JCAHO: CHANGING PROCESSES

Verification of Correct Patient, Procedure, and Site at Governor Juan F. Luis Hospital and Medical Center

The Failure Mode and Effect Analysis

Jill Price, RN, Head Nurse Cath Lab/Cardiology, Co-Chair FMEA Committee & the Surgical FMEA Committee
Governor Juan F. Luis Hospital and Medical Center (GJFL)
St. Croix, U.S. Virgin Islands

One of the new National Patient Safety Goals per the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards is verifying the correct patient, procedure, and procedure site when performing an invasive procedure. With extensive research of this standard, we discovered that not only is the standard required within an operating suite, but also a cardiovascular and/or catheterization suite, and any other department where a patient under goes an invasive procedure. While preparing for our most recent survey (June 2004) by the Joint Commission, the Governor Juan F. Luis Hospital formed a committee called the Surgical Failure Mode and Effect Analysis (F.M.E.A.) committee to assess the failure processes of potentially performing a cardiac cath on the wrong patient. We followed the guidelines provided by JCAHO regarding the FMEA process and analyzed the potential failure modes that occurred in our previous scheduling, admitting, and performance of cath procedures. Unbeknownst to us within the cath lab and FMEA committee, were several failure modes that could have potentially caused the wrong patient to be scheduled in the cath lab. Fortunately, all the patients that were to be scheduled for procedures were done and no one was cathed that was not supposed to be cathed. Once we identified the potential failures, a resolution was developed by the committee and a new process was put into place to prevent any future failures from occuring. Our committee used "Failure Mode and Effects Analysis in Health Care: Proactive Risk Reduction" (Ed. Joint Commission Resources, December 2002) as a resource for our presentation. To date, the redesigned process has been followed by all physicians and hospital staff without any difficulties. In this presentation, the definition of FMEA is explained as well as the the path we took to identify and redesign our processes. **CLD**

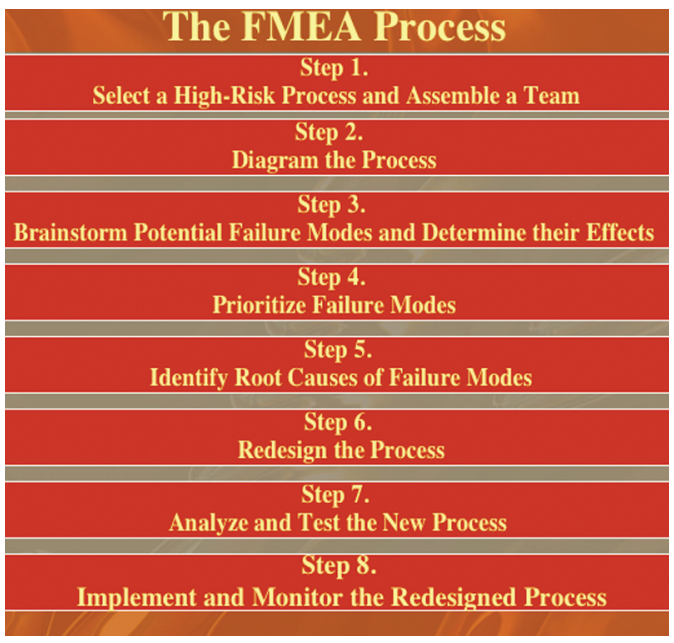
The Surgical FMEA Committee

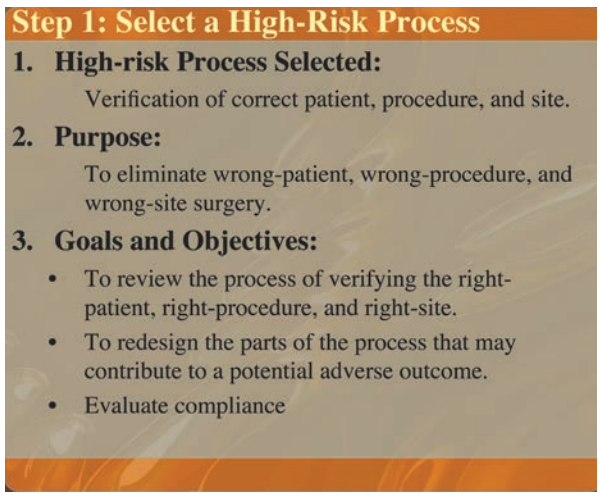
- *Darice Plaskett RN, MS* (Chief Operating Officer and Vice President of Patient Care services/Team Chair F.M.E.A. committee)
- *Jill Price RN*, Head Nurse Cath Lab/Cardiology — (Co-Chair F.M.E.A. committee & presentation submitter)
- *Wilhelmina Crawford RN* — Assistant Head Nurse Operating Room
- *Amie Bannis RNM* — Head Nurse Labor and Delivery
- *Dr. Cheryl Wade* — Chief of Surgery
- *Kathleen Ozelia Lewis RN MPH* — Infection Control Coordinator
- *Lydia Thomas RN MS* — Director of Risk Management
- *Colin McCammon MPA* — Safety Officer
- *Marion Wilson LPN* — Performance Improvement Nurse

