FLOYD MEDICAL CENTER
POLICY AND PROCEDURE MANUAL
PATIENT CARE SERVICES

TITLE: Universal Protocol for the Prevention of Wrong Patient, Wrong Procedure, Wrong Side and/or Site Surgery/Procedure	**Policy No.: PCS-03-003**
Purpose: To decrease the potential for wrong side/site, wrong patient and/or wrong surgery/procedure by providing guidelines to ensure accurate identification of patients and verification of proposed operative/procedure site.	**Developed Date:** 11/90 **Review Date:** 1/94, 9/97, 8/98, 10/01, 3/03, 10/18 **Revised Date:** 7/96, 6/99, 6/00, 9/02, 10/02, 5/05, 11/06, 8/07, 1/09, 12/10, 12/11, 12/13, 5/15, 5/17 **Review Responsibility:** Executive VP Chief of Patient Services/CNO, Nursing Leadership; Administrator/Medical Director of Surgical Services, Directors of Surgical Services, Executive Staff, Executive Committee of the Medical Staff
Expected Outcomes: Patients will be free from injury related to surgical/invasive procedure intervention regarding improper surgical/procedural site verification and/or identification.	
Reference Standards: Joint Commission Universal Protocol; AORN Standards and Recommended Practices	

Policy:

1. Correct identification of patients and proposed operative/invasive procedure site will be verified with multiple checks in the system to minimize the risk of surgical error including surgery/procedure on the unaffected side/site. The policy will be a coordinated effort between the attending surgeon, physician, nursing staff, perioperative nursing staff, and anesthesia service. In areas outside of the operating room, the policy will be a coordinated effort between the physician performing the procedure and the nursing staff member responsible for the patient. All persons involved will confirm the patient identification and appropriate side/site without assuming another individual has correctly performed the task. The policy applies to all surgical/procedure patients in regards to proper identification and to any surgical case in which there is the possibility of confusion regarding the side/site of proposed surgery.
2. All planned **operative procedures** will be documented on the surgeon's orders/progress notes, the hospital consent form, the informed consent form, the completed history and physical, the anesthesia record, and the pre and intraoperative nurse's record. Documentation of site-specific procedures (procedures involving extremities or the differentiation of a left side versus right side) will be noted in all of the above documents.
3. All planned **invasive procedures will be documented on the physician's orders/progress note, the hospital consent form, the proceduralist informed consent form, or document specific to individual units.**

4. Applicable x-rays, imaging studies and/or reports will be available in the operating/procedure room to assist in verifying the proposed operative side on all site-specific procedures.

5. Patient identification and site verification will be confirmed with the patient (and/or family, when appropriate) using active communication.

   Identification verification will include:
   - Patient name and birth date (asking the patient to state his/her name and birth date. If the patient is unable to communicate ask a responsible party or caregiver)
   - Hospital Number (F number)
   - Surgeon/Physician Name
   - Comparison of armband name and F Number with electronic chart name and F Number

   Verification on the operative or invasive procedure side/site involving laterality will include:
   - Verbalization of the proposed procedure and side/site by patient and/or family
   - Request patient and/or family to physically touch the proposed operative/procedure area site
   - For side/site specific procedures the physician performing the procedure will mark the affected side/site with his/her initials, using a permanent marker. The physician may delegate responsibility for site marking to his/her physician assistants (i.e. advanced practice registered nurses, anesthesia assistants, licensed athletic trainer/certified orthopedic tech) as long as they are familiar with the patient and will be present when the procedure is performed. For ophthalmic procedures, after the patient physically touches the site, it will be marked with the initials of the person performing the procedure above the operative eye.
   - For cases in which it is technically or anatomically impossible/impractical to mark the site for laterality (i.e.: mucosal surfaces, perineum) a wrist band will be applied to the wrist of the patient which confirms patient identification and side/site laterality.
   - For peripheral nerve block(s) involving laterality a wrist band will be applied to the extremity adjacent to the intended block site.

6. Refusal of the patient and/or family to allow the affected operative side on a site-specific procedure to be identified with the initials or to allow the affected eye to be marked for ophthalmic procedures will be documented in the perioperative notes or invasive procedure verification form for non-Operating Room (OR) procedures. A wrist band will be applied to the wrist of the patient on the operative side which confirms patient, surgical/procedure, and site/side.

