

Correct Patient, Correct Procedure and Correct Site Policy

Issue Date	Review Date	Version
April 2021	April 2025	7

Purpose

The purpose of this policy is to:

- Describe the principles by which the Trust will ensure that surgical interventions, invasive and investigative procedures are performed on the correct patient at the correct site, and if applicable, with the correct implant
- Ensure that patient safety is maintained through the consistent practices of pre-operative site marking and verification checks
- Ensure that pre-operative site marking and verification checks are carried out for all surgical interventions carried out under local and/or general anaesthetic, including those performed in settings other than operating theatres and where consent is normally required

Who should read this document?

All permanent, locum, agency or bank staff Surgeons, Clinicians and Anaesthetists working within University Plymouth Hospitals NHS Trust and Tavistock Hospital.

All staff carrying out procedures requiring consent.

All personnel involved in preparation of patients for surgery or invasive procedures.

Key Messages

Wrong person, wrong procedure and wrong site operations or procedures represent errors that result in avoidable harm.

This policy describes our approach to minimise the risk of these events by implementing a standardised approach that is applicable throughout the organisation.

Core accountabilities

Owner	Cindy McConnachie – Senior Matron Theatres and Anaesthetics, Quality, Governance and Strategy. Paul McArdle – AMD Safety and Quality/Consultant Maxillo-Facial surgeon
Review	Theatre Policy and Standards Committee.
Ratification	Theatre Governance Committee – Service Line Clinical Director/Clinical Governance Lead.
Dissemination	Cindy McConnachie – Senior Matron Theatres and Anaesthetics
Compliance	Theatre Matrons

Links to other policies and procedures

- Consent to examination and treatment policy 2012
- Identification of patients policy 2015
- Prep Stop Block 2020

Version History

1	May 2007	Correct Site Surgery Policy
2	June 2013	Correct Patient, Correct Procedure and Correct site Policy

3	March 2016	Policy updated
4	August 2016	Trust policy compliant National Safety Standards for Invasive Procedures (NatSSIP's) (NHS England, 2015).
5	April 2018	Revised in to new template and minor addition of urology process
6	March 2019	Revised, to add in changes following trial of new process for midline procedures with laterality.
7	April 2021	Small Amendment to add in changes following Incident

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available in the Document Library. Larger text, Braille and Audio versions can be made available upon request.

Contents

Section	Description	Page
1	Introduction	4
2	Purpose, including legal or regulatory background	4 - 5
3	Definitions	5
4	Duties	6
5	Main Body of Policy	7- 12
6	Overall Responsibility for the Document	12
7	Consultation and Ratification	12
8	Dissemination and Implementation	12 - 13
9	Monitoring Compliance and Effectiveness	13
10	References and Associated Documentation	14
Appendix 1	Dissemination Plan and Review Checklist	14 - 15
Appendix 2	Equality Impact Assessment	15 - 17
Appendix 3	Unilateral procedures list	17 - 19

1 Introduction

The incidence of wrong procedure being performed on a patient, or a surgical intervention being performed on the wrong site is rare.

Although the incidence of wrong patient, wrong site, or wrong procedure or intervention being carried out is rare the effect for the patient and their loved ones is devastating and is distressing for the staff involved.

Across the NHS there is no single standard method for ensuring correct site surgery. Even with high professional standards and good practice, safety can be improved by using a consistent method across all specialities and locations across the Trust, which in turn reduces risk.

2 Purpose

This document has been formulated in response to recommendations made by the National Patient Safety Agency (NPSA, 2006)) and incorporates the standards for procedural verification of site marking outlined in the National Safety Standards for Invasive Procedures (NHS England, 2015). The policy is designed to complement the World Health Organisation (WHO, 2009) Surgical Safety Checklist. It has particular reference to preventing a number of never events, in particular:

- Wrong site surgery
- Wrong implant
- Misidentification

Surgical, medical, anaesthetic, radiology and oncology procedures performed on the wrong patient, wrong body part, wrong side, site or level are preventable adverse events.

Adverse events involving wrong patient, site or procedure can be devastating and the harm that occurs can include death, disease, injury, suffering and/or disability. The cost to individuals and the health care system for such adverse events is significant.

University Hospitals Plymouth NHS Trust (UHP) is committed to ensuring the safety of patients undergoing surgical/invasive/interventional procedures and has introduced the Correct Patient, Correct Procedure and Correct Site policy to ensure a standardised approach and to prevent harm to patients.

