

Note: Every team / surgery should have their own form - for 'Multidisciplinary' or 'Multiprocedure' surgeries.

# PRE OPERATIVE CHECKLIST

## A. PATIENT PROFILE

Name  I/C Passport No

Age  Sex  Race  Hospital Reg. No

Unit  Ward  Weight

Diagnosis (as per OT list)

Planned Operation / Procedure (as per consent)

Checked By  (Ward Staff) Date  (DD/MM/YYYY) Contact person & HP no. (next of kin)

## B. PRE-TRANSFER CHECK

(Is done by the ward nurse before sending patient to OT and at Reception Area in OT by the OT Reception Nurse)  
Mark (✓) where check has been performed

No.	Ward	OT	Remarks
1. Patient's Name /unknown <input type="checkbox"/> Patient's ID <input type="checkbox"/> (use two identifiers)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Consent for : <input type="checkbox"/> Surgery <input type="checkbox"/> Anaesthesia <input type="checkbox"/> Transfusion <input type="checkbox"/> Photos Re-check procedure with : <input type="checkbox"/> Consent form <input type="checkbox"/> patient <input type="checkbox"/> OT list	<input type="checkbox"/>	<input type="checkbox"/>	
3. Check <b>side</b> of operation <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	
4. Site of operation marked ? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	
5. Last meal : date .....(dd/mm/yyyy) time.....H (24 hour format)	<input type="checkbox"/>	<input type="checkbox"/>	(specify)
6. Check for dentures, jewellery, contact lenses, implant/ foreign body etc. (for person incharge of removing the item(s), to write their name and quantity of item in the remarks)	<input type="checkbox"/>	<input type="checkbox"/>	
7. Allergies ? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	(specify)
8. Availability of implant / prosthesis ? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	
9. Premedication (drug,dose,route and time given)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Blood or Blood product availability (write what is available) <input type="checkbox"/> GSH <input type="checkbox"/> GXM <input type="checkbox"/> others <input type="checkbox"/> none	<input type="checkbox"/>	<input type="checkbox"/>	
11. <input type="checkbox"/> Case Notes <input type="checkbox"/> Relevent Old Notes <input type="checkbox"/> Other Document(s) (To specify other document(s) and type of imaging studies in the remarks)	<input type="checkbox"/>	<input type="checkbox"/>	
12. Imaging study	<input type="checkbox"/>	<input type="checkbox"/>	
13. B/P: ..... / ..... mmHg Pulse rate : ..... bpm Temperature : .....°C	<input type="checkbox"/>	<input type="checkbox"/>	

Handed over by Ward Nurse  (Sign & Stamp) Received by OT Nurse  (Sign & Stamp)

Any important issues to be highlighted (has been corrected or rectified)

## C. INFORMATION ON OPERATING ROOM / SURGEON / TIME OF SURGERY

(Written in OR by Checklist Coordinator )

Operating Room No.  Temperature  Humidity

Anaesthetist(s)

Surgeon(s)

Checklist Coordinator





## OPERATING TEAM CHECKLIST BEFORE INDUCTION OF ANAESTHESIA

SIGN IN (By Anaesthetist & Coordinator Nurse)	
<b>Confirmed patient's</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<ul style="list-style-type: none"> <li>Name</li> <li>Planned procedure</li> <li>Site/side</li> <li>Consent</li> </ul>	
<b>Op site marked</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>GA machine checked?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Pulse oximeter turned on and functioning?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Patient has allergy?</b> If yes, please specify	<input type="checkbox"/> YES <input type="checkbox"/> NO
.....	
<b>Difficult airway / aspiration risk?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Any GXM/GSH?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Adequate IV access?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Suction apparatus checked &amp; functioning</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>OT Table checked &amp; functioning</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO

### BEFORE SKIN INCISION

TIME OUT (By Surgeon, Anaesthetist & Scrub Nurse)	
<b>'WHITE BOARD'</b> written	<input type="checkbox"/> YES <input type="checkbox"/> NO
Introduce team members	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Confirmed patient's</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<ul style="list-style-type: none"> <li>Name</li> <li>Planned procedure</li> <li>Site/side</li> <li>Consent</li> </ul>	
<b>Antibiotic prophylaxis given within the last 60 minutes?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Essential imaging displayed?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Briefing by Surgeon:</b> Incision, critical steps, estimated duration and blood loss	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Anaesthesia review:</b> Any patient-specific concern?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Scrub nurse review:</b> Instrument/ implant available. Equipment (diathermy, suction) ready	<input type="checkbox"/> YES <input type="checkbox"/> NO

### CHECK IN

Surgeon inform anaesthetist & scrub nurse of his/her intention to start	<input type="checkbox"/> YES <input type="checkbox"/> NO
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### DURING PROCEDURE

