

<b>TITLE:</b>	<b>Surgical Site Verification and Time Out – <i>Pre-procedural Patient Safety</i> SITE VERIFICATION; LATERALITY; and TIME OUT PROCESSES</b>
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Document of (Entity) Hospital

**POLICY:** Surgical cases and invasive procedures require Pre-procedural Verification, Surgical Site Verification for Laterality Specification, when indicated and Time-Out for Final Verification.

**PURPOSE:** To define the requirements of pre-procedural verification, surgical site verification with laterality specification and time-out for final verification.

**DEFINITION:** **Pre-procedural Verification** = The process of reviewing all available data to verify the accuracy of the anticipated procedure. This includes the patient's and/or family's understanding the planned procedure.

**Site Verification** = The physical initialing of a site of operative or other invasive procedures, using a marking pen.

**Laterality** = Pertaining to a side of the body. Laterality is the word used by JCAHO and others to relate to the side of the body, i.e., left or right. While laterality is the usual site designation, site designations are also necessary for multiple structures (such as fingers and toes), or levels (as in spinal procedures).

**“Time-Out”** = A stopped period of time when all member of the surgical/procedure team participate in the positive identification of the patient, the intended procedure and the visualization of the marked site of the procedure. All staff present are to STOP what they are doing and participate in the Active Time out.

**NON-COMPLIANCE** Any staff member not adhering to this policy will be subject to disciplinary action, up to and including discharge from Memorial Hospital.

**PROCEDURE:**

1. The physician will verify the surgical procedure, including laterality (or digit or spine level), with the patient or legal representative at the time of planning for the procedure.
2. Preoperatively, each procedure involving laterality (or digit or spine level) will be scheduled with right, left, bilateral, or other required designation through the normal scheduling process for the procedure.
3. The physician will document the planned procedure, with the correct site (when appropriate for laterality, digit or level), in the patient's medical record using the word left, right, bilateral, etc. (Placement of this documentation may be in the History and Physical, Physician Orders, Progress Notes or other physician documentation.)
4. The surgical consent form will identify the specific planned procedure, with surgical site, as appropriate.
5. Preoperatively, an RN, or other appropriate clinician, will confirm the correct

surgical procedure and site through:

- The patient or legal representative will be asked to identify the planned surgery, including laterality, digit or level, if appropriate.
- Review of the surgical consent document noting the correct procedure and site, as appropriate.
- Review of the scheduled procedure, including site, as appropriate, for all procedures noted on a written schedule, and
- Obtaining all relevant imaging or other reports and reviewing of these documents for consistency of surgical procedure and site.

If there are any inconsistencies, the physician performing the procedure and the appropriate clinical staff member in the procedure area will be notified immediately.

6. In procedures for which laterality, digits, or levels are involved, pre-operatively, the physician performing the surgery/procedure will verify the surgical site with the patient or patient's representative prior to the patient receiving narcotics, sedation, or anesthesia. This cannot be delegated to an RN. This physician will initial the correct site with an appropriate marking pen or other approved means as noted below:
  - In cases of bilateral organ, limb, or anatomic site, multiple digits, or spinal levels, the performing physician will mark the site such that, once the patient is prepped and draped, the initials are visible in the operative field.
  - Marking of the surgical site is not required when the site is so clearly evident that it can not be confused, example, traumatic open fracture of femur with bone extension.
  - Technological markers (e.g., breast node visualized on radiography, etc, or needle placement, placed immediately prior to surgery) may be used instead of initials to mark sites.
  - Eye and facial procedures may be marked by tape rather than marking the skin.
  - Dental procedures are exempt from the site marking requirement (as are other procedures done through or immediately adjacent to a natural body orifice). Teeth identified for extraction prior to surgery should be identified by number.
  - For cases that would otherwise require site marking (as noted above), if the practitioner performing the procedure remains with the patient continuously from the time the decision is made to do the procedure and consent is obtained from the patient up to the time of the procedure itself, then site marking is not required. However, if the person performing the procedure leaves the presence of the patient for any amount of time during that interval, then the site should be marked (before leaving the patient).
  - When invasive procedures are performed under emergency or urgent conditions, the practitioner performing the procedure will be in continuous attendance of the patient from the point of decision to do the procedure. Under those circumstances, marking the site would not be necessary.
  - Site marking is not required for procedures which do not relate to laterality, digits, or levels, such as, mid-line sternotomy, Cesarean section, laparotomy and laparoscopy, cardiac catheterization and other interventional procedures for which the site of insertion is not predetermined. Procedures done through or immediately adjacent to a natural body orifice (e.g., GI endoscopy, dental procedures, tonsillectomy, hemorrhoidectomy, or procedures on the genitalia) or other situations in which marking the site would be impossible or technically impractical are also exempt. Certain

routine “minor” procedures such as venipuncture, peripheral IV line placement, insertion of NG tube, or Foley catheter insertion also do not require site marking.

