Sign In

Sign In is the point at which the team checks that it is safe and appropriate to commence anaesthesia. In minor procedures Sign In can be combined with Time Out. Sign In is not a replacement for safe and efficient processes in admissions and ward areas.

- All patients must undergo Sign In using a checklist.
- Sign-in must take place for all patients undergoing invasive procedures with general, regional or local anaesthesia, with or without sedation.
- Patient participation in the Sign In should be routine (when possible).
- Staff should treat the Sign In process as a safety critical moment. Completing other tasks, referring to the process as 'just some paperwork', 'more tick boxes' etc. is not reflective of a positive safety culture.
- Questions to the patient should be open, such as:
  - 'Can you confirm your name and date of birth?' Not 'Your name is XXX, is that correct?'
  - 'Tell us in your own words what procedure you are expecting and which side?' (where relevant) Not 'The form says we are fixing your right ankle, is that right?'
  - 'Do you have any allergies?' Not 'no allergies?'
- Specialty-specific checklists and checklists for minor procedures should be used where these have been risk assessed and agreed, e.g. in an outpatient setting Sign In and Time Out may be merged for speed and ease of use.
- The minimum documents (online or paper) required are valid consent, operating list and a robust form of patient identification.
- At least two people should complete the Sign In process, alongside the patient. For procedures performed under sedation or general /regional anaesthesia, this should be the anaesthetist and anaesthetic practitioner. For procedures not involving an anaesthetist, the operator and a registered member of staff should perform Sign In.
- Organisations should have agreed, risk-assessed approaches to whether a scrub team member and / or the operator should be present. These processes should be consistent within a specialty, and not varied by the preference of individual clinicians.
- The Sign In should not be completed until any omissions, discrepancies or uncertainties identified in the handover from the ward or admission area to the receiving practitioner in the procedure area or anaesthetic room have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of omissions, discrepancies, or uncertainties. Such occurrences should be reported as safety incidents.
- Provision must be made for patients who cannot speak English / Welsh or have other communication difficulties: interpreters should come into the anaesthetic room or procedure area, or an adult family member if this is not possible. Otherwise, the person confirming consent should be present to confirm prior comprehension via the interpreter.
- Organisations should develop processes to ensure transfer of patients from admissions areas / wards are safe and efficient, without unnecessary duplication of checks. Sign In is the key check at this point, and repeated checks of paperwork and patient identification around this time (e.g. in holding bays) are likely to detract from, rather than enhance, safety.
- Safety checks should include the following for any invasive procedures: (Basic)
  - Patient name, date of birth and medical record number check with the patient and the consent form. In major procedure areas, it must also be checked against the printed identity band, nursing documentation / perioperative care plan and operating list
  - In areas where ID bands are not used routinely (e.g. primary care, outpatient areas) organisations must have a robust standard identification process in place
  - The consent form should be checked to confirm the absence of abbreviations, understanding of patient and date of consent
  - Site marking, if applicable, to be cross-checked with the patient, consent and operating list
- Allergy status should be checked and indicated by a red wrist band.[91]

- Safety checks should also include the following where appropriate: (Advanced/additional)
  - Pregnancy status
  - Infection risk to staff
  - Starvation time
  - Anaesthetic and emergency equipment/drugs checks
  - Airway strategies and preparedness
  - A re-cap on the plan for management of blood loss. This goes beyond the previously used question about expected volume of blood loss and includes (where appropriate) questions around tourniquet, anticoagulant use, tranexamic acid, cell salvage etc[35]. This should be planned at the Team Brief
  - Regional anaesthesia 'Stop Before You Block/Prep Stop Block' checks[77]
  - Availability of essential instrumentation
  - Availability of implants, stents, prostheses
  - Implants (surgical metalwork, pacemakers etc.)
  - Availability of additional staff e.g. radiography
  - Others to be decided locally as appropriate for specialty

Priority checks are appropriate in life threatening situations and by nature are always major procedures and include command and control from team lead and role allocation, and blood management plan.

Caution moments during Sign In

Emergency and urgent work

Confused patients or those less fluent

Patients presenting for second procedures

Disengagement of staff

Risks	Availability
Infection including Covid	Regional block kit
Pregnancy	Anaesthetic kit and emergency drugs
DVT	Implants
Pressure sores	Instrument trays
Metalwork	Blood
	Staff/Experts

Please see the 'Performance Indicators NatSSIPs'