RANZCO

The Royal Australian
and New Zealand
College of Ophthalmologists

Ocular Surgery Guidelines for Ensuring Correct Patient, Correct Eye, Correct Site and Correct Procedure

Approved by: Board

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The Royal Australian and New Zealand College of Ophthalmologists
ACN 000 644 404
94-98 Chalmers Street, Surry Hills NSW 2010
Phone: +61 2 9690 1001 Fax: +61 2 9690 1321
www.ranzco.edu

1. Purpose and scope

RANZCO recognises the paramount importance of patient safety and expects day surgeries, hospitals and surgeons to adopt protocols utilising multiple, complementary strategies for ensuring correct patient, correct eye, correct site and correct procedure. To the extent possible, the patient or their designated representative should be involved in the process.

Adopting a 'team approach' in the theatre will reduce risk but the operating ophthalmologist is ultimately responsible. Every member of the operating theatre team has a duty to be aware that the correct patient, eye/side and site are operated on. If any member of the team believes that the incorrect patient, eye/side or site is being prepared for surgery they should immediately voice their concerns. There should be no criticism of persons raising concerns even if their concerns prove to be unfounded. Ophthalmologists should be aware of the level of risk for wrong site or eye/side surgery for a particular procedure.

2. Consent and documentation

Verification of the patient must be made prior to surgery. Appropriate legal requirements in this matter must be met. Patient consent must be obtained by the medical personnel. A consent form must be completed and show at a minimum, that the patient has confirmed:

- the site of the operation
- the procedure to be carried out
- their consent

The site and side of the operation should be written in full (i.e. RIGHT or LEFT) and not abbreviated to R or L whenever the side is recorded. All documentation must include which eye is to be operated on. This includes patient notes, hospital forms and operating theatre lists; records on these documents may be abbreviated to R or L.

3. Marking the site of the procedure

a. The surgeon must be satisfied on which eye the procedure is to be performed. This should occur in consultation with the patient if they are able (NB they may be unable due to age, mentation, sedation etc) and the eye/side marked.

b. An indelible pen, firmly attached sticker or other form of identification that cannot be easily washed off or otherwise removed is used to unambiguously mark the eye/side of the procedure before anaesthesia. This is done by the surgeon, anaesthetist or a

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nominated deputy in consultation with the patient and operative notes. The patient is informed that the pen mark indicates the side of the operation.

c. The mark must be visible within the operating field at the time of preparation and draping.

d. The pen mark is checked by the nurse as the patient leaves the ward or holding area for the operating theatre. The pen mark is checked by the scout nurse prior to the patient entering the operating theatre. This mark must then be verified by the scrub nurse.

e. The surgeon visibly checks the pen mark prior to commencing surgery and ensures this is in accord with his/her intended operation.

f. A surgical safety checklist adapted from the World Health Organization Surgical Safety Checklist is provided at **Attachment A.**[2]

g. These Guidelines and attached checklist are not intended to be comprehensive and additions and modifications to fit local practice and accreditation requirements are encouraged. Some hospitals/day surgeries may not require all the elements of this guidance because of the extreme rarity of wrong-site surgery in certain instances. Consistent site marking in all cases does, however, provide a backup check confirming the correct site and procedure.[1]

4. Implants

The surgeon is responsible for ensuring that the correct implant/prosthesis is available and should check for the presence of the correct implant before surgery commences.

5. Imaging and investigations

The surgeon is responsible for ensuring that the correct images and /or diagnostic investigations are available for the planned procedure.

6. Final verification

The surgeon, anaesthetist and nursing team must make a final check prior to surgery (by the surgeon) and at the induction of general anaesthesia (by the anaesthetist) to ensure the correct patient, procedure, site and eye/side and implant, if appropriate.