7. Planned operative procedure documentation will reflect that the circulating nurse required oral verification of the correct operative side/site by all members of the surgical team prior to incision or prior to initiation of the proposed procedure. This final verification process will be a **"time out"** to confirm the correct patient, procedure, side/site, position, diagnostic studies, implants, equipment, and blood using active communication techniques.

8. Planned invasive non-operative procedure documentation will reflect that the nurse responsible for the patient required oral verification of the correct side/site with all team members including surgeon/physician prior to the start of procedure on all invasive procedures. This final verification process will be a **"time out"** to confirm the correct patient, procedure, side/site, position, diagnostic studies, implants, equipment, and blood using active communication techniques.

ACTIONS	KEY POINTS
PRE-OPERATIVE VERIFICATION	
1. The surgery-scheduling clerk will verify the operative procedure to include identification of site-specific procedures at the time of scheduling.	1. Scheduled procedures that involve anatomical sites that have laterality, the word(s) right, left, or bilateral will be written out fully on the procedure/operating room schedule and all relevant documentation (e.g. consents).
2. The pre-operative nurse/nurse responsible for the patient and the circulating nurse will verify the proposed procedure, surgical side /site, position, special equipment, diagnostic studies, implants, and availability of blood through review of appropriate documents and records (i.e. surgery schedule, H & P, x-ray, imaging reports etc.) prior to moving the patient into the operating/procedure room.	2. For patients going to surgery from a nursing unit (floor unit, ECC, ICU, CCU, etc.) the nurse caring for the patient will be responsible for initiating the verification process ***and completing the Surgical Check List form.***
3. The pre-operative nurse/nurse caring for the patient will verbally verify the procedure site with the patient and/or family by having them state the proposed procedure and in the event of a side-specific procedure, the procedure side or eye. The nurse will also request that the patient and/or family physically touch the proposed procedure side/site or eye, if possible.	3. The patient should be involved in the process to the extent possible with verbal and visual responses. If the patient is a minor, incompetent or sedated, has a language barrier, or is a trauma/emergency victim, impeding communication, the patients' family, healthcare proxy agent, interpreter, or legal guardian may be requested to participate in the verification process.

ACTIONS	KEY POINTS
SITE MARKING	
4. Surgical markings should be completed **before** the patient enters the procedure/operating room; a site mark is required for all patients having an invasive/surgical procedure, including bedside invasive procedures.	
5. If a side/site-specific procedure is proposed, the physician performing the procedure will mark the affected side with his/her initials. If the procedure involves multiple sites/sides and/or multiple physicians, during the same operation, each physician involved will mark the side/site for the procedure they will be performing, with his/her initials. For ophthalmic procedures, after the side/site has been verified, initials of the person performing the procedure will be marked above the operative eye.	5. The physician may delegate responsibility for site marking to his/her physician assistants (i.e. advanced practice registered nurses, anesthesia assistants, licensed athletic trainer/certified orthopedic tech) as long as they are familiar with the patient and will be present when the procedure is performed. Document site marking in the nurse's record, on the Surgical/Procedure Checklist form.
6. If the patient/family refuses marking the nurse will document the refusal in the nurse's record and notify the pre-op holding and/or circulating nurses. In non –OR areas, the nurse will document the refusal in the nurse's notes and on the Surgical/Procedure Checklist form.	6. The refusal will be documented in the nurse's record and on the Surgical/Procedure Checklist. A wrist band confirming surgical/procedure and site/side will be applied to the wrist on the surgical/procedure side.

ACTIONS	KEY POINTS
7. The ***Pre-op and Circulating nurse(s)***will verify the proposed procedure, side/site, position, special equipment, diagnostic studies, implants, and availability of blood through review of appropriate documents and records (i.e. surgery schedule, H & P, x-ray etc.) prior to moving the patient into the operating/procedure room. Side/site specific marking and verbalization by patient/family by having them state the proposed operative procedure and in the event of a side/site specific procedure, the operative side or eye. The nurse will also request that the patient and/or family physically touch the proposed surgical side or eye and document in the Preop Assessment Record in the appropriate sections.	7. In the event that the patient has not been marked prior to arrival, the Pre OP nurse will have the patient/family verify the site and have the site marked according to the policy and procedure.

Spinal surgery procedures will have a two-stage marking process. First, the general level of the procedure (cervical, thoracic or lumbar) must be marked preoperatively indicating anterior, posterior, or right versus left. Intraoperatively, the exact interspace(s) will be precisely marked using the standard intraoperative radiographic marking technique.