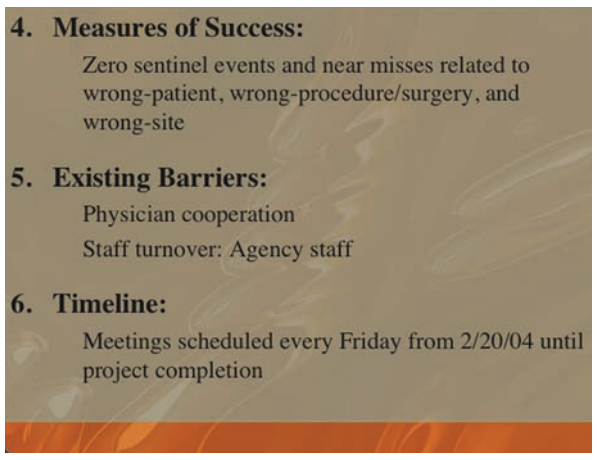
The Surgical FMEA Committee can be contacted via Jill Price at JPrice@jflusvi.org

Legend (for excel charts, following)

- Criticality analysis is a technique for prioritizing failure modes. **Criticality index** is the total sum of the severity, frequency, and detectability.
- **Severity** is the degree of seriousness of the injury that could ultimately result from the effect.a
- **Frequency** is the likelihood that something will happen.
- **Detectability** is the degree to which something can be detected.





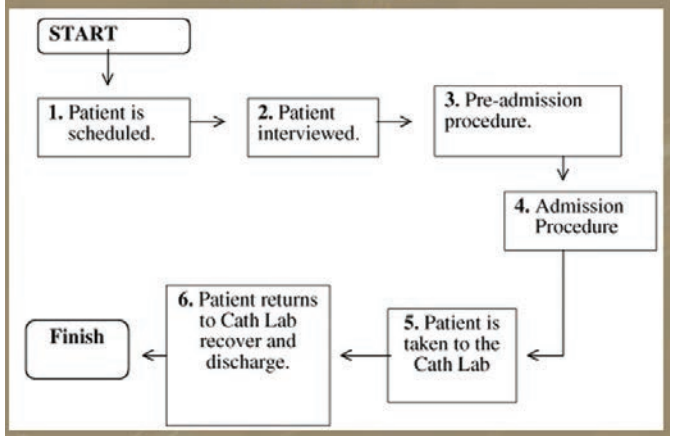


See JCAHO, page 42

JCAHO, *Continued from page 40*

Step 2: Diagram the Process Step

Cardiovascular Lab



Step 2: Diagram the Process Step

Cardiovascular Lab

1. Patient is scheduled for surgery by:
   a. Physician evaluating patient in their private office.
   b. Physician notifies the staff of the patient and procedure by faxing.
   c. Physician evaluates the patient on the admitted unit/floor.
   d. Physician notifies the staff through verbal communication.
2. Patient interviewed:
   a. Cath lab staff contacts the patient to verify and discuss date time, procedure, and pre-admission requirements
3. Pre-admission procedure (2-3 days prior to procedure):
   a. The nurse fills out "Physician Order of Services" per verbal order from the attending physician.
   b. The nurse meets with the patient and discusses pre-registration instructions, need for passport, labs , x-ray, and EKG.
   c. Admission office pre-registers patient for the procedure; labs, x-ray and EKG.
   d. Day prior to the procedure: labs, x-ray, and EKG are reviewed by the nurse and any abnormal results are reported to the attending MD.
4. Admission to the Cath Lab:
   a. Outpatients register with the admission office.
      The admission office notifies the cath lab and provides the nurse with the patient's admission package, or the patient reports to the cath lab and the cath lab nurse obtains the admission package from the admission office. Initial assessment and preparation is conducted, labs are reviewed.
   b. Inpatient
      The cath lab nurse goes to the patient's bedside to conduct the initial assessment and preparation for the procedure.
      Labs and the consent are reviewed.
   c. Physician performs initial assessment and fills out the anesthesia plan of care on the conscious sedation record and obtains consent for procedure.
5. Patient is taken to the Cath Lab:
   a. Patient is prepped
   b. Physician notified when patient is prepped
   c. Procedure starts
6. Recovery and Discharge:
   a. Outpatients recovered and discharged with instructions
   b. Inpatients are recovered and returned to the floor
   c. Patient satisfaction survey completed

