

# **Washington Patient Safety Coalition (WPSC)**

## **Coordinated Quality Improvement Program**

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# Washington Patient Safety Coalition (WPSC)

## I. Background and Mission

The Institute of Medicine's landmark 1999 report, "To Err is Human," alerted the nation to the patient safety challenge in ways that prior studies had not. This study, as well as Agency for Healthcare Research and Policy publications and meetings, ignited a national dialogue and nationwide effort to improve patient safety in the 21<sup>st</sup> Century.

Along with other health care leaders in Washington, the Department of Health and the Health Care Authority approached the Foundation for Health Care Quality (FHCQ) in 2002 to convene and facilitate a work group representing a broad spectrum of those interested in patient safety challenges. This group's discussion led to an inaugural conference in June 2002 at which health care leaders from across the state discussed patient safety issues, prioritized topics, and made a public commitment to work together to decrease medical errors and improve safety for all people receiving health care in Washington. The FHCQ was asked to continue to provide a home for the ongoing work of what became the Washington Patient Safety Coalition, a voluntary, statewide organization. The Foundation is a private, 501(c) 3 organization that is a trusted venue for collaborative with a wide variety of stakeholders in health care; its status helps health care leaders stay focused on the core mission of advancing a patient safety agenda in Washington.

The Coalition builds on Washington's significant history of diverse groups working together toward innovative quality improvement efforts. Participants offer time, knowledge and experience in a collaborative atmosphere to achieve shared goals. The Coalition welcomes the involvement of individuals and organizations from all parts of the health care system: patients, providers, purchasers, regulators, quality improvement and risk reduction organizations, researchers, and others.

### **Mission**

The mission of the Washington Patient Safety Coalition is to reduce medical errors and improve patient safety for people receiving health care in Washington.

### **Goals**

WPSC fosters working relationships among the many communities interested in and committed to patient safety. The members work toward these goals:

- Create a common agenda, with shared measures, high safety standards and methods for reaching goals.
- Develop knowledge about effective processes and promote the infrastructures necessary to assure safe clinical care.

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- Promote a non-punitive environment where errors are identified and addressed promptly, best practices are freely shared and improvements in safety are widely demonstrated.

**Guiding Principles**

- The methods employed or promoted by the Coalition to reduce medical errors or promote patient safety shall be non-punitive in nature.
- The Coalition will focus on systems changes that create and sustain a safe and error-free environment in which patients receive the best possible health care.
- The methods and activities undertaken or promoted by the Coalition to reduce errors will be evidence-based and will accommodate new research and applications.
- The Coalition will be sensitive to the resources required to implement change.
- The Coalition will promote responsible and accountable public education about promoting safety and decreasing error.
- The Coalition depends on its members for information and data to assure that its activities and recommendations best meet members’ needs.
- The Coalition will continually seek consensus and will make collaboration a foundation of its activities.

The Coalition seeks CQIP approved status in order to facilitate its activities to improve safety; CQIP status will enable entities (e.g., hospitals, clinics) participating in its programs to share quality improvement lessons and activities in greater detail, which will benefit all participants.

**II. WPSC Administration, Authority and Accountability**

The WPSC is administered as a self-governing program under the auspices of the Foundation for Health Care Quality (FHCQ), an independent privately funded, non-profit entity that provides requisite stewardship over the data collection, analysis, and reporting of confidential data. When necessary to support and facilitate the work of the WPSC, the FHCQ can enter into contracts with organizations such as hospitals, health plans, data management firms, and/or other entities.

1 A. Steering Committee

2  
3 The Steering Committee provides leadership and strategic planning for the Coalition's  
4 goals and activities; its members represent the major interests and stakeholders in health care  
5 and patient safety. It develops and maintains the Coalition; identifies priorities; nurtures  
6 and provides coordination for work groups; measures progress toward goals;  
7 communicates with stakeholders and disseminates information and materials; and  
8 identifies sources of financial support. The initial composition of the Steering Committee  
9 was determined following the Coalition's inaugural conference in June 2002, and  
10 membership was recruited from organizations and others representing key interests in  
11 addressing patient safety. The membership and participation of a wide range of  
12 stakeholders cannot be overemphasized. Current Steering Committee membership is in  
13 Appendix A.

