KPJ KLANG SPECIALIST HOSPITAL

NURSING SERVICES
INVASIVE PROCEDURE TIME OUT CHECKLIST

Name :
MRN :
D.O.B :
SEX :
Ward :
Bed No : Date :

DETAILS

DATE : TIME :

LOCATION : ICU ☐ HDU ☐ A&E ☐ OTHERS ☐

PLANNED PROCEDURE : ☐ EMERCENGY PROCEDURE : ☐

PROCEDURE

Type of Procedure		**Insertion Site**		**Side Inserted**	
Central Line	☐	IJV	☐	Right	☐
Arterial Line	☐	Subclavian	☐	Left	☐
Chest Tube	☐	Radial/Brachial	☐		
Pericardia Tapping	☐	Femoral	☐	***(If possible avoid using the femoral site)***	

Other : _____

*Patient Identification : Name/MRN/IC ☐

*Availability of Consent for the procedure ☐

*Correct Procedure site ☐

*Ultrasound / Imaging required ☐

*Sedation / Local anaesthesia ☐

Number of skin punctures : 1 ☐ 2 ☐ 3 ☐ ≥ 4 ☐

Number of needle passes : 1 ☐ 2 ☐ 3 ☐ ≥ 4 ☐

The catheter was secure with _____

Name of Consultant: : _____ Signature : _____

Name of Nurse(Assist) : _____ Signature : _____

Name of Nurse (Runner) : _____ Signature : _____

*Please (√) at appropriate column and N/A if not applicable