Procedural Safety Checklist – Family Birthing Center Mercy Tiffin Hospital

BEFORE INDUCTION OF ANESTHESIA	BEFORE INCISION OR INVASIVE PROCEDURE	BEFORE STAFF LEAVE ROOM POST PROCEDURE
SIGN IN	TIME OUT	SIGN OUT
PATIENT CONFIRMED: □ SHOWER OR SURGICAL SCRUB AS INDICATED	□ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE	NURSE VERBALLY CONFIRMS WITH THE TEAM: □ PROCEDURE RECORDED
□ IDENTITY-NAME AND BIRTH DATE □ SITE-ABDOMEN AND OR BACK FOR EPIDURAL OR SPINAL OR VAG DEL UNDER DOUBLE SET UP. CIRCLE AS APPROPRIATE	□ SURGEON, ANESTHESIA STAFF AND NURSE VERBALLY CONFIRM PATIENT, SITE, PROCEDURE AND PERFORM TIME OUT TIME__________	□ SPONGE AND INSTRUMENT COUNTS ARE CORRECT □ SPECIMENS ARE LABELED □ NA
TIME OUT FOR ANESTHESIA TIME________ □ PROCEDURE-C-SECTION OR OTHER □ CONSENT SIGNED AND PATIENT UNDERSTANDS □ ASSESS FHT IMMEDIATELY AFTER SPINAL OR EPIDURAL DOSING. FHT'S____TIME____ □ DVT PROPHYLAXIS IN PLACE	□ SURGEON REVIEWS: • WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION AND ANTICIPATED BLOOD LOSS	□ SPECIFIC PROBLEMS TO ADDRESS AND KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THE PATIENT HAVE BEEN COMMUNICATED TO PATIENT, NURSING STAFF AND FAMILY/SIGNIFICANT OTHER.
□ SITE MARKED OR NOT APPLICABLE □ SKIN PREP COMPLETE AND DRY X 3 MINUTES	□ ANESTHESIA TEAM REVIEWS ANY PATIENT SPECIFIC CONCERNS	NOTES:
□ ANESTHESIA SAFETY CHECK COMPLETE	NURSING TEAM REVIEWS: □ ANY EQUIPMENT ISSUES OR CONCERNS	NEONATAL DATA: MALE FEMALE DELIVERY DATE AND TIME__________________
□ PULSE OX ON PT AND FUNCTIONING □ SIGNIFICANT OTHER AT BEDSIDE_________NAME	□ STERILITY OF INSTRUMENTATION CONFIRMED BY INDICATOR STRIP	APGAR SCORES 1 MIN_______5 MIN_______ 10 MIN______ AS APPLICABLE
DOES PATIENT HAVE A (N): PREVIOUS ABDOMINAL INCISION? YES NO	□ HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN 60 MINUTES OF INCISION? YES NO	ANY NEONATAL TRANSITION ISSUES? YES NO IF YES, DESCRIBE______________
ALLERGY BAND ON? YES NO FALLS BAND ON? YES NO	ANTIBIOTIC NAME (S)____________ AND TIME START________________________________	PEDIATRICIAN PRESENT FOR DELIVERY? YES NO
DIFFICULT AIRWAY/ASPIRATION RISK? YES NO IS EQUIPMENT AVAILABLE? YES NO	INCISION TIME:__________________________	RESPIRATORY STAFF PRESENT FOR DELIVERY? YES NO
RISK OF > 500ML BLOOD LOSS? YES -ADEQUATE IV ACCESS AND FLUIDS ARE AVAILABLE/PLANNED. YES NO	SURGERY STOP TIME______________________	OTHER:
PLATELET COUNT IS____________	SPECIAL DRESSING FOR > BMI? YES NO	PATIENT LEAVING SURGICAL SUITE TIME_______
• BLOOD TYPE IS _______	IF YES, WHICH DRESSING? ACTICOAT	REPORT GIVEN TO:____________________
• PATIENT IS BREAST OR BOTTLE FEEDING (CIRCLE ONE)	LABOR________HOURS. NA ROM ___________HOURS NA	
• PATIENT HAS BEEN ON BLOOD THINNING MEDICATION WITHIN THE LAST 72 HOURS YES NO LAST DOSE_____________	SPECIAL DRESSING FOR PROLONGED LABOR OR RUPTURE OF MEMBRANES? ____YES ____NO	SIGNATURE OF PERSON COMPLETING FORM DATE________________ TIME___________

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