Process Step	*Failure Mode*	*Effect of Failure*
1. Patient is scheduled for Survey: a. M.D. evaluates the patient in the private office b. M.D. notifies the staff of the patient and procedure by faxing information or by verbal communication. c. M.D. evaluates the patient on the admitted unit. d. M.D. notifies the staff through verbal communication.	Miscommunication or incorrect information faxed to the cath lab. ~Doctor documents on the wrong medical record. ~Doctor evaluates the wrong patient through consultation. ~ Miscommunication.	~ Wrong patient scheduled. ~ Delay in the correct procedure ~ Nurse evaluates the wrong patient, or preps the wrong patient.
2. Patient Interviewed: a. Cath lab staff contacts the patient to verify and discuss date, time, procedure, and pre-admission requirements.	~Wrong patient verified and scheduled.	~ Pre-admission completed on the wrong patient, including: labs, EKG, and x-ray.
3. Pre-admission procedure (two- three days prior) a. Nurse fills out the *Physician Order of Service form* , per verbal order of the attending M.D. b. Nurse meets with the patient to discuss pre-registration instructions, need for pass port, labs, x-ray, and EKG. c. Admission office pre-registers the patient for the procedure, labs, x-ray, and EKG. d. Prior to the procedure labs, x-ray and EKG are reviewed by the nurse & abnormals are reported to the attending M.D.	~ Nurse fills out the *physician order of service form* , per verbal order from the attending physician.	~ Wrong patient information is transcribed. ~ Wrong patient is scheduled for a procedure. ~ Pre-admission process intervention is completed on the wrong patient including labs, x-ray, and EKG. ~ Non-payment of the hospital bill secondary to inadequate documentation.

Step 3. Brainstorm Potential Failure Modes and Determine their Effects

Process Step	*Failure Mode*	*Effect of Failure*
4. Admission to the Cath Lab: a. The patient registers with the admission office. The admission office notifies the cath lab and provides the nurse with the patient admission package. b. The patient reports to the cath lab. The cath lab nurse obtains the admission package from the admission office. c. Initial nursing assessment and preparation for procedure conducted, final labs reviewed by nurse and physician. d. If the patient is inpatient then the cath lab nurse goes to the patient's bedside to conduct an initial assessment and prepares the patient for the procedure, nurse reviews labs and ensures that the consent is signed. e. Physician assessment, consent, CS	~ Admission office enters the wrong patient information. ~ Initial nursing and physician assessments conducted on the wrong patient.	~ Incorrect patient documentation conducted leading to the wrong patient scheduled for the wrong procedure. ~ Wrong patient prepared for the procedure. ~ Wrong billing for the patient and the pre-op process conducted.
5. Patient to the cath lab. a. Patient is prepped. b. Physician notified when the patient is prepared. c. Procedure starts.	~ Wrong patient, procedure, and site.	~ Patient suffers medically ~ More supplies used; increased cost. ~ Negative public media coverage
6. Recovery and Discharge. a. Outpatients recovered and discharged with instructions. b. Inpatients recovered/returned to floor c. Patient satisfaction survey's done.	~ Discharge complications	~ Delay in the recovery process ~ Failure to conduct a follow up evaluation.

Criticality Analysis

Criticality analysis is a technique for prioritizing failure modes. It is a procedure by which each potential failure mode is ranked according to the following defined criteria:

- **Severity:** the degree of seriousness of the injury that could ultimately result from the effect.
- **Frequency:** the likelihood that something will happen.
- **Detectability:** the degree to which something can be detected.

Severity Score

Rating	Definition
1	Mode of failure would produce no significant impact on the results of the process, with no impact on the clinical outcome.
3	Mode of failure would produce mild impact on the result of the process if not detected. Negative impact on the clinical outcome is low.
5	Mode of failure would produce moderate impact on the result of the process if not detected. Negative impact on the clinical outcome is moderate.
7	Mode of failure would produce significant impact on the result of the process if not detected. Significant impact on the clinical outcome would be moderately high.
10	Mode of failure would cause the entire process to fail if not detected, resulting in a virtual certainty of negative impact on the clinical outcome

Frequency (occurrence) score

Rating	Definition
1	Likely to occur very infrequently, once in a hundred years.
3	Likely to occur infrequently, once every five years.
5	Likely to occur with moderate frequency, once a year.
7	Likely to occur with significant frequency, once a month.
10	Likely to occur with high frequency, one or more times a day.