14  
15 This Committee may revise or establish new by-laws and rules of conduct, however the  
16 governing structure is as follows:

- 17  
18 1. The Steering Committee has been established as the Coalition's primary  
19 governing body.
- 20 2. The Foundation for Health Care Quality has recognized the members of the  
21 Steering Committee and delegated control to the Steering Committee over the  
22 Coalition rules of operation and program activities, which may include directing  
23 strategic planning and quality improvement activities.
- 24 3. The Steering Committee will be self-perpetuating: it will elect additional  
25 members as needed, as terms expire or vacancies are created.
- 26 4. Composition of the Steering Committee includes the appointment of persons from  
27 participating organizations to fill an adequate number of seats (10-20) providing  
28 wide representation of stakeholders. Any vacant seats will be filled at the group's  
29 discretion.
- 30 5. The Steering Committee will elect a Chair and Vice-Chair from the committee  
31 members to serve renewable one-year terms.
- 32 6. Steering Committee members will serve renewable two-year terms.
- 33 7. The Steering Committee may create subcommittees at its own discretion.
- 34 8. The Steering Committee may identify individuals to serve as non-voting advisors  
35 to itself.
- 36 9. Steering Committee meetings and related business will be conducted by agreed-  
37 upon Rules of Order.
- 38 10. The Steering Committee will conduct regularly-scheduled meetings.
- 39 11. Minutes of Committee meetings will be kept, and will be made available to all  
40 Coalition members.

- 1 12. Steering Committee actions require a quorum, defined as “attendance by half of  
2 all Steering Committee members plus one.”
- 3 13. All actions of the Steering Committee will be taken by a simple majority vote plus  
4 one.
- 5 14. In the absence of a quorum, those present may recommend that an action take  
6 place, which may then be voted upon by the Steering Committee via e-mail; such  
7 action may include but is not limited to approval of minutes and voting on  
8 membership.
- 9 15. In the absence of both the Chair and Vice-Chair, meetings may be chaired by the  
10 CEO or the Quality Improvement Director of the Foundation for Health Care  
11 Quality.
- 12 16. The Committee was populated and convened in October 2002; subsequent  
13 elections will take place in December 2003 and each December after that, with  
14 new members taking their seats in January of the year. To ensure that not all two-  
15 year terms expire at the same time, the initial term of half the initial membership  
16 (to be randomly determined) will expire in December 2003, and new members  
17 nominated; the initial term of the other half will expire in December 2004. Terms  
18 of the initial Chair and Vice-Chair will expire in December 2003.

19 Minutes will be recorded at each Steering Committee and sub-committee meeting and  
20 will be distributed to appropriate participants in WPSC.

21  
22 B. Program Director

23  
24 The WPSC program director will serve as a compensated employee of the FHCQ, shares  
25 responsibility for strategic planning with the Chair and Vice-Chair of the Steering  
26 Committee, and will be responsible for managing day-to-day operations, including  
27 implementation of policies and procedures approved by the Committee. This position  
28 will have joint accountability to the WPSC Steering Committee for all program activities  
29 and to the CEO of the FHCQ for general administrative and resource management issues.  
30

31 C. Subcommittees

32  
33 The Steering Committee will be responsible for creating and delegating to subcommittees  
34 specific tasks related to and necessary for planning and for the development,  
35 implementation, and evaluation of policies and procedures to support the work of the  
36 Coalition. These subcommittees will advise the Steering Committee on issues related to  
37 Coalition activities. Subcommittees meet on schedules according to the topic and work  
38 they are carrying out.  
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1  
2 Examples of subcommittees at this time that are essential to the WPSC are the following:  
3

- 4 • Strategic Planning
  - 5 • Conference and Event Planning
  - 6 • Medication Safety Initiative
  - 7 • Eliminating Wrong-Site Surgery (Surgical Site Verification)
- 8

9 Additionally, the Steering Committee may convene annual general meetings at least  
10 twice each year to present the work of WPSC to the Coalition members and the public.  
11 Invitations will be directed to a wide, diverse community of those interested in and  
12 responsible for decreasing error and improving safety. At these meetings all attendees  
13 will be encouraged to bring to the Committee’s attention issues of patient safety so that  
14 the Committee can prioritize its plans and actions.  
15

