**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

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| **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:** |  |