This policy is designed to ensure that any procedure performed on a patient reflects what has been consented to and that the procedure/treatment has been performed on the patient's correct site and correct side.

This policy applies to **ALL** surgical, anaesthetic and medical procedures that can potentially expose patients to harm, including diagnostic procedures and those procedures performed in settings other than operating rooms.

This policy applies to all areas across UHP including satellite areas such as Tavistock, Mount Gould and other areas where UHP personnel are deployed to undertake procedures for patients under the care of the Trust.

Key principles:

- Wrong patient, wrong procedure and wrong site incidents can and **must** be prevented.
- ALL team members are responsible for ensuring correct procedure is performed on the correct patient and at the correct site.
- The appropriately qualified person undertaking the procedure carries overall responsibility for ensuring the correct patient is appropriately marked at the correct site for the correct procedure.
- Where possible active involvement and communication between the patient and all members of the surgical or medical team is required to ensure that the correct treatment or procedure is performed on the correct patient and at the correct site.
- The patient (or authorised representative) **must** be involved in identifying and confirming the marking of the correct site. When this is not possible alternative strategies **must** be used to mitigate the increased level of risk.
- There **must** be verification that the site is marked in accordance with the procedure and site listed on the consent form.
- In circumstances where imaging data is used to confirm the side and site of a procedure is correct, this **must** be confirmed by two or more members of the clinical team who should also check that the radiographic images are properly labelled.

3 Definitions

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage and/or complaint.

Never event:	Reportable clinical incidents in the patient care setting that are serious and largely preventable as defined in the Never event list.
Near miss:	Is a health care event that did not result in injury, illness, or damage but had the potential to do so.
Adverse event:	an incident in which harm resulted to a person. Harm includes death, disability, disease, injury and/or suffering.

Medical Director

The Medical Director has ultimate responsibility for ensuring that appropriate processes are in place for the safe management of all patients undergoing procedures within the hospital.

Service line leads

Service line leads in each speciality have the responsibility for ensuring their clinicians mark patient's where possible and adhere to this policy.

Operating Surgeon/operator undertaking invasive procedure (or suitably trained deputy)

It is the responsibility of the operating surgeon, or healthcare professional performing the invasive procedure to ensure the verification processes and site marking are undertaken in accordance with this policy.

Anaesthetists

The operating or supervising Anaesthetist is responsible to mark the site of any proposed local or regional block when performing a sided technique not associated with an operation e.g. a facet joint injection in the pain clinic.

Where anaesthetists are performing regional blocks for post-op analgesia the surgical mark will be used to identify the correct side.

This is accordance with prep stop block policy

All permanent, locum or agency staff

All permanent, locum and agency staff have an operational obligation to comply with the Correct Patient, Correct Procedure and Correct Site Policy.

Staff are required to report non-adherence to the Correct Patient, Correct Procedure and Correct site Policy utilising the Trusts Electronic Incident Reporting system (Datix).

Key stakeholders include:

- Patient (or responsible other)
- Lead Clinician (Surgeon/Anaesthetist/Radiologist etc)
- Pre-operative team (Ward or Day of Surgery staff)
- Transfer staff
- Intra-operative staff

Escort to theatre

The staff member, who is 'designated' to collect the patient for theatre, is responsible for ensuring that each patient has been marked before transfer to theatre.

The Procedural Team

The procedural team is responsible for ensuring all pre-procedural checks, final time out and for confirming the correct surgical site has been marked before the start of the intervention.

5 Main Body of Policy

5.1 **Step 1: Ensure that valid consent has been obtained.**

The consent for treatment policy outlines the process and requirements that are to be followed by clinicians within UHPNT. **All** patients admitted to procedural areas **must** be accompanied by a valid consent form completed in accordance with National and Local guidance.

5.2 **Step 2: Confirm the patient's identity.**

The patient is an integral member of the team undertaking the verification process and **must** be involved wherever possible.

The verification process **must** be undertaken prior to them receiving any medication that could affect their cognitive ability. The patient **must** be asked to state their:

- Full name and date of birth
- The type of procedure/treatment being performed
- The reason for procedure/treatment.
- The side and site of the procedure/treatment

Staff **must** check the patient's responses against their identification band, consent form, information within their medical records and within Theatres against the operating list.

Step 1 and Step 2 must be documented within the Patient record/Perioperative pathway; this must be stored within the patient's medical records.