7. Emergency

In emergency (sight or life threatening situation) some of these steps may be omitted. At all stages of this process, there should be consistency of documentation of the correct eye. If any inconsistency arises, progress towards the operation should be suspended if

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and when it is safe to do so, the incorrect documentation should be changed and signed, and an explanation of the inconsistency recorded in the patient's medical history and signed by the surgeon. The surgeon should satisfy him/herself of the appropriate eye for surgery and record this in the patient's medical notes before proceeding with surgery. An incident form should be completed if the patient is not aware of the change and all the documentation altered until after they have received sedation or are otherwise impaired in their decision making. If the surgeon remains uncertain of the correct eye for surgery or the side differs from that previously discussed with the patient, the procedure should be postponed or cancelled and the patient returned to the ward.

8. References

1. World Health Organisation (2008) Implementation Manual – WHO Surgical Safety Checklist (First Edition) p 10.)

2. American Academy of Ophthalmology, Ophthalmic Mutual Insurance Company, American Society of Cataract and Refractive Surgery, American Society of Ophthalmic Registered Nurses, and Outpatient Ophthalmic Surgery Society (2012) Sample Ophthalmic Surgery Checklist <http://www.ascrs.org/resources/asc-surgical-safety-checklist-ophthalmology> Accessed 31 October 2014.

9. Record of Amendments

Page	Details of amendment	Date approved
2,3	Clarified points 3 a, b, d and e. Added 3 f and g, and Attachment A.	13/11/14

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Attachment A

SURGICAL SAFETY CHECKLIST

Before Anaesthesia →→→→→→→→→→

SIGN IN

☐ **PATIENT HAS CONFIRMED:**
- IDENTITY
- SITE
- PROCEDURE
- CONSENT

☐ **SITE MARKED**

☐ **HISTORY AND PHYSICAL REVIEWED**

☐ **PRESURGICAL ASSESSMENT COMPLETE**

☐ **PREANAESTHESIA ASSESSMENT COMPLETE**

☐ **ANAESTHESIA SAFETY CHECK DONE**

DOES PATIENT HAVE:

DIFFICULT AIRWAY/ASPIRATION RISK?

☐ NOT APPLICABLE

☐ NO

☐ YES: EQUIPMENT/ASSISTANCE AVAILABLE

HISTORY OF FLOMAXTRA/ALPHA 1-A INHIBITOR?

☐ NO

☐ YES

HISTORY OF ANTICOAGULANTS?

☐ NO

☐ YES
- ☐ CONTINUED
- ☐ STOPPED AS INSTRUCTED

Before Incision →→→→→→→→→→→→

TIME OUT

☐ **ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE**

☐ **SURGEON, ANAESTHESIA PROVIDER, AND NURSE ORALLY CONFIRM**
- PATIENT
- SITE
- PROCEDURE

☐ **SURGEON AND NURSE ORALLY CONFIRM**
- ANTIBIOTIC
- MITOMYCIN-C/ANTI-NEOPLASTICS
- IMPLANT STYLE AND POWER
- DEVICES
- TISSUE
- GAS
- DYES

ANTICIPATED CRITICAL EVENTS

☐ **SURGEON REVIEWS**
- CRITICAL OR UNEXPECTED STEPS

☐ REVIEWED

☐ NONE ANTICIPATED
- OPERATIVE DURATION

☐ **ANAESTHESIA PROVIDER REVIEWS**
- ANY PATIENT SPECIFIC CONCERNS

☐ **NURSING TEAM REVIEWS**
- STERILITY (INCLUDING INDICATOR RESULTS)
- EQUIPMENT ISSUES
- CONCERNS

Before leaving operating room

SIGN OUT

NURSE ORALLY CONFIRMS WITH TEAM:

☐ NAME OF PROCEDURE RECORDED

☐ INSTRUMENT, SPONGE, SHARP COUNT CORRECT
- ☐ YES
- ☐ NOT APPLICABLE

☐ SPECIMEN LABELLED (INCLUDING PATIENT NAME)
- ☐ YES
- ☐ NOT APPLICABLE

☐ EQUIPMENT ISSUES ADDRESSED

SURGEON, ANAESTHESIA PROVIDER, AND NURSE

☐ KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF PATIENT REVIEWED

Based on the AAO, OMIC, ASCRS, ASORN, OOSS 'Sample Ophthalmic Surgery Checklist' (2012)

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