See JCAHO, page 44

JCAHO, *Continued from page 42*

Detectability Score

Rating	Definition
1	Very easy to detect, so the failure is virtually certain to be detected after it has occurred.
3	Fairly easy to detect, so there is a significant likelihood the failure will be detected after it has occurred.
5	Moderately detectable, so there is a moderate likelihood the failure will be detected after it has occurred.
7	Moderately difficult to detect, so there is a low likelihood the failure will be detected after it has occurred.
10	Extremely difficult to detect, so there is essentially no chance the failure will be detected after it has occurred.

Step 4. Prioritizing the Failure Mode

Process Step	*Failure Mode*	*Effect of Failure*	*Severity*	*Occurrence*	*Detectability*	*Criticality Index*	*Priority*
1. Patient is scheduled for Survey: a. M.D. evaluates the patient in the private office b. M.D. notifies the staff of the patient and procedure by faxing information or by verbal communication. c. M.D. evaluates the patient on the admitted unit. d. M.D. notifies the staff through verbal communication.	Miscommunication or incorrect information faxed to the cath lab. ~Doctor documents on the wrong medical record. ~Doctor evaluates the wrong patient through consultation. ~ Miscommunication.	~ Wrong patient scheduled. ~ Delay in the correct procedure ~ Nurse evaluates the wrong patient, or preps the wrong patient.	4	3	3	36%	2
2. Patient Interviewed: a. Cath lab staff contacts the patient to verify and discuss date, time, procedure, and pre-admission requirements.	~Wrong patient verified and scheduled.	~ Pre-admission completed on the wrong patient, including: labs, EKG, and x-ray.	5	3	1	15%	6
3. Pre-admission procedure (two- three days prior) a. Nurse fills out the *Physician Order of Service form* , per verbal order of the attending M.D. b. Nurse meets with the patient to discuss pre-registration instructions, need for pass port, labs, x-ray, and EKG. c. Admission office pre-registers the patient for the procedure, labs, x-ray, and EKG. d. Prior to the procedure labs, x-ray and EKG are reviewed by the nurse & abnormals are reported to the attending M.D.	~ Nurse fills out the *physician order of service form* , per verbal order from the attending physician.	~ Wrong patient information is transcribed. ~ Wrong patient is scheduled for a procedure. ~ Pre-admission process intervention is completed on the wrong patient including labs, x-ray, and EKG. ~ Non-payment of the hospital bill secondary to inadequate documentation.	5	3	1	15%	5

Step 4. Prioritizing the Failure Mode *continued*

Process Step	*Failure Mode*	*Effect of Failure*	*Severity*	*Occurrence*	*Detectability*	*Criticality Index*	*Priority*
4. Admission to the Cath Lab: a. The patient registers with the admission office. The admission office notifies the cath lab and provides the nurse with the patient admission package. b.The patient reports to the cath lab. The cath lab nurse obtains the admission package from the admission office. c. Initial nursing assessment and preparation for procedure conducted, final labs reviewed by nurse and physician. d. If the patient is inpatient then the cath lab nurse goes to the patient's bedside to conduct an initial assessment and prepares the patient for the procedure, nurse reviews labs and ensures that the consent is signed. e. Physician assessment, consent, CS	~ Admission office enters the wrong patient information. ~ Initial nursing and physician assessments conducted on the wrong patient.	~ Incorrect patient documentation conducted leading to the wrong patient scheduled for the wrong procedure. ~ Wrong patient prepared for the procedure. ~ Wrong billing for the patient and the pre-op process conducted.	5	1	3	15%	4
5. Patient to the cath lab. a. Patient is prepped. b. Physician notified when the patient is prepared. c. Procedure starts.	~ Wrong patient, procedure, and site.	~ Patient suffers medically ~ More supplies used; increased cost. ~ Negative public media coverage	10	1	7	70%	1
6. Recovery and Discharge. a. Outpatients recovered and discharged with instructions. b.Inpatients recovered/returned to floor	~ Discharge complications	~ Delay in the recovery process ~ Failure to conduct a follow up evaluation.	5	3	2	30%	3

