UHL Surgical Site Marking in Gynaecology Standard Operating Procedure (SOP)

University Hospitals of Leicester NHS Trust

Trust Ref: C13/2019

Contents

1. Introduction and this SOP applies to

In many surgical specialities, ensuring correct laterality of surgery (e.g. hip replacement, arthroscopy, nephrectomy) is essential. Marking is important so that factors such as site, type of incision and type of prosthesis can be selected correctly, and the appropriate surgery carried out.

In gynaecology, the need to identify laterality in order to plan surgery is less clear. Perineal/vulval lesions are often obvious on inspection and the laterality of ovarian /tubal lesions cannot always be determined preoperatively with accuracy. It is very common, for example, that ovarian cysts are found to arise from the contralateral side than expected based on the scan.

Nevertheless, 'Never Events' involving wrong-site surgery do occur in Gynaecology. The wrong vulval lesion may be operated on or lesions may be missed because they are less obvious. There is a risk of removing the wrong tube or ovary when preoperative expectation of laterality is found to be inconsistent with the intraoperative findings. Hence, surgical site marking in Gynaecology is relevant where laterality is indicated in the pre-surgical diagnosis. It is intended to indicate the side on which the anticipated surgery is likely to occur.

This SOP covers the marking of surgical sites for elective and emergency gynaecology procedures. Marking should be carried out with the active involvement of the patient who should be conscious and alert.

This SOP should be used in conjunction with the **Safer Surgery UHL Policy (Trust ref: B40/2010)** and Prevention of retained foreign objects as per **Surgical Swabs Instruments Needles and Accountable Items UHL Policy** (Trust ref: B35/2007)

This SOP applies to all clinical staff involved in caring for patients undergoing elective and emergency gynaecological surgery. This includes the surgeon, anaesthetist, ward and theatre staff.

2. Surgical site marking guidance

2.1 Patient preparation:

The operating surgeon is responsible for marking the patient. This task may be delegated to another doctor; however, this person should be present in theatre during the operation.

Marking should be carried out with the active involvement of the patient who should be conscious and alert.

Marking for abdominal procedures should be in the form of an 'X' in the supra-pubic region on the side that corresponds to the side of expected laterality. For external genital lesions a similar mark should be made on the inner thigh on the side of the lesion to be treated surgically. Provided this is done correctly there should be no need for marking the labia itself.

- The mark must be clearly visible and made with a permanent marker.
- Marking should remain visible after draping.
- The mark must not be ambiguous and should indicate the site to be operated on.
- Patients have the right to refuse marking. This should be clearly documented.
- The operation does not need to be cancelled if marking is refused.

2.2 Workforce Staffing Requirements:

The operating surgeon or an appropriately delegated doctor should mark the patient with their consent.

2.3 Ward checklist, and ward to procedure room handover:

A member of the ward staff should confirm the site is marked correctly against the patient's documentation and verbal agreement by the patient prior to the patient leaving the ward.

2.4 Procedural Verification of Site Marking:

The responsible surgeon or their nominated deputy should check the marked site against written documentation and verbal agreement by the patient at 'Sign in' in the anaesthetic room.

Marking should be carried out for any surgery which involves laterality. This includes surgery on either the left or right ovary or fallopian tube in patients with bilateral structures (i.e. a "choice" between ovaries, tubes, labia).

The marking should indicate the side on which the preoperative clinical assessment and imaging suggests there is most likely to be surgically treatable pathology.

Examples of procedures for which marking is appropriate:

- Right oophorectomy for persistent right-sided pelvic pain
- Left ovarian cystectomy for an ultrasound diagnosis of a left ovarian cyst
- Total abdominal hysterectomy and right oophorectomy where the right ovary contains a symptomatic cyst, and the patient wishes to retain her ovarian function
- Right salpingectomy where ultrasound suggests a probable right-sided ectopic pregnancy.

Marking should also be carried out for labial/vulval surgery involving laterality of if specific lesions are to be operated on (especially if multiple lesions are present).

- Mark the lesion to be removed, if multiple are present
- Mark the leg or mons pubis to indicate the laterality of the procedure, in a place that will be visible after draping

2.5 Team Safety Briefing:

Confirmation of the intended procedure and correct site marking should be undertaken prior to induction of anaesthesia and the intended procedure using the written documentation and verbal agreement by the patient. This should be verified by the whole theatre team using the WHO Safety checklist.

2.6 Sign In:

As per WHO Safety Checklist 'Sign In' documentation

2.7 Time Out:

As per WHO Safety Checklist 'Time Out' documentation

2.8 Performing the procedure:

On the ward – responsibility person is the operating surgeon or nominated deputy who will be present in theatre during the procedure.