### 16 **III. Steering Committee Responsibilities**

17

18 The Steering Committee provides guidance and inspiration for the development and  
19 implementation of selected activities to improve patient safety in Washington, while  
20 adhering to the Coalition’s principles outlined earlier.  
21

22 Specific responsibilities include the following: the Steering Committee provides  
23 leadership and strategic planning for the Coalition by considering and addressing the  
24 primary question: How best can patient safety be improved effectively and efficiently  
25 throughout Washington? The Committee identifies and prioritizes opportunities for  
26 partnership or collaboration with organizations across the state and regionally, develops  
27 the statewide agenda for patient safety, participates in dialogue about policy at the state  
28 level, and provides guidance and coordination for the interest groups.  
29  
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31

### 32 **IV. Information Collection and Maintenance**

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34 The Steering Committee will oversee the collection and maintenance of any information;  
35 the nature of the information will be determined by the quality improvement activity. For  
36 example, in the ongoing efforts to eliminate wrong-site surgery, it may be helpful to  
37 gather, analyze, and disseminate information about the following: “near-misses;” wrong-  
38 site or wrong-patient procedure; hospitals’ compliance with or deviation from their  
39 surgical site verification policy; root cause analyses; changes in policy associated with  
40 improvements. (See VI below for more detail and examples.)  
41

42 WPSC may contract with a data management vendor and/or analyst (e.g., biostatistician)  
43 for the direct management and/or analyses of data collected. Such contracts would be  
44 between the FHCQ and the vendor.  
45  
46

1 **V. Quality Improvement Activities, Education, and Dissemination**

2  
3 Activities sponsored and/or carried out by the Coalition will vary in response to  
4 opportunities, community interest and priorities, and resources. Activities will be  
5 selected, developed, and implemented using the criteria in the Coalition’s mission, goals,  
6 and principles. Appendix B displays the criteria used by the Steering Committee to  
7 prioritize and select the Coalition’s initiatives, and the activities under consideration as of  
8 April 2004. For example, the material in Appendix C describes the initiative to eliminate  
9 wrong-site surgery in Washington by 2005; this goal was selected because it is  
10 achievable; it is unambiguous (it should never happen); there was wide community  
11 interest; it is applicable across care settings (invasive procedures are performed in  
12 inpatient and ambulatory settings); it is amenable to system changes; and it can best be  
13 achieved by collaboration across providers. In the time since the technical conference on  
14 this topic in 2003, the Coalition has distributed an evidence-based recommended policy  
15 throughout the state; included tools and information on its web site; initiated and  
16 facilitated regular quarterly teleconferences on the topic; and conducted a follow-up  
17 survey of hospitals to learn if surgical site verification policies had been updated, and to  
18 assess the barriers to adopting the recommendations to eliminate wrong-site surgery. A  
19 second initiative under development focuses on improving medication safety by  
20 promoting clear, unambiguous communication between prescribers and recipients of the  
21 information (pharmacists, patients), using tools such as the elimination of dangerous  
22 abbreviations and including the diagnosis or notation of purpose on all prescriptions.  
23 Other activities under consideration by the Coalition include the following: (1) reduce  
24 infections acquired in the health care setting; (2) educate and empower  
25 consumers/patients to be more active partners in their care; (3) develop and test an error-  
26 reporting system.

27  
28 Effective quality improvement activities of all types are dependent on the use of  
29 information to identify improvement opportunities, direct participants’ direction to those  
30 opportunities, and evaluate the effectiveness of the activities. Sharing of processes and  
31 best practices is helpful and productive, but limited; being able to collect, analyze, and  
32 share data with CQIP status of data related to the prioritized patient safety issues would  
33 enhance the effectiveness of the WPSC participants, and would be essential for some of  
34 the activities under consideration. It is the intent of the WPSC to broadly disseminate the  
35 lessons learned from its activities via conferences, e-mail distribution lists, its web site,  
36 through its partner organizations, and other means that are appropriate, effective, and  
37 efficient.

