# To mark or not to mark? Pre-procedural checks in interventional radiology [QSI Ref: IR-801]

**Descriptor:**

To establish the adequacy of pre-procedural checks as applied to interventional radiology in line with the recent NPSA safe surgery alert.

**Background:**

Wrong site surgery is described as a “never event” by the national quality forum. The NPSA has published an alert on the use of checklists and pre-procedural site marking to ensure safe surgery occurs. These guidelines apply to most, if not all, of interventional procedures. There are deadlines for their implementation within each trust.

There are unique aspects to interventional radiology that make it inappropriate/impossible to mark the intended site before the procedure. For example:

• Bilateral hydronephrosis, with only one side to be drained. The assessment of the side is often performed at the time of the procedure

• Puncturing the right CFA to access the left renal artery

• Often the site is only decided after a review of the previous imaging combined with up to date imaging at the time of the procedure

The RCR has issued its own guidance and published an example of a checklist that may be appropriate use in radiology whilst still complying with the NSPA alert.

## The Cycle

**The standard:**

- All procedures undertaken in interventional radiology should have a checklist completed that complies with RCR guidelines and the NPSA alert

- This should be filed within the patients notes

**Target:**

100%

## Assess local practice

**Indicators:**

The percentage of patients notes that have an appropriate interventional checklist.

**Data items to be collected:**

- For each procedure a coded identifier for the radiologist that carried out the procedure

- Record from the patient’s notes whether the site has been marked or there is documentation that the site has been checked by the radiologist

**Suggested number:**

10 cases per operator (in larger centres suggested numbers of up to 100 retrospective cases).

**Suggestions for change if target not met:**

- Departmental discussion with agreement of the need for either site marking or clear documentation of the correct site following a review by the responsible radiologist

- Implementation of RCR guidance or similar in house checklist

- Repeat of the audit cycle after implementation of a checklist and an appropriate number of cases

**Resources:**

• Data collection:

   - Local RIS (or similar hospital system) to identify cases

   - Notes retrieval and search

• Assistance required:

   - Note retrieval by clinical audit department.

• Estimated time required for audit:

   - 10 hours to review 100 case notes

**References:**

1. [WHO Surgical Safety Checklist](https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources)
2. [RCR Guidelines for radiologists in implementing the NPSA safe surgery requirement](http://www.rcn.org.uk/__data/assets/pdf_file/0010/258742/BFCR094_safe_checklist.pdf)
3. [National Quality Forum](http://www.qualityforum.org/)

**Editor's comments:**

PCT requires compliance with the issue of “never events”. Demonstration of compliance will therefore be useful for departmental validation.

It is thought, a WHO surgical checklist is going to be introduced for interventional radiology shortly. The NPSA alert and WHO surgical checklist are very similar, so the audit should apply in either situation - the references can be modified at a future date if WHO replaces NPSA. Trusts must comply with the NPSA alert at present, hence the focus on this.

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