Step 5. Identify Root Causes of Failure Modes

Process Step	*Failure Mode*	*Effect of Failure*	*Priority*
1. Patient is scheduled for Survey: a. MD evaluates the patient in the private office b. MD notifies the staff of the patient and procedure by faxing information or by verbal communication. c. MD evaluates the patient on the admitted unit. d. MD notifies the staff through verbal communication.	Miscommunication or incorrect information faxed to the cath lab. ~Doctor documents on the wrong medical record. ~Doctor evaluates the wrong patient through consultation. ~ Miscommunication.	~ Wrong patient scheduled. ~ Delay in the correct procedure ~ Nurse evaluates the wrong patient, or preps the wrong patient.	2
2. Patient Interviewed: a. Cath lab staff contacts the patient to verify and discuss date, time, procedure, and pre-admission requirements.	~Wrong patient verified and scheduled.	~ Pre-admission completed on the wrong patient, including: labs, EKG, and x-ray.	6
3. Pre-admission procedure (two- three days prior) a. Nurse fills out the *Physician Order of Service form,* per verbal order of the attending MD. b. Nurse meets with the patient to discuss pre-registration instructions, need for pass port, labs, x-ray, and EKG. c. Admission office pre-registers the patient for the procedure, labs, x-ray, and EKG. d. Prior to the procedure labs, x-ray and EKG are reviewed by the nurse & abnormals are reported to the attending MD.	~ Nurse fills out the *physician order of service form,* per verbal order from the attending physician.	~ Wrong patient information is transcribed. ~ Wrong patient is scheduled for a procedure. ~ Pre-admission process intervention is completed on the wrong patient including labs, x-ray, and EKG. ~ Non-payment of the hospital bill secondary to inadequate documentation.	5

Process Step	*Failure Mode*	*Effect of Failure*	*Priority*
4. Admission to the Cath Lab: a. The patient registers with the admission office. The admission office notifies the cath lab and provides the nurse with the patient admission package. b.The patient reports to the cath lab. The cath lab nurse obtains the admission package from the admission office. c. Initial nursing assessment and preparation for procedure conducted, final labs reviewed by nurse and physician. d. If the patient is inpatient then the cath lab nurse goes to the patient's bedside to conduct an initial assessment and prepares the patient for the procedure, nurse reviews labs and ensures that the consent is signed. e. Physician assessment, consent, CS	~ Admission office enters the wrong patient information. ~ Initial nursing and physician assessments conducted on the wrong patient.	~ Incorrect patient documentation conducted leading to the wrong patient scheduled for the wrong procedure. ~ Wrong patient prepared for the procedure. ~ Wrong billing for the patient and the pre-op process conducted.	4
5. Patient to the cath lab. a. Patient is prepped. b. Physician notified when the patient is prepared. c. Procedure starts.	~ Wrong patient, procedure, and site.	~ Patient suffers medically ~ More supplies used; increased cost. ~ Negative public media coverage	1
6. Recovery and Discharge. a. Outpatients recovered and discharged with instructions. b.Inpatients recovered/returned to floor	~ Discharge complications	~ Delay in the recovery process ~ Failure to conduct a follow up evaluation.	3

Step 6. Redesign the Process

Process Step	*Failure Mode*	*Effect of Failure*	*Cause of Failure*	*Severity*	*Occurrence*	*Detectability*	*Criticality Index*	*Priority*	*Solution*
1. Patient is scheduled for surgery	Miscommunication or incorrect information faxed to the cath lab. ~Doctor documents on the wrong medical record. ~Doctor evaluates the wrong patient through consultation. ~ Miscommunication.	~ Wrong patient scheduled. ~ Delay in the correct procedure ~ Nurse evaluates the wrong patient, or preps the wrong patient.	~ Doctor gave the wrong patient name. ~ Information faxed was not legible or incorrectly faxed. ~ Delay in documentation. ~ Incorrect interpretation of the documents.	4	3	3	36%	2	~ All physicians must fill out the physician order of service form and it can be hand delivered or fax. ~Admission procedure process will not be initiated until physician order of service form is completed by the MD.
2. Patient interviewed.	~Wrong patient verified and scheduled.	~ Pre-admission completed on the wrong patient, including: labs, EKG, and x-ray.	~ Patient knowledge deficit. ~ Inadequate patient verification by the attending physician. ~ Inadequate patient identifiers used.	5	3	1	15%	6	~Verification with the MD of patient, procedure,pre-admission requirements, prior to the patient interview.
3. Pre-admission admission procedure (two-three days) prior.	~ Nurse fills out the *physician order of service form* , per verbal order from the attending physician.	~ Wrong patient information is transcribed. ~ Wrong patient is scheduled for a procedure. ~ Pre-admission process intervention is completed on the wrong patient including labs, x-ray, and EKG. ~ Non-payment of the hospital bill secondary to inadequate documentation.	~ Unclear practice; the patient should not be pre-registered without the attending physician's signature. ~ The patient is registered by admitting without the MD's signature.	5	3	1	15%	5	~ All physicians must fill out the physician order of service form and it can be hand delivered or fax. ~Admission procedure process will not be initiated until physician order of service form