38  
39 All documents generated by the WPSC that include QI data or information will be  
40 identified as protected under the “Coordinated Quality Improvement Program,” unless  
41 specifically described by the steering committee. It is the intent of WPSC that program  
42 documentation and reports shall be protected from legal discovery to the fullest extent  
43 allowed by law.

1 Reports and information provided by WPSC to organizations participating in its  
2 initiatives will be gathered and developed with the oversight of the Steering Committee,  
3 with the goal of identifying opportunities for improvement. Since the function of this  
4 program is to promote and support improved safety, reduced error, and enhanced quality,  
5 it will be the responsibility of the participating institution to identify changes that should  
6 take place in response to the data. The Steering Committee takes responsibility for  
7 producing the most accurate and clinically meaningful reports possible based on the  
8 available data.

9  
10 Reports' content, format, and frequency will be determined by the QI activity to be most  
11 pertinent and useful for the participants, who are expected to use the information  
12 provided, coupled with their standard policies and procedures, to provide education and  
13 training on the following: 1) safety, injury prevention, infection control and hazardous  
14 materials; 2) responsibilities for reporting professional misconduct; 3) legal aspects of  
15 providing health care; 4) improving communication with health care recipients; 5) cause,  
16 prevention and reduction of malpractice claims; 6) identification of opportunities for  
17 improvement, to identify goals, and take steps to achieve those goals.

## 18 19 20 **VI. Provider Evaluation**

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22 Periodic evaluation of each provider participating in Coalition-sponsored activities will  
23 be delegated to the organization(s) in which that provider practices or provides health  
24 care. It is recommended that periodic evaluation of mental and physical capacity,  
25 competence in delivery of health care and verification of current credentials be done at  
26 least every two years.

27  
28 Information gathered under the purview of the WPSC will be maintained in a confidential  
29 format. When reports are generated for participants, organization (e.g., hospital, clinic)  
30 and provider (e.g., physician, pharmacist) identifiers will be coded. It will be left to the  
31 policies and procedures of each institution as to how they wish to convey provider level  
32 information. It is our recommendation that provider specific reports generated by  
33 participating organizations be included in that individual's personnel file. Patient  
34 identifiers will not be included with such reports.

## 35 36 37 **VII. Adverse Outcomes Reporting**

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39 Through the process described in this proposal, an individual report from a patient or  
40 provider describing a negative consequence of care that would require communication  
41 with the physician, hospital or health plan involved may come to the Steering  
42 Committee's attention. In these cases, it is our plan to pass along the information in a  
43 discreet form to the appropriate contact, and not represent the incident to general WPSC  
44 participants. Information on professional liability premiums, settlements, awards and  
45 costs for injury prevention, safety improvement and health care improvement activities

1 where obtained by the Steering Committee will be forwarded to appropriate personnel at  
2 each institution for internal review.

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5 **VIII. Dispute Resolution**

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7 The program will incorporate a mechanism to investigate and resolve, in a timely and  
8 appropriate fashion, disputes that emerge between participating parties. Responsibility  
9 for dispute resolution will lie with the Steering Committee and with the program director.

10 Where disputes occur, the program director and steering committee will investigate the  
11 situation by reviewing relevant documents and listening to differing perspectives, after  
12 which recommendations for a fair solution will be made. Where disputes occur within  
13 the Steering Committee and can not be resolved through deliberation and voting  
14 procedures, the program director and FHCQ will help provide guidance and make  
15 recommendations as to ways to resolve the matter.

## APPENDIX A: WPSC Steering Committee, Advisors, and Staff

### Steering Committee Members:

John Arveson  
Washington State Medical Association

Fred Drennan, MD MHA  
Qualis Health

Peter Dunbar, MD  
Harborview Medical Center

Gary Feldbau, MD  
Community Health Plan of Washington, and  
Association of Washington Health Plans