All staff collecting patients for a surgical or invasive procedure **must** receive a verbal handover and confirmation from ward/department staff that they are transferring the Correct Patient.

If a patient is transferred between different locations within the hospital and is incapable of personally participating in the verification process and has no authorised representative present, a member of staff from the preceding location (e.g. ward or Emergency Department) **must** act as the patient representative during the verification process.

If the patient is unable to participate with the verification process due to lack of mental capacity or language barriers, another appropriate adult or approved interpreter should be asked to assist with the communication process. Details of the discussions and names of the participants **must** be recorded within the patient record. Verification of the site position and identity should be sought from multiple sources to ensure veracity.

5.3 **Step 3: Mark the site of the surgery or invasive procedure.**

The site of the surgery or invasive procedure **must** be marked shortly before the procedure by the person performing the surgical or interventional procedure.

Site marking should not be undertaken within the anaesthetic or procedure room. However, it is recognised consenting may have to be undertaken within minor op rooms within clinics or outpatient areas.

The surgeon/operator who marks the patient **must** be present for that specific operation. When this is not possible the surgical site marking should once more be agreed by checking against the consent, clinical records, and verified with the patient.

Delegation of site marking can only be done by a clinician who is sufficiently competent and knowledgeable about the procedure and individual patient's case to be able to undertake this task and who **will** be present during the procedure.

If at any time a patient or health care practitioner is concerned that the incorrect side/site is being prepared for surgery or invasive procedure, or as a practitioner they do not feel to be adequately qualified to undertake the verification task they **must** immediately voice their concerns. There **must** be no criticism of the health care practitioners raising concerns even if the concerns are unfounded.

Where the patient refuses marking, this **must** be documented in the patient's record and alternative strategies must be employed to prevent the procedure being performed on the wrong site.

The clinical practitioner in charge of the patient retains overall responsibility for ensuring that the site of the surgery/invasive procedure has been correctly identified and marked, and that the surgery/invasive procedure is performed on the correct side and at the correct site.

The senior clinical practitioner responsible for the care of the patient may be held responsible, where the site of the procedure was not marked or the task was not appropriately carried out and results in the procedure being performed on the wrong site.

Process for marking:

- The intended site of incision or site of insertion **must** be unambiguously marked. (Appendix 4 Site marking unilateral procedures)

- Multiple operation or procedural sites **must** be individually marked.
- The non-operative side **must never** be marked.
- All cases involving laterality, multiple structures (e.g. fingers, toes or lesions) or levels (e.g. spines) **must** be clearly marked as close to the procedural site as possible.
- The mark **must** be visible and sufficiently permanent so as to remain visible following skin preparation and draping. Site marking **must** be done with an indelible marker.
- Stoma sites should be marked by a professional experienced in siting stomas and an indication of the planned stoma position **must** be maintained during the procedure
- Marking of the operative or limb site should be done in such a way as to ensure that when a patient is turned or placed in to position for surgery e.g. prone position, the site of the surgery or procedure is remains clearly visible to members of the clinical team.
- Marking **must** take place when the patient is awake and before the patient enters the procedure room. This may not be possible in some emergency situations or where imaging is required to mark the site while in the procedure room.
- Acceptable methods of marking include an arrow that extends to or near to the incision site, or in cases of lesions a circle drawn around the lesion.
- 'Left' or 'Right' **must** be written in full on **all** documentation.
- Where imaging data is used during the marking process, members of the clinical team must confirm the images are properly labelled and are for the correct patient.
- **During minimally invasive endoscopic urological procedures**, consent will be undertaken on checking of imaging. Site marking will be undertaken immediately following the consenting process. A further check and confirmation of site will be undertaken immediately prior to the intervention by the clinician performing the procedure. This final check will be against the operating list, theatre white board and imaging. The final check will ensure that the Theatre white board, consent and all staff involved in the procedure understand and can confirm with the clinician the side/site of procedure is correct.
- Documentation of completion of marking **must** be included in the patient's medical record before the patient can be transferred to the operating theatre suite or procedure room.

Possible exceptions to the requirement for operative sites to be marked:

Exceptions to surgical site marking should be rare. Marking may not be considered possible in the following circumstances.