See JCAHO, page 46

JCAHO; *Continued from page 44*

Step 6. Redesign the Process *continued*

Process Step	*Failure Mode*	*Effect of Failure*	*Cause of Failure*	*Severity*	*Occurrence*	*Detectability*	*Criticality In*	*Priority*	*Solution*
4. Admission to Cath Lab.	~ Admission office enters the wrong patient information. ~ Initial nursing and physician assessments conducted on the wrong patient.	~ Incorrect patient documentation conducted leading to the wrong patient scheduled for the wrong procedure. ~ Wrong patient prepared for the procedure. ~ Wrong billing for the patient & the pre-op process conducted.	~ Inadequate training. ~ Human error. ~ Physician use of medical terminology and medical abbreviations unknown to admission clerks.	**5**	**1**	**3**	**15%**	**4**	~Provide an in-service education to all admission clerks on the physician order of service form and pre-admission requirements for all cardiovascular procedures.
5. Patient to the cath lab.	~ Wrong patient, procedure, and site.	~ Patient suffers medically ~ More supplies used; increased cost. ~ Negative public media coverage	~ Lack of a verification process.	**10**	**1**	**7**	**70%**	**1**	~Verification process established to include a verification checklist, marking of the site and a time out form.
6. Recovery and discharge.	~ Discharge complications	~ Delay in the recovery process ~ Failure to conduct a follow up evaluation.	~ Knowledge deficit related to discharge instructions. ~ Inadequate patient education. ~ Patient non-compliance.	**5**	**3**	**2**	**30%**	**3**	~ Implement a patient follow up evaluation form to assess compliance & patient education. ~ Continue with patient satisfaction surveys.

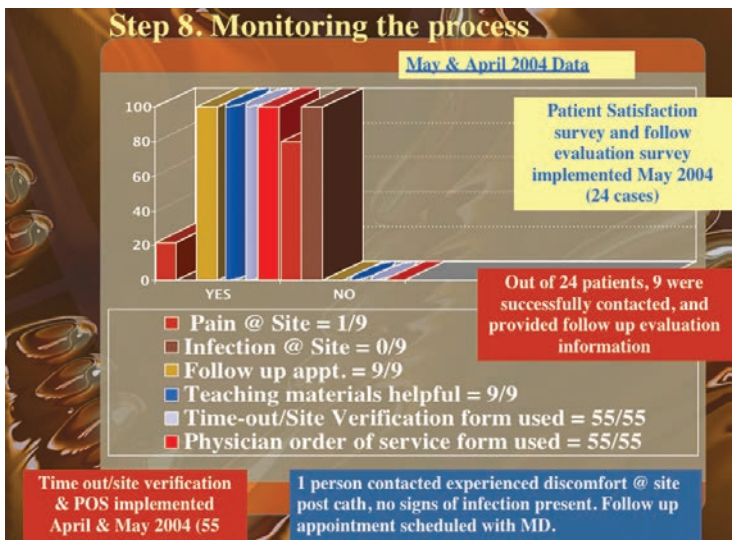
Step 7. Analyze and test the new process

Problem (prioritized)	*Suggested Resolution (prioritized)*
Wrong patient, procedure, and/or site.	Create a verification process to include a verification checklist, marking of the site and a time out form.
Miscommunication or incorrect information faxed to the cath lab.	All physicians must fill out the physician order of service form and it can be hand delivered or faxed.
Discharge complications.	Implement a patient follow up evaluation form to assess compliance and patient education and continue with patient satisfaction surveys.
Admission office enters the wrong patient information.	Provide an in-service education to all admission clerks on the physician order of service form and pre-admission requirements for all CVL procedures
Nurse fills out the physician order of service form, per verbal or telephone order from the M.D.	All physicians must fill out the physician order of service form before the admission procedure process will begin.
Wrong patient verified and scheduled	Verification process with the MD of pt., procedure, and pre-admission requirements.

