HENDRICK HEALTH SYSTEM

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Owner:	*Adalia Provance: Contract Manager*
Policy Area:	*Patient Care*
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Site-Procedure Verification, 3.1088

PURPOSE:

To outline the process for making sure relevant documents and related information or equipment is available prior to the start of the procedure, correctly identified, labeled and matched to the patient's identifiers. Once reviewed, these must show to be consistent with the patient's expectations and with the teams' understanding of the intended patient, procedure and site (UP 01.01.01). There are three components according to Universal Protocol: Pre-procedural verification, site marking, and the time out.

General Rule: This policy applies to all surgical and non- surgical invasive procedures (UP 01.01.01). These procedures, as defined by UP, include: those involving the puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body.

POLICY:

Pre-procedural Verification

1. The procedure will be confirmed and the site verified by the patient whenever possible, or by the patient's family, prior to the procedure start.
2. The site for the procedure will be verified by the following as appropriate: Verbal identification by the patient and/or family, informed consent documentation with site correctly identified, history and physical, and physician's orders.
3. Verification of the correct procedure, person and site may occur multiple times, including (but not limited to):
    - At the time the surgery/procedure is scheduled
    - At the time of pre-surgical testing and assessment
    - At the time of admission or entry to the facility for the procedure
    - When the responsibility for care of the patient is transferred to another caregiver
    - Before the patient leaves the preoperative area or enters the procedure/surgery room (UP 01.01.01)
4. To verify the correct procedure, patient and site, the following will be reviewed prior to the start of the procedure and matched to the (UP 01.01.01 EP1 & 3):
    - Relevant documentation (e.g. H&P, signed consent form, nursing assessment, and pre-anesthesia assessment)

- Labeled diagnostic and radiology test results (e.g. radiology images and scans or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices and/or special equipment (UP 01.01. EP2)

5. In the event that any discrepancies are found in the documentation compared to the patient's or physician's understanding or the appropriate site / procedure, the case will not commence. A re-verification with the patient and/or family and the appropriate documentation will take place prior to anesthesia and before beginning the procedure.

Site Marking

RULES:

1. For those cases that require site marking, the procedure site will be marked by the licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. (UP 01.02.01 EP3) The procedural / operating physician will mark the site with his/her initials. Note that an 'X' will NOT be used as it may be interpreted as "not here."
2. For any non-surgical admissions there are circumstances where the site for the procedure needs to be identified due to:
   - Unusual orientation of affected site
   - For those patients that cannot communicate
   - For those patients who do not have the mental ability to determine the site (pediatric, for example)

   Under any of these circumstances, at the initial point of entry of the patient into our facility, a plain white band will be placed around the site including a description of the site handwritten on the band. The same verification of the site will take place in these circumstances which include:
   - Verbal identification by the patient and/or family
   - Informed consent documentation with site correctly identified
   - History and physical
   - Physician's orders
3. Sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
   Note: for spinal procedures, in addition to preoperative skin marking of the general spinal region, special intra-operative imaging techniques may be used for locating and marking the exact vertebral level (UP 01.02.01 EP1)
4. The method for marking the site and type of mark is unambiguous and is with an indelible marker for consistency.
5. For patients who refuse site marking, a *Refusal to Mark Surgical Site Form* will be completed and the procedure / surgery will be cancelled.
6. Certain sites are not marked and an alternative process is in place for these cases. They include:
   - Technically or anatomically impossible or impractical cases (perineum, mucosal surfaces, etc.)
   - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice (e.g. bronchoscopy, cystoscopy, esophagogastroduodenoscopy, etc.)

- Needle localized breast biopsy: the needle inserted using fluoroscopy and remaining protruding through the skin will be utilized as the mark.
- Interventional procedures for which the catheter/instrument insertion site is not the predetermined site of insertion (cardiac catheterization, pacemaker, etc.)
- Dental procedures performed on the teeth
- For premature infants, for whom the indelible ink risks becoming a permanent tattoo
- Bedside procedure (e.g. patient room / Emergency Department); if the practitioner performing the procedure remains with the patient continuously from the time the decision to do the procedure, through the end of the procedure itself, then site marking is not required
- For obvious wounds or lesions (i.e., lacerations, compound fractures) or the presence of a single cast, splint, laceration or dressing, and it is the site of the surgical intervention. However, if there are multiple wounds, lesions, casts, splints or dressings, the sites will be marked following hospital policy.
- Diagnostic laparoscopy or exploratory laparotomy for ectopic pregnancy and the side cannot be determined with preoperative diagnostic testing.

7. In the event of an emergency, the primary nurse will document on the patient assessment form that the surgical or non-surgical invasive procedure was an emergency and how the site was properly identified.
8. Site markings will be removed as much as possible following the procedure, prior to exiting the procedure room.

Time Out

RULES:

1. A Time Out will be conducted immediately before starting the invasive procedure or making the incision (UP 01.03.01).
2. The Time Out will be initiated by the RN / circulator and conducted by the immediate members of the surgical / procedural team including: the individual performing the procedure, anesthesia providers, circulating nurse, operating room technician and other active participants that will be in the procedure from the beginning.
3. The Time Out (which is the final verification stage) will actively communicate at least the following three components:
   - Correct patient identity
   - Correct site
   - Correct procedure to be done (UP01.03.01 EP2)
4. An audible response will be made by each member of the team. No other actions or activities will take place during the Time Out.
5. The RN is responsible to document the Time Out. Documentation will include, at a minimum:
   - The Time Out was conducted
   - Who was involved in the Time Out
   - When/Where the Time Out was conducted

6. If any discrepancies are noted between team members during the Time Out, the procedure will not commence until all members of the procedural / surgical team are in agreement and documentation of correct procedure verified.
7. When two (2) or more procedures are being performed on the same patient and the person performing the procedure changes, a new Time Out should be initiated and documented before the next procedure begins (UP 01.03.01 EP3).

Attachments:

No Attachments

Applicability

Hendrick Medical Center