Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: **UNIVERSAL PROTOCOL**
Surgical and Non-Surgical Time Out Process

Policy No.: B504.5
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PURPOSE:

Universal Protocol is used to promote patient safety by providing guidelines and instruction for verification of correct site, correct procedure, and correct patient for invasive/surgical procedures done throughout Rancho Los Amigos National Rehabilitation Center.

Performed by: Physicians, Nurses and all others involved in the delivery of patient care.

SCOPE:

The Universal Protocol (UP) will apply to all surgical and non-surgical invasive procedures performed at RLANRC.

GUIDELINES:

In the pre-procedure/preoperative area and prior to the start of any invasive procedure/surgical procedure, confirmation of correct site, correct procedure, and correct patient will be completed and documented in a collaborative manner. Universal Protocol must be used on all procedures, which are not only invasive, that present more than minimal risk to the patient.

1. The process of site verification shall be followed for all invasive procedures/surgical procedures.

2. Marking of the site(s) is required for all procedures except larynx/trachea/bronchus and gastroenterology endoscopic cases, tonsillectomy, hemorrhoidectomy, or intraoral procedures (including dental/tooth procedures).

3. Marking of invasive cases for which catheter (e.g., epidural/lumbar puncture) and instrument site **is not predetermined** is an exception to skin marking.

4. In the case of an emergency, a site mark may be omitted, but a "time out" should be performed unless the risk outweighs the benefit.

5. Site markings **will not** be required for starting intravenous therapy or Foley catheter insertion.

6. The Health Care Provider (HCP) performing the procedure will mark the procedure/surgical site(s) with his/her initials. **Key Point:** Elsewhere in the hospital the HCP is defined as the Proceduralist. In the Operating Room, the HCP is defined as the Attending Surgeon.

7. The site mark must be visible after the skin is prepped and the drape is applied.

8. Non-operative site(s) will not be marked unless medically indicated (e.g., pedal pulse mark, no B/P cuff).

9. The patient should be involved in the process to the extent possible, (e.g., verbalize procedure to be done and/or point to site/side).

10. If the patient is a minor or unable to verify the information for his or herself, the verification process must include parent, legal guardian or health care proxy.

11. A discrepancy at any point in time must stop the case from proceeding until resolved. All team members and patient (if possible) must agree on the resolutions to the identified discrepancy. The discrepancy and resolution must be documented by the physician and/or registered nurse.

12. A "time out" surgical verification must be done immediately before the start of the case with relevant team members to discuss minimally the identity of the patient, procedure, and surgical site.

13. Once the patient has been prepped and draped and the site mark is visible, a "time out" will be performed (prior to an instrument being passed) to validate correct patient, required medical record documentation, correct site, correct procedure, correct position, correct radiological exams, and correct implants/instruments.

14. Preoperative verification and "time out" will be performed and documented as outlined for all cases except in an emergency if the risks outweigh the benefits.

15. In all instances, it will be the responsibility of the nurse or other HCP in charge of the patient to insure the Universal Protocol policy is followed. If any part of the policy is not adhered to by any member of the team, stop the procedure until issue is resolved and inform his/her immediate supervisor.

Procedural Steps:

1. Pre-procedure

a. The HCP will verify patient's identity according to RLANRC policy and will verify the procedure/surgery that will be performed.

b. If the patient's identification cannot be confirmed as correct, whoever has authority to provide informed consent for the patient should be contacted for confirmation of the patient's identity.

c. The patient will be involved in the process to the extent possible with verbal and visual responses (e.g., stating name and pointing to correct site location).

d. The patient's responses will be verified with hospital ID, posted schedule, consent(s) radiographic films, site mark (if applicable), and information in the medical record including history and physical with any discrepancies addressed.

2. Site Marking

Unless the anatomical site is exempted per policy guidelines, the site will be initialed by the HCP performing the procedure/surgery with:

a. An approved marker will be used prior to the patient being transferred to the procedure/operating room; the site will be initialed prior to the procedure with the HCP performing the procedure.

b. Placement of the initials will occur on the day of the procedure/surgery or prior to the procedure as long as the mark(s) is visible at the time of the procedure/surgery.

c. Prior to marking the site(s) the HCP performing the procedure verifies the patients identity, consent(s), medical record data including history and physical, and radiographs (as applicable) to confirm accuracy.

d. The HCP performing the procedure asks the patient (legal representative) to state the procedure(s) and site(s)/side(s) of surgery (having patient provide visual clues, if appropriate, such as pointing).

e. Telephone consents should follow facility policy and should consider site, procedure, and patient identification in the process.

f. A site mark (initials) will be made at or adjacent to the incision site and must be visible after the patient is prepped and draped,

g. The site will not be marked with the letter "X" or word's (e.g., yes, no).

h. Non-operative sites will not be marked unless medically indicated (e.g., pedal pulse markings or no B/P cuff).

i. The action taken and resolution of any discrepancy are to be documented by the HCP performing the procedure and the RN.

j. A team member needing to perform treatment (e.g., anesthesia block) or medication administration (e.g., eye drops) prior to the site being marked must follow patient verification process as outlined above that includes a time out: confirmation of the patient identification, verifying the patient's verbal responses with the ID band, medical record, diagnostic test and informed consent(s) and H&P, prior to the administration of any per-procedure treatment or medication.

k. When confirmation of the procedure/surgical site is completed, the team member may perform the treatment or administer medication. If applicable, the patient cannot be moved to the

procedure/surgical suite until the procedure/surgical site(s) is marked by the HCP performing the procedure.

l. If a patient refuses to have the site marked, the patient's physician will review with the patient the rationale for site marking. If the patient still refuses site marking, an alternative method should be used before the case can proceed.

m. Documentation of patient refusal and alternative method is documented.

n. Multiple sides or sites: If the procedure involves multiple sides/sites during the same operation, each side and site must be separately marked and visible especially if change in the patient's position is involved.

o. Spine surgery is a two stage marking process.