Step 8. Implement the new process

- See Pre-op Verification checklist
- See Time-out form
- See Patient Satisfaction survey
- See Patient evaluation form

Failure Mode and Effects Analysis Definition: A systematic way of examining a process prospectively for possible ways in which failure can occur, and then redesigning the process to eliminate the possibility of the failure, stop the failure before it harms an individual, or minimize the consequences of the failure.



Evaluation of Compliance

Goals and Objectives:

- To review the process of verifying the right-patient, right-procedure, and right-site.
  - **Completed a step-by-step team approach analysis.**
- To redesign the parts of the process that may contribute to a potential adverse outcome.
  - **Completed with the implementation of Pre-procedure verification form, marking of the site, and time out process form.**
  - **Implementation of the Physician order of service form. (Implemented in April 1, 2004).**
  - **Implementation of a post-procedure follow up patient evaluation process. (Implemented May 1, 2004).**
- Evaluate compliance
  - 100 % compliant to date with all of the above forms.
  - Future goals:
    - **Continue to monitor for potential failure mode processes.**

THE GOVERNOR JUAN F. LUIS HOSPITAL AND MEDICAL CENTER
No. 4007 Estate Diamond Ruby
Christiansted, St. Croix, USVI 00820-4421

Tel: (340) 778-6311
Ext. 2513, 2514, or 2515
Fax: (340) 772-7391

PHYSICIAN'S ORDER FOR SERVICE

Date: _____

Physician's Name: _____

To the Admission officer: Admission is requested for the following Patient

Patient Name _____ Patient Telephone No.
Home Address: _____ Work _____
Mailing Address: _____ Res. _____
Date of Birth: ___/___/___ Patient SS#: ___-___-___ Sex: M☐ F☐
Procedure Services required: _____
Admitting Diagnosis: _____
Remarks and/or special instructions: _____

MEDICAL CATEGORY:

☐ Urgent
☐ Emergency
☐ Elective Urgent
☐ Elective Not Urgent
☐ Treatment
☐ Diagnostic
☐ Newborn

Physician's License Number: _____
Physician's Upin Number _____
Physician's Phone #: ( ) _____
Signature of Physician

Information for Business Office: (Please Check):
Person Contacted: _____
Pre-Certification No. _____
Pre-Certified ☐ Yes ☐ No
Date Certified: ___/___/___
☐ Wkman Compensation
☐ Veteran Administration
☐ Court / Law Enforcement
☐ Emergency Patient ☐ Staff Patient
☐ Emergency Room ☐ Private Patient
☐ Other _____
☐ Insurance _____ Insured SS# ___-___-___
☐ Co-Insurance _____ Insured SS# ___-___-___
Insured Name: _____

☐ Patient has been advised that a deposit is required by the hospital.
NOTE: Emergency Patients admitted from The Emergency Room must sign the written Notice to the Business Office, advising that the physician's services were requested on a private basis. Without this notice patient will be billed as a non-private case.

KB/REV 10/01

Governor Juan F. Luis Hospital & Medical Center
Pre-Procedure Verification Checklist

Procedure_____Date_____Time_____
Initial each line when verified or completed. Write not applicable (n/a) for those items that are not applicable. * Indicates this must be verified by two licensed nurses.

Preoperative verification checklist:

Initial	Initial	Verification of procedure/side
_____	_____	Patient identified by ID band and picture ID
_____	_____	Patient understanding confirms physician's order*
_____	_____	Schedule coincides with physician's order for site/side procedure
_____	_____	Physician's order matches consent*
_____	_____	Patient and/or family member coincide with site/side (specify)*
_____	_____	Site marked by _____surgeon _____ patient _____ family _____other

Initial	Initial	Verification of the presence of
_____	_____	Informed consent for treatment (completed and signed)
_____	_____	Blood consent (needed for type and cross-match or type and screen)
_____	_____	Sterilization consent (if applicable)
_____	_____	Medicaid Sterilization (if applicable)
_____	_____	Other consents: _____
_____	_____	Identification band *
_____	_____	History and physical examination report

Initial	Initial	Verification of the presence of Peri-operative Nursing Assessment/ Care Plan
_____	_____	Attending Physician Pre-Operative Note
_____	_____	Allergy profile completed and in chart
_____	_____	Laboratory results reviewed and in chart; abnormal results reported to:
_____	_____	Electrocardiogram results reviewed and in chart.
_____	_____	Preoperative medications given (Specify)
_____	_____	Patient profile, patient care summary, and graphics completed on chart
_____	_____	NPO since_____
_____	_____	Last voided at_____
_____	_____	Preps completed_____
_____	_____	Antiembolism devices on (if ordered)
_____	_____	Loose teeth? No_____Yes_____Specify_____