INTRA-OPERATIVE COMMUNICATION (By Surgeon, Anaesthetist & Scrub Nurse)	
<b>PERIODIC UPDATES</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>SHOUT - OUT</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PRE-CLOSURE DISCLOSURE</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO

### BEFORE SURGEON LEAVES OPERATING ROOM

SIGN OUT/Debriefing (By Surgeon / Checklist Coordinator Nurse)	
<b>The final procedure, findings and post-op orders</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Final instrument &amp; swab count was done</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Specimen(s) to be labelled</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<b>Any incidents or issues to be addressed?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Any special post op instructions by anaesthetist or surgeon?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Inform relative(s)</b> If no, why?	<input type="checkbox"/> YES <input type="checkbox"/> NO

### ISSUES/ INCIDENTS OCCURRED (IF ANY)

**Checklist Coordinator**  
(name, signature & stamp)

### AUDITING PURPOSE ONLY

Sign In=	/10	Sign Out =	/6
Time Out =	/8		
Check In =	/1		
IntraOp =	/3	<b>TOTAL =</b>	<b>/28</b>

# SWAB & INSTRUMENT COUNT FORM

PLANNED SURGICAL PROCEDURE

1<sup>st</sup> TEAM

1<sup>st</sup> TEAM

2<sup>nd</sup> TEAM

2<sup>nd</sup> TEAM

DATE / TIME START

(Use 24 hour format of time, e.g. 2315H)

DATE / TIME END

(Use 24 hour format of time, e.g. 2315H)

## SET & INSTRUMENTS

BASIC SET USED IN PROCEDURE

SUPPLEMENTARY SET USED IN PROCEDURE

Items	Initial count	Additional	Extra count	Additional	2nd count	Additional	Final count
Gauzes							
Abdominal packs							
Blades							
Atraumatic Needles							
Loose Needles							
Diathermy cleaner							

Actual operation(s)/ procedure(s) done

Specimen(s) sent

Name of 1st Scrub Nurse

Time start

Time End

Signature

24 H 24 H

Name of 2nd Scrub Nurse

Time start

Time End

24 H 24 H

Name of Circulating Nurse

Time start

Time End

24 H 24 H

Name of Surgeon & MMC No.

Time start

Time End

24 H 24 H



**PRE-DISCHARGE CHECK**

(Is done by the Ward Nurse in the presence of the Recovery Nurse before the patient leaves the OT)

	OT	Ward	Remarks
1. Patient's Name/unknown <input type="checkbox"/> Patient's ID <input type="checkbox"/> (use two identifiers)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Consciousness level : <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Intubated	<input type="checkbox"/>	<input type="checkbox"/>	
3. Inform Vital Signs (BP , PR , SpO2) & pain score	<input type="checkbox"/>	<input type="checkbox"/>	
4. Check operative site / dressing	<input type="checkbox"/>	<input type="checkbox"/>	
5. Check drains, tubes, urinary catheter	<input type="checkbox"/>	<input type="checkbox"/>	
6. Check IV lines and infusions	<input type="checkbox"/>	<input type="checkbox"/>	
7. Blood used and unused	<input type="checkbox"/>	<input type="checkbox"/>	
8. Specimens (culture(s) etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
9. <input type="checkbox"/> Case Notes <input type="checkbox"/> Relevent Old Notes <input type="checkbox"/> Other Document(s) <input type="checkbox"/> Operative Notes <input type="checkbox"/> GA form  (To specify other document(s) and type of imaging studies in the remarks)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Imaging Studies	<input type="checkbox"/>	<input type="checkbox"/>	
11. Check post-operative pain relief order	<input type="checkbox"/>	<input type="checkbox"/>	
12. Others, e.g. : amputated parts , placenta etc.	<input type="checkbox"/>	<input type="checkbox"/>	
13. Arterial Line (should be removed if not needed)	<input type="checkbox"/>	<input type="checkbox"/>	
14. PCA pump or epidural checked	<input type="checkbox"/>	<input type="checkbox"/>	
15.	<input type="checkbox"/>	<input type="checkbox"/>	
16.	<input type="checkbox"/>	<input type="checkbox"/>	
17.	<input type="checkbox"/>	<input type="checkbox"/>	

**OT Nurse**

(Name, signature & stamp)

**Ward Nurse**

(Name, signature & stamp)

**Date**

(DD/MM/YYYY)

**Time**

(PLEASE USE 24 HOUR FORMAT OF TIME)

**'SAFER SURGERY THROUGH BETTER COMMUNICATION'**

*Safe Surgery Saves Lives Programme*

Safe Surgery Saves Lives Steering Committee & Patient Safety Unit  
Medical Care Quality Section Medical Development Division  
Ministry of Health, Malaysia

