

Room # _____ Procedure: _____



SURG

Procedure Safety Check List

Prior to induction of anesthesia (if applicable)		
Patient Identification:		
1. a. <input type="checkbox"/> Armband	<input type="checkbox"/> Chart	<input type="checkbox"/> Label <input type="checkbox"/> H & P
b. <input type="checkbox"/> Verbal	<input type="checkbox"/> Self	<input type="checkbox"/> Parent/Guardian
c. 2 patient identifiers - - - - -		<input type="checkbox"/>
d. NPO since: _____		
e. IV/INT <input type="checkbox"/> Yes <input type="checkbox"/> No	Where: _____	
f. Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	What: _____	
g. Pre-procedure briefing and introductions (by) _____		<input type="checkbox"/>
h. Patient verbalizes understanding of measures that will be taken to prevent adverse effects - - - - -		<input type="checkbox"/>
Procedure/Site Verification:		
2. Procedure/laterality scheduled correctly - - - - -		<input type="checkbox"/>
3. RN verifies correct procedure/site with schedule and patient's medical record - - - - -		<input type="checkbox"/>
4. Consent - - - - -		<input type="checkbox"/>
5. Patient or designee verifies procedure/site in the presence of RN - - - - -		<input type="checkbox"/>
6. Anesthesia provider and/or Physician interview patient/medical record/verify procedure site - - - - -		<input type="checkbox"/>
7. Site marking - right, left, level of spine or digits - - - - -		<input type="checkbox"/> N/A <input type="checkbox"/>
8. Skin assessment - - - - -		<input type="checkbox"/>
Before skin incision:		
9. Team introductions by _____ - - - - -		<input type="checkbox"/> N/A <input type="checkbox"/>
10. Blood products, Band # _____, implants, devices and/or special equipment - - - - -		<input type="checkbox"/>
11. Sterility indicator results confirmed - - - - -		<input type="checkbox"/>
12. Diagnostic & radiology tests in room - - - - -		<input type="checkbox"/>
13. RN, Anesthesia provider and Physician review medical record, H&P, test results, relevant images and verbally confirm procedure/site - - - - -		<input type="checkbox"/>
14. Anesthesia provider reviews patient risks for difficult airway, blood loss and IV access - - - - -		<input type="checkbox"/>
PROCEDURE FIRE RISK ASSESSMENT		
		Circle Correct Option
		YES NO
Alcohol based prep solution will be used		1 0
Procedure site or incision above the Xiphoid		1 0
Open oxygen source (patient receiving supplemental oxygen via any variety)		1 0
Available ignition source (i.e. electrosurgery unit, laser, fiberoptic light source)		1 0
Total Score:		
Score 3-4 = High Risk; 2 = Low risk with potential to convert to high risk; 1 = Low Risk; 0 = No risk/action required		
FIRE RISK SCORE "1-2" precautions implemented (Mark all that apply)	FIRE RISK SCORE "3-4" precautions implemented (Mark all that apply)	
<input type="checkbox"/> Observe prep is dry	<input type="checkbox"/> Observe prep is dry	
<input type="checkbox"/> Protect heat sources (cautery pencil holster, etc)	<input type="checkbox"/> Follow appropriate draping protocol (i.e. incise drape)	
	<input type="checkbox"/> Use wet sponges	
<input type="checkbox"/> Follow standard draping procedure	<input type="checkbox"/> Have basin of sterile saline available	
<input type="checkbox"/> Non alcohol prep	<input type="checkbox"/> Have syringe full of saline for procedure within the oral cavity	
"Prep Time Out" Time: _____	<input type="checkbox"/> Protect heat sources (cautery pencil holder, use standby mode for Laser, or turn off heat source with fiberoptic light source when not in use)	
	<input type="checkbox"/> Minimize electrosurgery settings	
After patient is draped, immediately before incision, the team performs a time out and verbally confirms:		
<input type="checkbox"/> Correct Patient	<input type="checkbox"/> Pre-operative antibiotics/fluids for irrigation	
<input type="checkbox"/> Correct Side/Site	<input type="checkbox"/> Relevant images appropriately displayed	
<input type="checkbox"/> Correct Procedure	<input type="checkbox"/> Safety precautions based on patient history	
<input type="checkbox"/> Correct Position	<input type="checkbox"/> Safety precautions based on patient history of medication use	
<input type="checkbox"/> Correct Implants and/or Special Equipment	<input type="checkbox"/> Fire Risk Assessment Score _____	
<input type="checkbox"/> DVT Protocol	<input type="checkbox"/> Fire Risk Protocol Implemented _____	
Date: _____	RN Initials: _____	
Time: _____		
Sign Out <input type="checkbox"/> _____		
Time out for 2nd procedure (if applicable): Circulating RN (initials): _____ Date: _____ Time: _____		
Re-verification of side/sites (if applicable): Circulating RN (initials): _____ Date: _____ Time: _____		
Initials	Signature/Title	Print Name



DOCUMENTATION / PROCEDURE / FIRE RISK ASSESSMENT AND UNIVERSAL PROTOCOL

▼ Addressograph / Patient Label ▼