SURGICAL TEAM SAFETY CHECKLIST (MR87)

UR Number: ...........................................................
Surname: ...........................................................
Given name: ...........................................................
Second given name: ...........................................................
Hospital: ...........................................................
D.O.B. / / Sex: ...........................................................

The operating surgeon leads the completion of the checklist. During the in theatre check all theatre attendees must participate. No other activities should be undertaken at this time.

1. IN THEATRE - PRE INCISION
- (a) Confirm all team members name and role is displayed on whiteboard or they have been introduced: Yes ☐ No ☐
- (b) Correct patient: Yes ☐ No ☐ N/A ☐
- (c) Correct site (check site marking)? Yes ☐ No ☐ N/A ☐
- (d) Correct procedure: Yes ☐ No ☐
- (e) Is the consent signed? Yes ☐ No ☐
- (f) Does patient have an allergy? If yes, provide detail: Yes ☐ No ☐ Unknown ☐
- (g) Antibiotic prophylaxis (within last 60 minutes): Yes ☐ No ☐ N/A ☐
- (h) Has thrombo prophylaxis been arranged? Yes ☐ No ☐
- (i) Is essential imaging available? Yes ☐ No ☐ N/A ☐
- (ii) Surgeon review: Yes ☐ No ☐
- (iii) Is there any critical/unusual step? If yes, provide detail: Yes ☐ No ☐
- (iv) What is the expected duration? Hrs. __ __ Mins. __ __
- (v) Is there likely to be blood loss requiring transfusion? Yes ☐ No ☐
- (vi) If the answer above is yes, is blood available? Yes ☐ No ☐
- (g) Anaesthesia review: Yes ☐ No ☐
- (i) Are there any patient specific concerns? Yes ☐ No ☐
- (j) Nursing review: Yes ☐ No ☐
- (k) Are there any equipment or other issues? Yes ☐ No ☐
- (m) Has any prosthesis (or special equipment) to be used in theatre been checked and confirmed? Yes ☐ No ☐ N/A ☐

2. IN THEATRE - POST PROCEDURE
- (a) Nurse verbally confirms with the team: Yes ☐
- (b) The name of the procedure recorded: Yes ☐ N/A ☐
- (c) Specimen is labelled correctly (including patient’s name): Yes ☐ N/A ☐
- (d) Are there any equipment problems to be addressed? Yes ☐ No ☐
- (e) Are there any unusual or specific concerns regarding recovery postop management? If yes, provide detail: Yes ☐ No ☐

3. CLINICIAN LEADING THE PROCESS

4. CHECKLIST CONDUCTED BY

Signature Date Time am pm

SA Health Revised January 2014