. 2<sup>nd</sup> ed. Denver: Association of Perioperative Registered Nurses; 2002.
2. Chassin M., & Becher, E.C. (2002). The wrong patient. *Annals of Internal Medicine*, 136(11), 826-833.
3. Collins J. Remedy for medical errors. 2004.  
<http://www.rfidjournal.com/article/articleview/961/1/1>; Accessed October 10, 2006.
4. *Core Curriculum for Surgical Technology*. 6<sup>th</sup> ed. Littleton, CO: Association of Surgical Technologists; 2011.
5. ECRI. Patient identification. Risk analysis. Risk and quality management strategies 16. *Healthcare Risk Control, Supplement A*. 2003.  
<http://www.saferhealthcare.org/uk/IHI/Topics/PatientIdentification/CaseStudies/DeliveringSaferPatientIdentification.htm>. Accessed October 9, 2006.
6. Joint Commission, The. Implementation expectations for the universal protocol for preventing wrong site, wrong procedure, and wrong person surgery. 2003.  
[http://www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal\\_protocol.pdf](http://www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal_protocol.pdf). Accessed October 10, 2006.
7. Joint Commission, The. 2003 national patient safety goals.  
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/03npsgs.htm>. Accessed October 10, 2006.

8. Joint Commission, The. 2006 national patient safety goals.  
[www.jointcommission.org/NR/rdonlyres/88ED0EA4-395A-4DBA-A12E-25C70AF72C00/0/06\\_npsg.ppt](http://www.jointcommission.org/NR/rdonlyres/88ED0EA4-395A-4DBA-A12E-25C70AF72C00/0/06_npsg.ppt) . Accessed October 12, 2006.
9. Joint Commission, The. Protocol for preventing wrong site, wrong procedure, wrong person surgery. 2003.  
[http://www.jointcommission.org/NR/rdonlyres/DEC4A816-ED52-4C04-AF8C-FEBA74A732EA/0/up\\_guidelines.pdf](http://www.jointcommission.org/NR/rdonlyres/DEC4A816-ED52-4C04-AF8C-FEBA74A732EA/0/up_guidelines.pdf). Accessed October 10, 2006.
10. Reason JT. *Managing the Risks of Organizational Accidents*. London, United Kingdom: Ashgate Publishing; 1997.
11. Strelec, SR. Anesthesia and surgery: Not always a one-sided affair. *American Society of Anesthesiologists Newsletter*, 60. 1996. 2006, from [http://www.asahq.org/Newsletters/1996/06\\_96/feature4.htm](http://www.asahq.org/Newsletters/1996/06_96/feature4.htm)  
Accessed October 10, 2006.
12. Veterans Administration National Center for Patient Safety. Steps to ensure correct surgery.  
[http://www.va.gov/neps/SafetyTopics/CorrectSurg/ECS\\_StepsBg.doc](http://www.va.gov/neps/SafetyTopics/CorrectSurg/ECS_StepsBg.doc)  
Accessed October 11, 2006.