UNIVERSAL PROTOCOL POLICY FOR CORRECT SITE IDENTIFICATION
(VERIFICATION OF CORRECT SITE FOR INVASIVE, HIGHLRISK,
OR SURGICAL PROCEDURES)

PURPOSE:

To promote patient safety by providing guidelines for verification of the correct patient, procedure, side/site, position and equipment/implant availability for invasive and surgical procedures.

DEFINITION OF INVASIVE PROCEDURE:

An invasive procedure is defined as a procedure in which the body cavity is entered by a tube, needle, or other device, or other invasion that could interfere with bodily function. Invasive procedures include, but may not be limited to aspiration, lumbar puncture, chest tube insertion, central line placement, bone marrow aspiration, paracentesis, and thoracentesis. Consider any procedure requiring written consent to be invasive. Surgical and endoscopic procedures have specific policies and forms. Refer to those policies for instructions.

POLICY:

A. In the pre-procedure/preoperative area prior to administration of any preoperative medications and prior to the start of any invasive, high risk or surgical procedure, a standardized process will be utilized for confirmation of the correct patient, procedure, side/site and position will be completed and documented in a collaborative manner by all members of the surgical/procedural team. The following items are matched to the patient:

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Date of Original: 11/03
POLICY (Con’t):

1. Relevant documentation (H & P must be 30 days or less and updated the day of surgery, nursing assessment and pre-anesthesia assessment (when applicable).
2. Accurately completed and signed procedure consent form.
3. Correct/properly labeled diagnostic and radiologic test results.
4. Any required blood products, implants, and/or special equipment for the procedure.

B. The pre-procedure verification process also ensures that all relevant documents, correct equipment, and implants are available prior to the onset of the procedure.

C. The process of site verification shall be followed for all invasive, high risk, and surgical procedures performed in all areas of the hospital.

D. All patients having an invasive, high risk, or surgical procedure that involves laterality, multiple structures (fingers and toes) or multiple levels (spinal surgery) anywhere in the hospital must have their surgical/invasive site marked. The site is marked by a licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure. This individual will be directly involved in the procedure and will be present at the time the procedure is performed.

In the event of a discrepancy, related to the surgical procedure, or non-compliance with the site marking requirements, the procedure will not begin until the issue(s) are resolved. The chain of command will be utilized to rectify the discrepancy if needed.

E. Bilateral Markings: Both sites in a bilateral procedure must be marked. All sites involving laterality must be marked.

F. Procedures exempt from site(s) marking include:

- G.I. Endoscopy Cases (no laterality)
- Tonsillectomy
- Hemorrhoidectomy
- Dental (Teeth) Cases

Note: In the case of teeth, the operative tooth and description will be documented in the patient’s medical record and on the x-ray.
POLICY (Con’t):

- Midline Single Organ Procedures.
- Interventional cases for which the catheter and/or the instrument site is not predetermined (Cardiac Catheterization).
- I.V. and Foley Catheter Placement.

G. In case of a surgical (life threatening) emergency, site(s) mark may be omitted but a surgical “time out” will be done unless the risk outweighs the benefits.

H. For a procedure involving an anatomical site that has laterality, the words “right, left, or bilateral” will be written out fully on the consent, and Operating Room/Department schedule. If the consent uses an abbreviation for laterality, the case will be held until there is a corrected consent.

*Note*: The Surgeon or his Credentialed Allied Health person shall mark the surgical site prior to the time the patient enters the Operating Room.

I. If a patient refuses to have the site(s) marked, the patient’s physician will review with the patient the rationale for site marking. If the patient still refuses site marking, the team will follow the policy for identification of the patient, side, site, position and availability of equipment and/or supplies. The “time-out” will be documented per policy and a notation regarding the patient’s refusal to have the site(s) marked will be made in the nurses’ notes and the physician’s progress notes.

J. The following two identifiers will be used to verify the patient’s identity:

1. Name
2. Date of Birth

*Note*: Each patient will be asked to state his or her full name and date of birth. (Active Communication)

K. The physician/surgeon performing the invasive, high risk or surgical procedure will mark the procedure/surgical site(s) with his or her initials or the word “yes” prior to the time the patient enters the procedure room or operating room.

