

**COMMUNICATION AND SAFETY;  
IT'S ALL A MATTER OF KNOWING WHEN TO "STOP" AND WHEN TO "GO"**

Team Leader: Kelly Cannizzaro, RN, CAPA

The URMC Surgery Center at Sawgrass, Rochester, New York

Team Members: Jean Gumina, BSN, CAPA, CPAN; Carol Ives, RNBS, CAPA;  
Kristen Kelly, BSN, CAPA; Stefan Lucas, MD; Cathy Wuest, RN, CAPA; Margaret Zotter, BSN

**Background:**

In our ambulatory surgery center, there were three incidences where a patient arrived in the operating room without proper consent. We realized that we needed a safe, "at-a-glance" way to communicate when a patient had all the key elements in place prior going to the operating room. We developed "STOP" and "GO" signs to help with this process.

**Objectives:**

- Construct and implement a process that would provide better communication across all disciplines and promote safety by:
  - Eliminating incomplete consents.
  - Assuring that site marking is done.
  - Double checking for antibiotics, UPT results and history and physicals.
- Institute a process that was easily understood and easy to enforce.

**Implementation:**

A check list and a "stop sign" were printed on a 9"x5.5" sheet of red card stock and then laminated. A "GO" was printed on the same size green card stock and laminated. The signs were put in every room along with dry erase markers. We educated all staff (nurses, surgeons and anesthesiologists). We set up clear guidelines, roles and established specific expectations.

**Results:**

This process has been extremely successful; consents, Day of Surgery Updates and site marking are consistently done prior to going to the operating room. This program has promoted collaboration among all team members and there is now a better understanding of how important this final checklist is to provide patient safety.

**Implications:**

This process is an easy, inexpensive way to communicate with one another and it promotes and sustains TJC National Safety Goals.