- Interventional cases where the catheter or instrument site is not pre-determined (e.g. cardiac catheterisation, epidural, spinal analgesia, or anaesthesia etc)

- Procedures on midline structures such as umbilical, perineal, or anal areas
- Endoscopic or other procedures performed through the mouth or anus.
- Single organ cases such as caesarean section, midline sternotomy, laparoscopy, laparotomy or urethrotomy
- Where the procedural site cannot be marked (e.g. teeth). Relevant radiographs or other scans **must**, if possible be marked to indicate the operative site. This **must** then be recorded on the intraoperative white board. Where this is not possible a diagram clearly indicating the site and side **must** be prepared and entered into the patient's medical record.
- Where marking of infants may cause permanent tattoos.
- Where the operative site is a single traumatic site (i.e: obvious surgical site).
- Where urgency of surgery precludes marking on the grounds of life threatening emergency.

NB: Where the procedural site is not marked for any procedures not previously agreed, clinicians will be required to develop and implement agreed processes and procedures to prevent errors. These processes will be audited to verify the agreed system of marking is implemented.

5.4 **Step 4: Ensure the correct and appropriate documents and diagnostic images are available**

Clinical errors caused by poor documentation or improperly labelled diagnostic images are a significant concern in the Correct Patient, Correct Procedure and site process. To mitigate this risk:

- Imaging data **must** be reviewed prior to commencement of the procedure by two members of the clinical team to ensure that all relevant documents include x-rays, imaging reports, pathology reports and other clinically relevant material are available and are for the correct patient, are properly labelled and presented.
- Discrepancies in information or disagreements in verification **must** result in the procedure being delayed until issues have been resolved. The decision to delay should be in keeping with the degree of urgency for the procedure. Justification for proceeding in the presence of discrepancies **must** be documented in the patient's medical record and Trust Electronic Incident report (Datix) completed.

Written confirmation of this step should be documented within the patient record/perioperative pathway document and filed in the patient's medical records.

5.5 **Step 5: Final 'WHO check list-Time-out' in the operating theatre, treatment or examination area**

The planned procedure **must** be confirmed and the surgical site marking checked at both sign in and time out. At sign out, confirmation that the procedure has been performed on the correct site and side should be obtained.

Process for 'WHO check- time-out'

When the patient arrives in the operating theatre or procedural room, **ALL** members of the clinical team (e.g. proceduralist, anaesthetist and nurse) **must** participate in the final 'WHO checklist- time-out'.

The 'WHO checklist- time-out' must be consistently initiated by a designated member of the clinical team. Active communication between **ALL** members of the team **must** occur to ensure the final verification process is conducted successfully.

'Time-out' must be performed immediately before the start of the procedure, in the room where the procedure will be undertaken. The clinical team **must** verify the following details:

- The presence of the correct patient
- The correct procedure to be performed
- That the correct procedural site has been marked or agreed method of indicating the site has been met.
- Availability of correct prostheses and/or any specialist equipment.

Time out **must** be documented within the patient's medical records/perioperative pathway documentation.

Documentation of sign in, time out and sign out **must** include verification of procedure, site and side.

5.6 Site marking and process for unilateral procedures which are undertaken via a midline incision.

Following a never event in UHP where the wrong side was operated on for a procedure with midline incision, it is necessary to introduce a '**Surgical Pause**' after the Surgeon has completed the midline incision.

For procedures where there is laterality undertaken via a midline incision it is imperative that the team follow a robust process of marking and checking as it is not always possible for the team as a whole to visualise what side the Surgeon is operating on once surgery commences (See example: appendix 4).

Process steps:

- Consultant to check relevant and current imaging (if appropriate)
- Consultant to check laboratory reports if relevant (if appropriate)
- Consultant to confirm with the patient and examine the patient.
- Site to be marked as per UHP policy.

- WHO checklist to be conducted as per UHP policy. Time out to be confirmed against the Consent, patient records and whiteboard.
- Knife to skin – midline incision.
- SURGICAL PAUSE – Surgeon to stop and declare the procedural SITE and SIDE to the team.
- TEAM to Respond – Members of the team must confirm to the surgeon that they are about to undertake the correct procedure and side.
- Surgeon to proceed.