1. A permanent marker will be used to mark the site and the initial marking will be visible after the skin prep is completed and the drape is applied.
POLICY (Con’t):

2. Non-operative site(s) will not be marked unless medically indicated (pedal pulse mark, no blood pressure cuff).

L. The patient will be involved in the process to the extent possible by being asked to verbalize the procedure to be done and/or point to the site/side.

M. If the patient is a minor or unable to verify the information for him or herself, the verification process will take place with the parent, legal guardian, or health care proxy.

N. Any discrepancy at any point in time will stop the case from proceeding until resolved.

O. All team members and the patient (if possible) must agree on the resolution(s) of the identified discrepancy.

P. The discrepancy and resolution will be documented in the medical record by the Physician and Register Nurse/Radiology Technologist.

Q. Once the patient has been prepped, draped and the site marked is visible, a “time-out” will be performed (prior to an instrument being passed) to validate correct:
   - Patient
   - Procedure
   - Side/Site
   - Position
   - Radiological/Other pertinent exams
   - Instruments/Implants/Equipment availability

R. The pre-procedure/preoperative verification and “time out” will be performed for all invasive, high risk, and surgical procedures including those done at the bedside, in the Emergency Department, in Special Procedures/Radiology, and in the Operating Room. The time of the “time out” will also be documented in the patient’s medical record.

Note: The “time out” will be done in the location where the procedure is to be performed, immediately before the start of the case. All members of the team must be present for the “time out”.

PROCEDURE:

A. Scheduling

1. The verification process for correct site procedure/surgery begins at the time of scheduling.

2. The following information is required when an invasive, high risk, or surgical procedure is being scheduled:
   - The correct spelling of the patient’s full name
   - The patient’s date of birth
   - The procedure to be performed
   - The physician/surgeon’s name
   - Any implants/special equipment required if applicable
   - Patient status (OP, SDS, OBS, Inpatient)
   - The need for Anesthesia

3. Scheduled procedures that involve anatomical sites that have laterality, “Right, Left, or Bilaterally” will be written out fully on the department’s scheduling form/book, on the Operating Room Schedule and on all relevant documentation including the consents.

4. Any discrepancies will be clarified with the physician/surgeon’s office.

B. Pre-procedure/Pre-operative Verification

1. Verification of the correct person, procedure and site should occur (as applicable):
   - At the time the procedure is scheduled
   - At the time of admission or entry into the system
   - Anytime the responsibility for care of the patient is transferred to another caregiver.
   - With the patient involved, awake and aware, if possible.
   - Before the patient leaves the pre-operative area or enters the procedure/surgical room.
   - In the Operating Room/Treatment Room before the start of the procedure.
PROCEDURE (Con’t):

2. All staff involved in the patient’s care will verify the patient’s identity by asking the patient to state his or her full name and date of birth and the procedure/surgery that will be performed.

3. If the patient is a minor, incompetent, or sedated; has a language barrier, or is a trauma/emergency victim, accurate communication may be impeded. In such cases, the patient’s family, legal guardian, interpreter, etc. will complete the identification process and verify the site mark.

4. The patient will be involved to the extent possible with verbal and visual responses. (State name and date of birth and pointing to the correct site location).

5. The patient’s response will be verified with the hospital I.D. bracelet, addressograph card, posted schedule, consent(s), radiographic films, site mark; (if applicable) and information in the medical record including the H&P, consult, etc.

C. Site Mark

1. Make the mark at or near the incision/invasive site. DO NOT mark any non-operative/non-invasive site unless necessary for some other aspect of care. A sterile marker is used.

2. The physician/surgeon will use his or her initials or “yes” to mark the site so the mark is unambiguous.

3. The mark must be positioned so it is visible after the patient is prepped and draped.

4. Mark the site on all cases/procedures involving laterality (left, right) multiple structures (toes, fingers) or multiple levels (spine).