Exceptions for Site Marking

- Routine “minor” procedures such as venipuncture peripheral IV line placement, insertion of NG tube, foley catheter
- Interventional procedure cases for which the catheter/instrument insertion site is not predetermined
- Cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, premature infants)
- Dental procedures are exempt from the site marking requirement (as are other procedures done through or immediately adjacent to a natural body orifice).
- Premature infants for who the mark may cause a permanent tattoo.
- Site marking may be waived in critical emergencies at the discretion of the operating physician, but a “time out” should be conducted unless there is more risk than benefit to the patient.
- Procedures which do not relate to laterality, digits, or levels, such as, mid-line sternotomy, Cesarean section, laparotomy and laparoscopy
- Procedures done through or immediately adjacent to a natural body orifice (e.g., GI endoscopy, tonsillectomy, hemorrhoidectomy, or procedures on the genitalia)

ACTIONS	KEY POINTS
TIME OUT	
8. The "Time Out" process should be completed and documented prior to the starting of the procedure and ideally, prior to the introduction of the anesthesia process. The process involves the interactive verbal communication between all immediate members of the procedure team.	8. The "Time Out" should be completed prior to all procedures regardless of location. The only exception to omitting the "Time Out" is in those situations where delay of care may result in patient harm.
9. The ***Circulating nurse*** will require verbal verification of the proposed operative procedure including patient, position, side/site, diagnostic tests, implants, equipment, and blood availability by the surgical team for all procedures. This verification will be confirmed before incision or prior to initiation of the proposed procedure on ALL procedures and will be documented in the intraoperative nurse's notes. In non-OR areas, the nurse responsible for the patient will require verbal verification of the proposed side/site by all members of the team. The surgeon/physician and nurse prior to the start of the procedure, will document in the nurse's notes and/or on unit specific documentation forms. In the Primary Care/Family Medicine Residency locations the staff member responsible for the patient will require verbal verification of the proposed side/site by all members of the team. The surgeon/physician and staff member prior to the start of the procedure, will document the "time out" in the patient's medical record and/or on specific documentation forms.	9. The "Time Out" requires confirmation and documentation of the following: ♦ Correct patient (verification using two patient identifiers. ♦ Correct side/site ♦ Correct and accurate procedure consent form ♦ Correct patient position ♦ Correct radiographs ♦ Correct implants and/or equipment ♦ Blood availability ♦ Personnel present at the time of the Time Out

NOTE: All activity will cease during the "Time Out" process. If a discrepancy is identified during the process the procedure will not resume until the issue is resolved. The surgeon/physician will have the final responsibility for procedure, side or site identification.

When two or more procedures are being performed on the same patient, a time-out is performed to confirm each subsequent procedure before it is initiated.

Most procedures that involve puncture or incision of the skin or insertion of an instrument or foreign material into the body are within the scope of this policy. Invasive procedures that apply to this policy may include chest tube insertion; thoracentesis; paracentesis; biopsies; central line placements; invasive vascular and cardiac procedures; invasive radiological procedures (CT billiary drainage, CT guided biopsy, CT guided cyst aspiration, CT guided drainage, CT localization, CT SI joint injection, FL arthrogram, FL myleogram, FL fluoro guidance for needle placement, FL sialogram, FL sinus tract injection, MA ductogram, MA needle localization, MA stereotactic breast biopsy, NM sentinel node localization, US guidance for aspiration, US breast aspiration, US biopsy, US localization); bronscopies; debridement; aspirations, PICC line insertions, STIC Monitor, epidural placement and lumbar puncture.

Approved by the Executive Committee of the Medical Staff: October 10, 2005

When two or more procedures are being performed on the same patient, a time-out is performed to confirm each subsequent procedure before it is initiated.

The “Procedural Time Out Record” is to be completed for EACH site and/or procedure performed.

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PROCEDURAL TIME-OUT RECORD

Patient Name:_____

Date:_____ Time:_____

Location:_____

Procedure to be performed:_____

Consents signed: ☐ Yes ☐ No

Informed Consents signed: ☐ Yes ☐ No

Performing Physician:_____

Anesthesia Provider (if present):_____

☐ Correct Patient

☐ Correct Procedure

☐ Correct site/side

☐ Correct Positioning

☐ Correct Supplies/Equipment/Implants

☐ Correct Radiographs ☐ N/A

Blood available ☐ Yes ☐ No ☐ N/A

Primary Nurse Signature:_____ Date AND Time:_____

Patient Identification