Please note that the following document was created by the former Australian Council for Safety and Quality in Health Care. The former Council ceased its activities on 31 December 2005 and the Australian Commission for Safety and Quality in Health Care assumed responsibility for many of the former Council’s documents and initiatives. Therefore contact details for the former Council listed within the attached document are no longer valid.

The Australian Commission on Safety and Quality in Health Care can be contacted through its website at http://www.safetyandquality.gov.au/ or by email mail@safetyandquality.gov.au

Note that the following document is copyright, details of which are provided on the next page.
The Australian Commission for Safety and Quality in Health Care was established in January 2006. It does not print, nor make available printed copies of, former Council publications. It does, however, encourage not for profit reproduction of former Council documents available on its website.

Apart from not for profit reproduction, and any other use as permitted under the Copyright Act 1968, no part of former Council documents may be reproduced by any process without prior written permission from the Commonwealth available from the Department of Communications, Information Technology and the Arts. Requests and enquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Intellectual Copyright Branch, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or posted at http://www.dcita.gov.au/cca
5 step correct patient, correct site, correct procedure protocol

Q. What is the 5 step correct patient, correct site, correct procedure protocol?

A. The protocol provides a standardised approach for health professionals in preparing patients for surgical, medical, radiology and oncology procedures. It consists of 5 steps:

Step 1: Checking the consent form or procedure request form is correct
Step 2: Marking the site for the surgery or other invasive procedure
Step 3: Confirming identification with the patient
Step 4: Taking a ‘team time out’ in the operating theatre, treatment or examination area
Step 5: Ensuring appropriate and available diagnostic images.

The protocol has been developed by the Council based on a proven product evaluated in the United States. It is intended to reduce the likelihood of procedures being performed on the wrong patient, wrong side or wrong site of the body.

Q. Why is this protocol necessary?

A. Procedures carried out on the wrong patient or part of the body are infrequent but can have alarming consequences. Patient safety incidents such as these occur in all health systems around the world, including in Australia.

Publicly reported incidents at hospitals across Australia show that the availability of practical approaches to reduce the number of patient safety incidents, such as procedures involving the wrong patient or part of the body, is very important.

All jurisdictions and Health Ministers in Australia have agreed to a National Core Set of Sentinel Adverse Events. Some jurisdictions have already started collecting information about patient safety with the goal of improving national reporting. One of the core sentinel events is Procedures involving the wrong patient or body part (this encompasses procedures performed on the wrong side or wrong site). At least one state has begun publicly reporting state wide sentinel events and this type of patient safety incident was reported to have occurred 9 times in the year 2001/02 in that state. Anecdotal reports also suggest that these types of events occur in other jurisdictions as well.

Q. Can this protocol make a difference?

A. In the United States, the Veterans Affairs National Center for Patient Safety has produced guidelines for preventing wrong site procedures, ‘Ensuring Correct Surgery’. They have piloted these guidelines at a number of sites with success, and they are now being implemented in all of the Veteran Affairs health care facilities in the United States. The Center has examined cases of surgery being conducted on the wrong patient or part of the body and found that a large proportion of these cases could have been prevented if the steps in the protocol were carried out.

There is also evidence from both the health system and other high-risk industries such as aviation and mining that having standardised procedures and protocols in place can reduce the likelihood of an error. Having nationally uniform procedures is also important as the health
work force is very mobile with different protocols in each state or hospital which can lead to important steps being forgotten, confused or misread by even staff moving into a new operating environment.

Q. Who developed these guidelines?

A. The Council was granted permission by the Veterans Affairs National Center for Patient Safety to adapt these guidelines for Australian conditions.

Q. How are these guidelines being implemented in Australia?

A. The 5 step correct patient, correct site, correct procedure protocol kit has been developed and includes a fact sheet, consumer brochures and workplace posters. These resources can be downloaded free from the Council’s website www.safetyandquality.org.

The procedures are applicable to all operative and other procedures that potentially expose patients to harm, such as chemotherapy and radiotherapy.

Q. Do these guidelines have the support of major health organisations in Australia?

A. Council has gained the support of the Royal Australasian College of Surgeons and is also seeking the support of other health care bodies.