5. Active communication with the patient involved if possible, will be used when determining the correct site.

6. Immediately before the procedure begins, the entire team will stop what they are doing and take the “Time Out” to perform the final verification process.
PROCEDURE (Con’t):

D. Time Out

1. Conducted in the location where the procedure will be done.

2. Completed just before the start of the procedure

3. Involves the entire team

4. Involves active communication

5. Is documented in the:
   - O.R. Nurses Notes (O.R.)
   - Conscious/Moderate Sedation Flowsheet (ED, Special Procedures, G.I. Lab)
   - Invasive Procedure: Universal Protocol Verification Form (all other departments, i.e., Nursing Units, Radiology, etc., where invasive procedures are performed without moderate/conscious sedation).
   - High Risk (Invasive) Procedures include but are not limited to the following:
     a. Thoracentesis
     b. Paracentesis
     c. Liver Biopsy
     d. Kidney Biopsy
     e. Invasive procedures involving stent placement
     f. Needle localization of the breast

6. Documentation of the verification process will include but is not limited to the following:
   - Correct patient identity
   - Patient verbalization of planned procedure/site
   - Physician identification/site and mark as appropriate
   - Laterality (if applicable)
   - Correct patient position
   - Availability of special equipment, implants or other special requirements
PROCEDURE (Con’t):

- Consent(s)
- H&P
- X-rays/other diagnostic tests
- Antibiotics given
- Expected blood loss
- Documentation of the time of the “Time Out”

E. Procedures for Non-O.R. Settings Including Bedside Procedures

1. The verification process, site marking and the “Time Out” procedures are the same in the Operating Room and in all areas of the hospital where procedures are done (E.E., Special Procedures, Radiology, Cardiac Cath and on the Nursing Units.)

Note: The “Time Out” Procedures must be completed on all patients in the cardiac cath lab, but the site marking is not required.

- Correct patient identity
- Patient verbalization of planned procedure/site
- Physician identification/site and mark as appropriate
- Laterality (if applicable)
- Correct patient position
- Availability of special equipment, implants or other special requirements
- Consents
- H&P
- X-rays/other diagnostic tests
- Documentation of “Time Out”

EXCEPTION:

Cases in which the individual performing the procedure is in continuous attendance with the patient from the time the decision is made to do the procedure, consent is obtained, to the performance of the procedure may be exempted from the site marking but THE REQUIREMENT FOR A “TIME OUT” FINAL VERIFICATION IS STILL REQUIRED
EXCEPTION (Con’t):

F. Reconciliation of Differences in Staff Responses During the “Time Out”

1. When a discrepancy occurs at any time in the process, the procedure will be stopped until the discrepancy is resolved.

2. All team members are the patient (when possible) must agree on the resolution of the discrepancy before the procedure may proceed.

3. The discrepancy and resolution will be documented in the nurses’ notes and the physician progress notes.

Note: The Radiology Technologist will document on the Invasive/High Risk Procedure Verification Form
**UNIVERSAL PROTOCOL DOCUMENTATION**

**SURGICAL INVASIVE/HIGH RISK PROCEDURE VERIFICATION**

**PATIENT NAME:** ___________________________  **DOB:**

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<td>2.</td>
<td>Patient/designee verbalization of planned procedure/site (active communication).</td>
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<td>3.</td>
<td>Physician identification correct invasive/surgical site and mark as appropriate.</td>
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<td>4.</td>
<td>Identification of laterality (if applicable): □ Left □ Right</td>
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<td>5.</td>
<td>Correct patient position.</td>
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<tr>
<td>6.</td>
<td>Equipment/implants available (as applicable).</td>
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</table>
| 7. | • Consent  
   • H & P  
   X-rays/Other diagnostic tests verified. |
| 8. | In room “Time Out” procedure done. **TIME** |
| 9. | Discrepancy noted  
   • Surgeon/M.D. Notified  
   • Date: _____ Time: _____  
   • Surgeon final site and side verified and communicated with team.  
   Documented note completed. |

**REGISTERED NURSE/TECHNOLOGIST**

**PHYSICIAN**  **DATE**

(POL05/OR/UnivChecklst 4/05)