- Check the patient's identity
- Check documentation and imaging to ascertain intended surgical site
- Mark the intended site with an 'X' using a permanent marker

Before leaving the ward – responsible person(s) – ward staff

The mark is inspected and confirmed against the patient's supporting documentation

At the 'Sign In' in the anaesthetic room – responsible person is the operating surgeon or nominated deputy.

Before induction of anaesthesia, the mark is inspected and checked against the patient's supporting documentation.

At the 'Time Out' in the operating theatre – responsible person – The surgical, anaesthetic and theatre team.

Prior to starting the operation, confirm:

- The correct patient
- Procedure to be performed
- Correct site marking

2.9 Circumstances where marking may not be applicable:

- Urgent lifesaving surgery should not be delayed due to lack of marking
- Bilateral organ surgery such as bilateral oophorectomy, bilateral salpingectomy, hysterectomy and bilateral salpingo-oophorectomy. However, it is good practice to stop the procedure and pause to confirm the plan for removal or retention of ovaries prior to clamping the infundibulo-pelvic ligament or ovarian ligament. This will help prevent inadvertent removal of the ovaries in women who are consented to retain their ovaries. This should be documented in the operation notes.
- Situations where laterality needs to be confirmed following examination under

anaesthetic or during the laparotomy/laparoscopy procedure. This would include situations where imaging is unable to specify the side of ovarian or tubal pathology with any degree of certainty.

Circumstances where surgery may proceed on the contralateral side to the marking/consent:

- **Where the pathology is found to be on the contralateral side to that which was expected.** Ovarian or tubal pathology is not always on the expected side based on imaging. The procedure may continue despite marking or consent stating the site of the pathology is on the contralateral side, if the surgeon is happy that the laterality of pathology identified on the preceding scan was incorrect. However, there should be a pause and discussion between the team members before proceeding with removal of the pathology. This should be documented in the operation notes.

2.10 Documentation:

Documentation of laterality of pathology in the operation notes and important discussions around removal of organs especially where the laterality is in question must be clear. It is good practice to document that a pause was taken prior to clamping the IP/Ovarian ligament at hysterectomy.

3. Training & Education:

Training of all surgeons and junior doctors must be carried out at their induction. This should cover the WHO Safety Checklist and SOP for Surgical Site Marking.

4. Monitoring & Audit criteria:

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Failure to follow this procedure	Incidents will be reported on Datix	Consultant	As occurs	CMG Q&S board
WHO safety checklist adherence	Audit as per W&C audit schedule	Consultant	As per W&C audit schedule	CMG Q&S board
Evidence of training by staff	Audit as per W&C audit schedule	Consultant	As per W&C audit schedule	CMG Q&S board

5. References to other standards, alerts and procedures:

- World Health Organisation (WHO) – Implementation manual, Surgical Safety Checklist 1st Edition (2009)
- National Patient Safety Agency (NPSA) – Patient Safety Alert 06 – Correct Site Surgery, making your surgery safer (2005)
- How to guide to the five steps to safer surgery (NPSA) http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901
- Good Surgical Practice (2008) The Royal College Surgeons of England
- Guide to Surgical Site Marking High 5s CEPPRAL
- https://www.aezq.de/high-5s-toolboxen/markierungsguide-engl.-kurz-und-langfassung/markierungsguide-eingriffsverwechslung-lang.pdf
- ACOG Committee Opinion 2010
- https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Patient-Safety-in-the-Surgical-Environment
  National Safety Standards for Invasive Procedures, NHS England 2015: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety-standards.pdf
- UHL Safer Surgery Policy: B40/2010
- UHL Management of Surgical Swabs, Instruments, Needles and Accountable Items Policy B35/2011

Other relevant UHL policies:

- UHL Consent to Treatment or Examination Policy A16/2002
- UHL Delegated Consent Policy B10/2013

6. Key Words

Sign in, Time out, WHO Safety Checklist

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Rod Teo – Consultant Gynaecologist Rachelle Bowden - Matron			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
May 2019	**1**		New document
March 2023	**2**	**R Teo**	Re-formatted in line with Trust guidance
September 2023	**3**	**R Teo** **O Barney**	Added to the intro - It is very common, for example, that ovarian cysts are found to arise from the contralateral side than expected based on the scan. Added to marking section – Mark the lesion to be removed, if multiple are present Mark the leg or mons pubis to indicate the laterality of the procedure, in a place that will be visible after draping Updated guidance to pause to confirm intended procedure and to plan for removal or retention of ovaries prior to clamping the infundibulo-pelvic ligament or ovarian ligament. Guidance now includes Where the pathology is found to be on the contralateral side to that which was expected.