



SES090005



**Health**  
South Eastern Sydney Local Health District  
Sydney Children's Hospital Randwick

If this checklist is not completed or check is incorrect, IIMs notification to be entered.

Facility: \_\_\_\_\_

Name of Proceduralist who led checklist: \_\_\_\_\_

FAMILY NAME		MRN
GIVEN NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____ / ____ / ____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

### CLINICAL PROCEDURE SAFETY CHECKLIST LEVEL 3

**SIGN IN - Before Induction of Anaesthesia/Sedation**

**PATIENT / CARER HAS CONFIRMED**  
 Identity     Procedure  
 Site         Consent

**SITE MARKED**  
 Not Applicable

**ANAESTHESIA / SEDATION SAFETY CHECK COMPLETED**  
 Not Applicable

**PULSE OXIMETER ON PATIENT AND FUNCTIONING**

**DOES PATIENT HAVE A KNOWN ALLERGY / ADVERSE REACTION**  
 Yes  
 No

**KNOWN DIFFICULT AIRWAY/ ASPIRATION RISK**  
 Yes, and Equipment/Assistance available  
 No

**RISK OF >500mL BLOOD LOSS (7mL/kg in Children)**  
 Yes and Adequate Intravenous Access and Fluids Planned  
 No

**PROSTHESIS / SPECIAL EQUIPMENT:**  
 Special equipment needed is available and functional  
 Yes

Name ..... Designation .....

Signature ..... Date .....

**TIME OUT – Prior to Commencement of Procedure**

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

**SURGEON, ANAESTHETIST AND NURSE VERBALLY CONFIRM**  
 Patient     Procedure  
 Site         Allergies

**ANTICIPATED CRITICAL EVENTS**  
 **SURGEON REVIEWS:**  
 What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss

**ANAESTHESIA TEAM REVIEWS:**  
 Are there any Patient-Specific concerns

**NURSING TEAM REVIEWS:**  
 Has Sterility (including indicator results) been confirmed  
 Are there Equipment Issues or any concerns

**HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES**  
 Yes         Not Applicable

**SPECIAL MEDICATION ADMINISTERED**  
 Yes         Not Applicable

**HAS THE PATIENT RECEIVED THROMBOPROPHYLAXIS**  
**ANTICOAGULANT**     Yes     Not Required  
**MECHANICAL**         Yes     Not Required

**IS ESSENTIAL IMAGING DISPLAYED**  
 Yes         Not Applicable

**PRESSURE INJURY PREVENTION PLAN IMPLEMENTED**  
 Yes         Not Applicable

**HAS POSITION OF PATIENT BEEN CONFIRMED**  
 Yes         Not Applicable

Name ..... Designation .....

Signature ..... Time..... Date.....

**SIGN OUT - Before patient leaves Operating/Procedure Room**

**NURSE VERBALLY CONFIRMS WITH THE TEAM:**

**NAME OF THE PROCEDURE RECORDED**

**ACCOUNTABLE ITEMS / INSTRUMENT CHECKS COMPLETED**

**SPECIMEN / IMAGES ARE LABELLED CORRECTLY**  
 Not Applicable

**WHETHER THERE ARE ANY EQUIPMENT PROBLEMS / ISSUES DOCUMENTED & RELEVANT STAFF ADVISED**  
 Not Applicable

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**SURGEON, ANAESTHETIST AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT IN CLINICAL HANDOVER (PRIOR TO LEAVING OPERATING ROOM)**

**BLOOD LOSS DOCUMENTED AND ONGOING MANAGEMENT DISCUSSED**  
 Not Applicable

**POST PROCEDURE VTE PROPHYLAXIS ORDERED.**  
 Yes  
 Not Required

**PROCEDURAL TEAM CONFIRMS ADVICE FOR CLINICAL HANDOVER (IN POST ANAESTHETIC CARE UNIT)**  
 Yes  
 Not Applicable

Name ..... Designation .....

Signature ..... Date .....