Nancy Fisher, MD  
Washington State Health Care Authority

Lynn Zimmerman, MHA  
Washington Health Foundation

Joan Garner, RN  
Washington State Nurses Association

Michael Glenn, MD  
Virginia Mason Medical Center

Tom Kirchmeier  
Physicians Insurance

Tanis Marsh  
League of Women Voters

Judy Morton, PhD (Vice-Chair 2003-2004)  
Swedish Health Services

Patti Rathbun  
Washington State Department of Health

Jeff Rochon, PharmD  
Washington State Pharmacy Association

Hugh Straley, MD (Chair 2003-2004)  
Group Health Cooperative

Brenda Suiter, MHA  
Washington State Hospital Association

Jeffery Thompson, MD, MPH  
Medical Assistance Administration

Elizabeth Ward, RN, MN  
West Seattle Psychiatric Hospital

Ze'ev Young, MD  
First Choice Health

Advisor:  
Andy Fallat, CEO, FHCQ

Program Director:  
Miriam Marcus-Smith, RN, MHA, QI Program Director, FCHQ

## APPENDIX B: Washington Patient Safety Coalition Activities Planning Matrix

Suggested criteria for selection:

Measurement:

Change from baseline is measurable by reasonable methods.

Consumer/patient role:

Activating and involving the patient is part of the process.

Setting:

The topic or initiative is transferable to different health care settings

Evidence:

Interventions have support in the evidence of medical literature

Opportunity:

There is a perceived or demonstrated gap between ideal and actual practice

Scope:

The scope or extent of the activity is reasonable for the Coalition's current capacity.

Impact:

This activity will have an effect upon significant numbers of patients, and/or will avoid significant risks; it will make a difference.

Likelihood of success:

The goal(s) can be accomplished.

Patient Safety Coalition Activities Planning Matrix 3.04

Purpose: Evaluate potential projects against our aims, priorities, and capacity  
 Choose the next project / activity to adopt in 2004

Criteria for selection (meets criterion, doesn't meet, unknown)

- Measurement: change from baseline is measurable by reasonable methods
- Consumer/patient role: activating and involving the patient is part of the process
- Setting: the topic or initiative is transferable to different health care settings
- Evidence: interventions have support in the evidence of medical literature
- Opportunity: perceived or demonstrated gap between ideal and actual practice
- Scope: must be reasonable for Coalition's current capacity
- Impact: "significant" number of patients can be affected, and risks avoided, by the activity
- Likelihood of success: goal can be achieved

**Options for next initiative, compared to criteria:**

Patient Safety Issue	Measurement	Consumer	Transferable	Evidence	Opportunity	Scope	Impact	Success	Comments
In process: eliminate wrong-site surgery	x	x	x	x	x	x	x	x	
<b>AHRQ recommendations:</b>									
Improve informed consent	?	x	x	x	x	x	x	?	Baseline measurement may be difficult
Prevent surgical site infections (antibiotic prophylaxis)	x	?	?	x	x	x	x	x	
Improved anticoagulation management	x	?	?	x	x				
Prevent intra-op MI with beta blockers	x			x	x	x	x	?	
Prevent central venous cath infections	x			x	?	x		?	
Prevent malnutrition (enteral nutrition)	x	?		x	?				
Prevent pressure ulcers	x	?	x	x					
Prevent DVT/VTE	x	?		x					
Aspiration of subglottic secretions				x	?				
US guidance of central line cath				x					
Sterile barriers during central lines				x					
<b>LeapFrog recommendations:</b>									
CPOE	x			?					Costly, controversial
Intensivists in hospitals	x			?	x				
Evidence-based (volume) hospital referrals				?	?				Controversial issue for payers and hospitals

Patient Safety Issue	Measurement	Consumer	Transferable	Evidence	Opportunity	Scope	Impact	Success	Comments
<i>Other options: *see note below</i>									
Campaign to educate patients to be more knowledgeable and active partners (medications, procedures, handwashing)*.		x	x	?	x	?	x	?	
Reduce medication error (various methods: eliminate dangerous abbreviations; include indication for drug; improve handwriting; e-prescribing; bar-coding)*	x	x	x	?	x		x	?	All providers probably working on this in some way. Major IOM focus.
Reduce hospital- or care-associated infection	x	x	x	x	.x		x	x	Existing Qualis effort; cuts across NQF, AHRQ, JCAHO standards & recommendations
Promote adverse event disclosure		x	x						
Low-tech solutions to PS problems*			x		?				
Develop, test, implement statewide error reporting system			x						

*Note:* Many issues can be addressed via either low- or higher-tech interventions, or combination of both.