Valuables checklist:	None	Removed	To procedure	Given to
Orthodontic appliances/dentures	_____	_____	_____	_____
Eye glasses	_____	_____	_____	_____
Contacts_____right_____left	_____	_____	_____	_____
Prosthesis	_____	_____	_____	_____
Jewelry/earrings	_____	_____	_____	_____
Hearing aids _____right_____left	_____	_____	_____	_____
Other:_____	_____	_____	_____	_____

To procedure at_____via_____

Signature/time **Initials**

_____

NUR 3/04

Governor Juan F. Luis Hospital & Medical Center
Surgical/Invasive Verification and Time Out Form

Surgeon Verification **Initial Appropriate Space**

Proposed Surgical Procedure:_____

1. I have verified the operative site and side by review of the following and placed my initials in indelible ink on the patient's operative site: Right_____ Left _____
- Physical Examination
- Review of Radiological studies (if applicable) Multiple Structures _____(i.e.: fingers,toes)
- Informed Consent
- Patient/Family confirmation of the operative site and side Level _____(i.e.: vertebral, or spinal)

Date_____Time_____ Surgeon's Signature _____Print Name _____

Anesthesiologist Verification **Initial Appropriate Space**

1. I have verified the operative site and side by review of the following: Right _____ Left _____
- Clinical Examination
- Review of the Medical Record, Radiological Reports (if applicable).
- Marking of the Surgical Site confirmed Multiple Structures_____(ie:fingers,toes)
- Patient/Family confirmation of the operative site and side Level _____(ie:vertebral,or spinal)

Date _____Time_____Anesthesiologist Signature_____ Print Name_____

TIME OUT PROCESS

The Surgical Team has orally verified the above noted items in the Operating room before induction of Anesthesia

Patient Name and Visit Number ☐Yes ☐No
Right_____Left_____
Multiple Structures_____
Level_____

Proposed Surgical Procedure: _____

The following items are in agreement with the surgical procedure, and location:
Attending M.D. Pre-Operative Note ☐Yes ☐ No **Surgical Site Marked** Yes☐ No ☐
Operative Schedule ☐Yes ☐No **Completed Consent** Yes ☐ No ☐

Date _____Time_____
Circulating Nurse's Signature _____ Print Name_____

Attending Anesthesiologist's Signature _____ Print Name _____

Attending Surgeon's Signature _____ Print Name _____

Comments or Discrepancy Resolution *(if needed)*

Circulating Nurse's Signature _____ Print Name_____
Date _____Time_____

NUR 3/04

Governor Juan F. Luis Hospital & Medical Center
Dr. Andre Galiber Sr.
Cardiovascular and Hemodynamic Laboratory

Post Procedure Patient Assessment
To be completed by an RN within 10 days after discharge!

1. Have you noticed any redden areas or skin break-down to your back? _____

2. Have you noticed any swelling, redness, fever, drainage, or odor to the procedure area (groin, chest)? _____

3. Have you experienced any pain in the procedure area? _____

4. Do you have a follow up appointment scheduled with your physician? _____

5. Do you have any questions related to your prescribed medicines and/or treatment? _____

Patient Name:_____

Cath and Angio number:_____

Procedure Date:_____

Procedure Performed:_____

Person retrieving questionnaire:_____

Date of questionnaire: _____

Cc: Cath chart: (CVL)

To be filed in Medical Records after evaluation completed- NUR- 3/04

Governor Juan F. Luis Hospital & Medical Center
Dr. Andre Galiber Sr.
Cardiovascular and Hemodynamic Laboratory

Patient Satisfaction Survey

Obtained 5 days after discharge; to be conducted by a cath lab staff member and the following scale is to be used to answer the questions

	Yes (Y)	***No (N)***	
1. Was your overall experience in the cath lab pleasant?	☐		**Comments**:
2 Was the staff helpful or supportive in addressing your concerns and questions related to the procedure?	☐		**Comments:**
3. Was the pre-procedure instructions or teaching material provided to you helpful?	☐		**Comments:**
4. Was your overall hospitalization pleasant?	☐		**Comments:**
5. Do you have any suggestions for improvements?	☐		**Comments:**

Patient Name:_____

Cath & Angio Number:_____

Procedure performed & Date:_____

Person retrieving and Date of questionnaire:_____

Cc: Performance Improvement: (Nursing)