(Appendix 2: Stop before you Cut Thyroid Surgery)

5.7 Verification of the Correct Patient, Correct Procedure and Correct site checking process

The verification process **must** be undertaken at **all** stages of the treatment process to include:

- At the time the procedure is scheduled (e.g. outpatients, Emergency Department)
- At the time of giving consent.
- At the time of admission (e.g.: Ward or Day of Surgery Admission area)
- During preparation of the patient for their procedure
- Any time the responsibility for care of the patient is transferred between clinical teams and/or departments (e.g.: on collection/transfer to the operating theatres)
- On entry to the procedural suite and before general anaesthetic (e.g. anaesthetic room).
- At 'team time-out' and immediately prior to undertaking the procedure.

Wherever possible the patient **must** be involved in the verification process as part of the team confirming Correct Patient, Correct Procedure and Correct Site.

5.8 Risk Management

If discrepancies are identified in any of the pre-procedure verification checks, the patient **must not** be allowed to progress onto the next stage. Any discrepancies **must** be resolved before patients are transferred to operating theatres or procedural rooms.

The Clinician in charge of the case **must** be informed immediately. The clinician will be responsible for assessing the situation with the patient and will decide whether it is safe to continue with the procedure or to cancel and reschedule. Any changes **must** be agreed with patient and surgical team and documented within the patient medical record. An Electronic Clinical Incident record (Datix) **must** be completed.

Clinical incidents involving the wrong patient, wrong procedure and wrong site must be escalated according to trust policy for escalation of serious incidents, at a point when it is safe to do so. An Electronic Clinical incident record (Datix) **must** be completed and an investigation will be initiated according to the Trust's Serious Untoward incident policy. Action plans resulting from the review must be implemented within the agreed time-scales and will be monitored by the Trust Clinical Governance Committee

6 Overall Responsibility for the Document

Assistant Medical Director for Quality – Paul McArdle

Senior Matron Theatres and Anaesthetics, Quality, Governance and Strategy – Cindy McConnachie

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Theatre Policy and Standards Committee and ratified by the Theatre Governance Committee.

Non-significant amendments to this document may be made, under delegated authority from the Service Line Clinical Director/Clinical Governance Lead, by the nominated owner. These must be ratified by the Service Line Clinical Director/Clinical Governance Lead.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Service Line Clinical Director/Clinical Governance Lead and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

Monitoring of compliance with the Correct Patient, Correct procedure and Correct site policy will be undertaken in those areas where surgical or invasive procedures are undertaken.

Clinical Service Line Directors and Matrons will be ensuring that audit of practice is undertaken within their own area.

Performance against this policy will be communicated to the Care Group Clinical Director and onto the Senior Management team.

Non-compliance with the policy will be escalated to the Care Group Clinical Director

Performance will be reported to clinical teams via standard routes of communication ie: performance review, face to face, email and newsletter.

Key Performance indicator	Responsible lead	Evidence	Reviewed by/ frequency	Lead responsible for any required actions.
Compliance with Surgical Site marking	Clinical Service Line Directors	Audit through Meridian Observation of practice Fundamental of care (Theatres)	Theatre Management team Monthly to SMT	Individual Service Line Directors
100% compliance with Verification process	Individual Service Line Matrons.	Audit through Meridian Observation of practice Fundamentals of care (Theatres) Random sampling patient medical records	Theatre Management Team Monthly to SMT	Individual Service line Directors/Matrons

10 References and Associated Documentation

National Patient Safety Agency (2006) *Patient Safety Alert 06 – Correct site surgery, making your surgery safer.*

Department of Health (2006) *Correct Patient, Correct Procedure and Correct Site Policy and Guidelines for Western Australian Health Services.* Office of Safety and Quality in Health care.

World Health Organisation (2009) *Surgical Safety Checklist.* [online] www.nrls.npsa.uk/alerts/?entryid45=59860

Dissemination Plan and Review Checklist

Appendix 1

Dissemination Plan			
Document Title	Correct Patient, Correct Procedure and Correct Site Policy		
Date Finalised	3 rd August 2016		
Previous Documents			
Action to retrieve old copies			
Dissemination Plan			
Recipient(s)	When	How	Responsibility
All Trust staff		IG StaffNet Page	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been	Yes

	addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment Appendix 2

Core Information	
Date	April 2021
Title	Correct Patient, Correct Procedure and Correct Site Policy
What are the aims, objectives & projected outcomes?	<p>The purpose of this policy is to:</p> <ul style="list-style-type: none"> Describe the principles by which the Trust will ensure that surgical interventions or invasive investigative procedures are performed on the correct patient, at the correct site and if applicable with the correct implant. Ensure that patient safety is maintained through the consistent practices of pre-operative site marking and verification checks. Ensure that pre-operative site marking and verification checks are carried out for all surgical interventions carried out under the local and/or general anaesthetic, including those performed in settings other than operating theatres and where consent is normally required.
Scope of the assessment	
<p>The assessment covers all protected characteristics. The EIA was produced by the Trust's Equality and Diversity Leads Incidents and complaints are monitored via Datix and reported as necessary</p>	
Collecting data	
Race	<p>There is no evidence to suggest there is a disproportionate impact on race regarding this policy.</p> <p>Consideration has been made for the patient and family with regards to communication needs and information will be made available in different formats upon request or as required.</p> <p>Data will be monitored through incidents and complaints and reported as required.</p>
Religion	<p>There is no evidence to suggest there is a disproportionate impact on religion regarding the policy.</p> <p>Data will be monitored through incidents and complaints as reported as required.</p>

Disability	<p>There is no evidence to suggest there is a disproportionate impact on disability regarding this policy.</p> <p>Consideration should be made for those who may have a disability or learning disability and reasonable adjustments may be required when discussions are taking place or information is being provided.</p> <p>Data will be monitored through incidents and complaints and reported as required.</p>
Sex	<p>There is no evidence to suggest there is a disproportionate impact on sex regarding this policy.</p> <p>Data will be monitored through incidents and complaints reported as required.</p>
Gender Identity	<p>There is currently no data collected to show the impact in this area, however, this will be monitored through incidents and complaints.</p>
Sexual Orientation	<p>There is no evidence to suggest there is a disproportionate impact on sexual orientation regarding this policy.</p> <p>Data will be monitored through the incidents and complaints and reported as required.</p>
Age	<p>There is no evidence to suggest there is a disproportionate impact on age regarding this policy.</p> <p>Data will be monitored through incidents and complaints and reported as required.</p>
Socio-Economic	<p>There is currently no data collected to show the impact in this area</p>
Human Rights	<p>There is currently no data collected to show the impact in this area</p>
What are the overall trends/patterns in the above data?	<p>No trends or gaps have been identified at this stage</p>
Specific issues and data gaps that may need to be addressed through consultation or further research	

Involving and consulting stakeholders				
Internal involvement and consultation				
External involvement and consultation				
Impact Assessment				
Overall assessment and analysis of the evidence				
Action Plan				
Action	Owner	Risks	Completion Date	Progress update

Neuro Surgery

- Left/right burr hole
- Left/right EVD insertion
- Craniotomy – could be left/right

Patient is marked with an arrow to demonstrate the side of the procedure on either their forehead or by their ear. The side is confirmed during the sign in with the patient/anaesthetic practitioner/ Anaesthetist. This is then reconfirmed with the whole team and with the patient's scans. The Surgeon then shaves the patient's head and marks the incisional site.

General Surgery

- Mastectomy
- Axillary node clearance

Patients having breast surgery are marked by the operating surgeon high on anterior chest on the corresponding side.

- Femoral Hernia left/right/bilateral
- Inguinal Hernia left/right/bilateral

Patients are marked on the corresponding side; site marking can be either an arrow or a circle around the hernia.

Orthopaedics

- Surgery around the hip or femur

Patients are marked with an arrow on their thigh or laterally pointing to the hip/femur

- Surgery around the knee

Patients are marked with an arrow pointing to the corresponding knee, either on their thigh or on their tibia

- Surgery on the tibia

Patients are marked with an arrow pointing to the corresponding tibia, either on their thigh or on their tibia

- Surgery on foot/ankle

Patients are marked with an arrow on their tibia pointing to the corresponding foot or ankle. There may be a requirement for additional marks on toes or free text alongside arrow

- Surgery on the hand and wrist

Patients are marked with an arrow on the radial aspect of the arm or forearm, depending on the location of the surgery, and may require additional mark on digits or text to supplement arrow. Consideration must be taken when marking site to ensure marking is visible prior to surgical incision immediately

- Surgery on the elbow

Patients are marked on the forearm or humerus with an arrow pointing towards the elbow

- Surgery on the shoulder

Patients are marked with an arrow on the humerus of the corresponding arm.

- Manipulation under anaesthetic hip/shoulder/elbow/wrist

Patients should be marked as per corresponding surgery undergoing shoulder surgery are marked on the humerus of the corresponding arm.

