**WHO Surgical Safety Checklist**

**for Arthrogram (fluoroscopy) in Clinical Radiology**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **SIGN IN** | | | |
|  | **(Before any intervention)** | | | |
|  | **Radiographer / Radiology Department Assistant / Consultant Radiologist** | | | |
|  | **Patient Identity** | | | |
|  | Patient confirms name and DOB | | | Y / N |
|  | **Procedure and site** | | | |
|  | Confirm procedure, site and side on clinical referral | | | □ |
|  | Patient confirms procedure and site | | | Y / N |
| Patient confirms verbal consent | | | Y / N |
|  | Team members introduce themselves | | | □ |
|  | Patient confirms not driving home | | | Y / N |
|  | Essential imaging has been reviewed | | | □ |
|
|  | IR(ME)R requirements are met | | | Y / N |
|  | **Contraindications** | | | |
|  | Does the patient have any allergies? | | | Y / N |
|  | If ‘yes’ above, state:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Risk factors for bleeding checked | | | □ |
|  | Patient is suitable for MRI | | | Y / N |
|  | **Name:** |  | | |
|  | **Signature of person reading aloud:** | | | |
| **TIME OUT** | | | | |
| **(Before start of procedure)** | | | | |
| **All team** | | | | |
| **Patient, procedure and site** | | | | |
| Confirm correct patient name on monitors | | | | □ |
| Reconfirm procedure, site and side | | | | □ |
| Confirm required equipment is available and in date | | | | □ |
|  | | | | |
| **Name:** | |  | | |
| **Signature of Operator:** | | | | |
|
|
| **Job title:** | | |  | |
|  | | | | |
| **Patient details (Label)** | | | | |
|  | | | | |
|  | | | | |
| **Date:** | |  | | |

Approved by Radiology DMT April 2021

Review April 2023

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SIGN OUT** | | | | | | |
| **(Before patient leaves procedure room)** | | | | | | |
| **All team** | | | | | | |
| Aftercare advice given | | | | | Y / N | |
| All pieces of invasive equipment used been accounted for | | | | | Y / N | |
| Equipment problems identified that need to be addressed | | | | | Y / N / N/A | |
| **Drugs Given** | | | | | | |
|  | | | Quantity | Lot No. | | Expiry |
| Lidocaine 1% | | |  |  | |  |
| Levobupivacaine | | |  |  | |  |
| Omnipaque 300 | | |  |  | |  |
| Prohance | | |  |  | |  |
|  | | | | | | |
| **Comments** | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **Name:** |  | | | | | |
| **Signature of Operator:** | | | | | | |
| **Job title:** | |  | | | | |