**APPENDIX C: Wrong-Site Surgery Initiative**

**See following pages for materials.**

## Technical Conference on Eliminating Wrong-Site Surgery (complete materials available at [www.wapatientssafety.org](http://www.wapatientssafety.org))

### Brief Summary and Recommendations:

In the effort to eliminate wrong-site surgery in Washington by 2005, the Washington Patient Safety Coalition sponsored a technical workshop on this topic in May 2003. Teams representing 18 hospitals and other practice settings from across Washington participated in the workshop, learning from best practice and the challenges, barriers, and successes experienced by several health care systems and organizations. This paper summarizes the recommendations and consensus of those present.

### Summary:

Participants discussed key principles and agreed on specific recommendations:

### Principles:

1. **Standardization:** Errors are minimized as standardization of processes is increased. No matter the policy or how implemented, it should be the same for all staff. All surgeons and other operators are expected and required to adhere to the facility policy. Use of checklists decreases the chance of the omission of an agreed-upon critical process.
2. **Medical leadership:** Whatever the facility's policy, effective medical leadership in the form of physician champions is essential. Policies or procedures to assure correct-site surgery that are seen as 'administrative' or 'nursing,' and not helpful to physicians, are more likely to be minimized or ignored.
3. **Patient involvement:** The patient should be activated or involved in some way; this will vary, depending on the patient's unique situation (e.g., mental status).
4. **Team member accountability:** Each member of the operative or procedure team is responsible for his/her part(s), and also for monitoring and acting upon others' roles.
5. **Effective team process:** All team members should be trained in assertiveness, communication, and effectiveness, and clearly understand their roles.
6. **Audit, feedback and reporting:** These should be built in, to ensure that policy and procedure are followed, and to examine deviations from policy, regardless of outcome or severity (e.g., near miss, no harm, bad outcome).

The following table describes two categories of elements:

- **Required elements:** those that should be present in all facilities and used with all procedures, along with their rationale;
- **Acceptable process variation:** examples of reasonable and acceptable variation in how the required elements can be implemented.

<p style="text-align: center;">Required element</p> <ul style="list-style-type: none"> <li>• <b>Rationale</b></li> </ul>	<p style="text-align: center;"><b>Acceptable Process Variation</b></p>
<p><b>Preoperative period and permit process</b>  Marking the site:  Only the operative site is marked:</p> <ul style="list-style-type: none"> <li>• Marking the non-operative site contributes to confusion.</li> </ul> <p><b>Patient activation/involvement</b></p> <ul style="list-style-type: none"> <li>• Recognizes and formalizes patient's role in the consent process.</li> <li>• Recognizes patient's active contribution to safe care.</li> </ul>	<p>How/where on body the site is marked (on, adjacent to, with marker, dot, etc.).  Who marks the site (nurse, surgeon, patient, separately or in combination)  When is site marked (in MD office, pre-op room, before sedation)</p> <p>Begins with the process of informed consent; exact role may vary. E.g., patient may mark site, confirm site verbally, etc.</p>
<p><b>Pre-incision period in OR</b>  Pause or 'time-out'</p> <ul style="list-style-type: none"> <li>• Provides final check before initiation of procedure.</li> <li>• Confirm (verify) pertinent site details (laterality, implant, level) For cases of internal organs, i.e. brain, cord, lungs, kidneys, ovaries, the site <b>must</b> be confirmed with image studies in the OR.</li> </ul>	<p>Can be called by various members of the team: nurse, surgeon, anesthesiologist, etc.</p> <p>When confirmed? Before sedation and/or incision?  Who confirms? Surgeon, anesthesiologist, nurse, and/or patient  How? (e.g., xray in OR to confirm spinal level)</p>
<p><u>OR environment:</u>  Crew management in OR</p> <ul style="list-style-type: none"> <li>• OR team that understands its individual and group roles and has been trained in effective communication techniques more likely to be willing to call attention to real or potential errors.</li> </ul>	<p>Specific roles and responsibilities may vary; each person is responsible for monitoring their own activities and also is empowered to 'stop the line'</p>