Ophthalmology

- Eye surgery

All patients are marked above the eye which is to be operated upon. If bilateral surgery both eyes are marked.

Urology

- Biopsy – left/right kidney
- Ureteric stent/lasering
- Nephrectomy
- Orchidopexy
- Orchiectomy

Patients having testicular surgery are marked in the groin area on the corresponding side.

Patients having stent procedures are marked on the hand on the side of the procedure. Once in theatre they are draped and it is not possible to visualise this mark. The surgeon will then confirm with the rest of the team the side of the procedure and mark the drape on the corresponding side.

Gynae

- Salpingo-oophorectomy
- Oophorectomy

These patients are NOT currently marked

ENT

- Ear surgery

Patients are marked just behind or in front of the ear.

- Tonsil/Adenoid Surgery
- Nasal Surgery

Where a side is specified, patients will be marked on the corresponding cheek.

- Thyroid Surgery

Where a side is specified, patients will be marked on the corresponding side of the neck with an arrow. Laterality must be confirmed see App 4

- Neck Dissections

Where a side is specified, patients will be marked on the corresponding side of the neck with an arrow.

- Pharyngoscopy/laryngoscopy/oesophagoscopy

Tonsil/adenoid surgery, pharyngoscopy, laryngoscopy, oesophagoscopy and bronchoscopy patients will NOT be marked.

Plastics

- Upper arm and forearm (Limb trauma)

Patients are marked with an arrow to wound or injured limb.

- Digits (Limb trauma)

Patients are marked with an arrow to injured digit and dot on dorsal and volar aspect of digit. If dressing cannot be removed prior to marking use arrow and write injured digit on exposed skin adjacent to dressing

- Skin grafts

Patients are marked with an arrow to surgical site and to proposed area to be grafted and a square over proposed donor site made at the the appropriate point in the procedure

- Removal of skin lesions

Patients are marked with an arrow pointing to lesion or circle around lesion

- Sarcoma or lipoma excisions

Patients are marked with an arrow pointing to area of excision

- Breast surgery

Breasts are marked with arrow above the breast to be operated on. Arrow to mark site of free flap perforator if appropriate

- Flap Surgery

Patients are marked with an arrow to area to be reconstructed and an arrow to flap to be harvested

- Eyelid surgery

Patients are marked with an arrow on cheek +/- forehead pointing to surgical site

- Neck Dissections

Patients are marked with an arrow on neck

Vascular

- Carotid Endarterectomy

Patients are marked with an arrow on the lower neck pointing to the correct side, where visible after draping

- First/cervical rib resection

Patients are marked with an arrow on the chest wall/shoulder area pointing to the correct side

- Fistula or graft for dialysis access upper limb (usually) or lower limb.

Patients are marked with an arrow on the correct arm pointing to the site of surgery - either forearm for wrist fistula/graft, forearm/elbow for elbow- level fistula/graft or thigh for lower limb fistula/graft

- Embolectomy upper limb or lower limb.

Patients are marked with an arrow on the correct limb

- Bypass graft upper limb

Patients are marked with an arrow on the appropriate arm

- Exploration of artery for trauma/iatrogenic injury upper limb or lower limb.

Patients are marked with an arrow on the appropriate limb.

- Iliac artery surgery - either through a mid-line incision or unilateral retroperitoneal approach.

Patients are marked with an arrow on the abdomen pointing to the correct side.

- Femoral endarterectomy

Patients are marked with an arrow on the thigh, pointing to the correct groin.

- Lower limb bypass

Patients are marked with an arrow on the correct limb.

- Lower limb amputation (above or below knee)

Patients are marked with an arrow on the correct leg.

- Toe amputation

An arrow is placed on the foot pointing to the appropriate toe.

- Varicose veins

Patients are marked with an arrow on the correct leg

Thyroid surgery

- Consultant to check relevant and current ultrasound
- Consultant to check fine needle aspiration reports.
- Consultant to confirm with the patient and to feel for the lesion.
- Site to be marked (in thyroid surgery - this will be an arrow ABOVE the clavicle, as drapes will not cover the mark).
- WHO checklist to be conducted as per UHP policy. Time out will be confirmed against Consent, patient records and whiteboard)
- Knife to skin – midline incision
- Surgical Pause – Consultant surgeon, to stop and declare the procedure SITE and SIDE that will be undertaken.
- Team to confirm – that the surgeon is about to undertake the correct procedure and side.
- Surgeon – to proceed.