The physician or person performing the procedure is responsible for marking the site. The site marking should occur with the patient awake and aware. Placement of an X is not an acceptable substitute for initials as it can be confused as a mark by the patient to not perform surgery on this site.

7. In the surgery/procedure room, prior to positioning, if possible, the circulating RN or appropriate hospital staff member in the room (example: RN, Radiology Technician, Pulmonary Therapist) will
  - Review the planned procedure on the schedule, if a written schedule is used,
  - Review the written consent form for the planned site of surgery, including laterality, etc.
  - Identify the patient using patient name and birth date on the patient's ID band.
  - View initials, dot, needle placement, or other appropriate site marking indicating the site of surgery, and
  - Review all available reports which may relate to the procedure, such as, radiology reports for orthopedic cases.

The patient will not be positioned or draped for the procedure if there are any inconsistencies.

8. **Effective communication is essential when verbalizing correct surgical site, including laterality. This applies to all instances of affirmation. Saying the word “correct” is to be used when verifying the surgical procedure/site. Example of an “Active Time Out:”**

- **All staff in the room stops what they are doing and participates in the final verification. The circulating nurse or other appropriate clinician states, “This is Mary Smith and we are doing a left total hip. The team should respond with correct if indeed Mary Smith is the patient have a left total hip.”**

9. In the surgery/procedure room, immediately pre-procedure, the circulating RN or appropriate hospital staff member in the room (RN, Technician, etc) will facilitate the **Time Out** requesting persons who are present in the room to verbally confirm the correct patient, procedure, and laterality..

- **“Time out” immediately before starting the procedure is to be conducted in the location where the procedure will be done, just before starting the procedure. It is to involve the entire operative team, use active communication, and be briefly documented, and should include:**
  - **Correct patient identity,**
  - **Correct side and site,**
  - **Agreement on the procedure to be done,**
  - **Correct patient position, and;**
  - **Availability of correct implants and any special equipment or special requirements.**

**Reconciling differences in staff responses during the “time out” is to occur.**

**The procedure will begin following the Time Out when staff is confident the correct procedure is being performed on the correct patient.**

Procedures for non-OR settings including bedside procedures:

**DOCUMENTATION:**

- Site marking should be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).
- Verification, site marking, and “time out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time out” final verification still applies.

**PERFORMANCE  
IMPROVEMENT:**

10. Documentation of the planned procedure and consent will be noted in the medical record.
11. In keeping with the hospital philosophy that safety be incorporated in quality practice, checklist components of documentation are imbedded in the required documentation for the procedure. There is no requirement that any or all of the specific components of the Pre-Procedure verification or Intra-operative verification be documented.  
Refer to Appendix A for examples of documents used in documenting components of #5 and #7 above.
12. In some situations, the pre-procedural and intra-operative checklists may be combined into one checklist with only one review of each component. An example might be a chest tube insertion with sedation performed on a nursing unit.
13. The patient Safety Committee will oversee compliance with these requirements.
  - This may include direct surveillance of signing and time-out compliance.
  - Quality Management may assist in monitoring the medical record documentation requirements.

Resources:

American College of Surgeons: Statement on ensuring correct patient, correct site, and correct procedure surgery, 2002. (ST-41)

American Association of Orthopedic Surgeons: Advisory Statement: Wrong-Site Surgery, 2002.

JCAHO Patient Safety Standard – 4, 2002. *Sentinel Event Alerts* 12/2001 and 8/1998. And JCAHO Online Frequently Asked Questions regarding Patient Safety Standards. 7/30/03

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Signed Document Held By: *Linda Betz*

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**SIGNATURES OF APPROVAL:**

Date Signed	Signature	Name	Title
		Leonard Ferguson, MD	President, Medical Staff
		Cheryl Wibbens, MD	Vice President, Medical Staff
		Connie McCahill, RN	Vice President, Chief Nurse

## APPENDIX A:

### Routine Forms use for Documentation of Pre-procedural and Intra-operative Checklist data.

	<u>Pre-procedural Checklist</u>	<u>Intra-operative Checklist</u>
<b>Major Surgery</b>	Holding Room Record	Operative Nursing Record
<b>Outpatient Surgery</b>	OSC/ACC checklist	Operative Nursing Record
<b>GI Lab</b>	OSC/ACC checklist	GI Record
<b>Pain Clinic</b>	Pain Clinic Procedure Record	Pain Clinic Procedure Record
<b>Interventional Radiology</b>	Radiology Nursing Record	Radiology Nursing Record
<b>Cardiac Cath Lab</b>	Cardiac Cath Record	Cardiac Cath Record
<b>Breast Care Center</b>	Breast Care Center Procedure	Breast Care Center Procedure
<b>Any Patient Care Area</b>	Sedation Record	Sedation Record