Preoperatively
- The skin is to be marked at the level of the procedure (e.g., Cervical, Thoracic, or lumbar)
- The skin mark indicates anterior vs. posterior and right vs. left

Intraoperatively
- Intraoperative x-rays with immovable markers(s) will be used to determine exact location and level of surgery.
- X-rays will be reviewed by HCP performing the procedure for confirmation

Key Point: Once confirmed, the surgeon should mark the site with cautery, stitch, or bone bite before removing the x-ray marker.

a. Larynx/trachea/bronchus and gastroenterology-related endoscopic procedures do not need to be marked. The surgical site(s) will be identified to be included as part of the medical record and site confirmation.

b. Laparoscopic surgery - All laparoscopic cases involving laterality will be marked by initial, indicating the laterality. The mark must be visible after draping.

c. Ophthalmology surgery- Eye procedures are marked above the operative eye by the HCP performing the procedure with or without a line representing the proposed incision.

d. Intraoral and dental surgery – Intraoral operative sites and teeth do not need to be marked. The tooth number(s) will be noted or tooth/surgical site will be identified to be included as part of the medical record and site confirmation.

e. Skin integrity - The skin mark will not be placed on an open wound or lesion. In case of multiple lesions and when only some lesions are to be treated, mark initials as close as possible on intact skin adjacent to the lesions to be treated.

f. Emergency procedure - Site marking may be waived in critical emergencies at the discretion of the HCP performing the procedure, but a "time out" should be conducted unless there is more risk than benefit to the patient.

g. GYN/GU procedures - Site marking will occur on lateral sites (e.g., testicular/ovarian procedure/surgery). When operating through a natural orifice, where in which it is impossible to mark the site and the mark would not be visible after draping, site marking will not be required.

h. Bedside procedures (e.g., chest tube insertion) As long as the HCP performing the procedure identifies the patient and confirms all data, including consent, history and physical, and radiographs; and is in continuous attendance, he/she may perform the procedure without marking the site. A "time out" still must occur prior to the start of the procedure.

i. Radiology -Site marking will not occur with the use of real-time direct imaging and thus, the site is not predetermined prior to the procedure. This includes ultrasound, fluoroscopy, CT, MRI, and Mammogram. Note: An exception will be made for the ultrasound technician who marks the site prior to elective paracentesis and thoracentesis.

3. **"Final Surgical Time Out Procedure"**

a. In the Operating Room, all HCP's involved in the procedure will hold a patient conference to discuss, the identity of the patient, procedure, and surgical site. Discussion should involve all team members regarding the type of anesthesia, availability of blood, any relevant health conditions or risks, presence of x-rays or other relevant testing, presence of all surgical instruments and any intended surgical implants.

b. HCP performing the procedure is responsible for reading and interpreting the radiographic films to be used during the procedure and confirming that the films have been placed correctly for the correct patient if applicable.

c. A verbal "time out" must be done in the location where the procedure is to be performed, immediately before the start of the procedure. (After the patient is draped and before the first instrument is passed) by all in attendance. The patient does not have to be awake for the "time out".

d. A member of the Health Care Team (the circulating Nurse, as in the case of the operating room, or the person assisting for the procedure, as is the case elsewhere in hospital) will initiate the verbal "time out," and document the confirmation of the following: correct patient, correct medical record documentation, correct side/site, correct procedure, correct patient position, correct radiographs, and correct implants and equipment. All attendees must stop and focus on the "time out".

e. Site marking, if applicable, must be visible at the "time out".

f. A time out may be performed by the physician without the assistance of another HCP as long as the documentation of the time out is completed.

g. At the end of the case, an attempt should be made to remove the site mark in the event the patient may need subsequent surgical procedures.

4. **Non-OR Time Out Procedure**:

a. When doing procedures requiring written informed consent that are performed outside of an OR, workforce members shall utilize the DHS Standardized Non-OR Procedural Time Out Checklist *(Attachment I)*.

b. If possible, the patient should be involved in the process

c. In the event that a written informed consent is not obtainable (e.g. life threatening emergency), some or all of the elements may be deferred.

d. During the Non-OR Procedural Final Time Out, activities are suspended to the extent possible so that the operator and other participants (if any) can focus on active confirmation of the patient, site, and planned procedure(s).

e. As applicable to the procedure performed and/or per facility policy, all relevant team members of the procedure team must be present before the Non-OR Procedural Time Out is initiated.

f. The operator (and relevant team members, if any) must utilize and actively verify core components of the DHS Standardized Non-OR Procedural Time Out checklist *(Attachment I)*.

g. If there are any discrepancies, questions, or concerns during the Non-OR Procedural Time Out, the process is halted and will not start until the discrepancies, questions, or concerns are resolved.

h. Documentation of completion of the Non-OR Procedure Time out process will be noted in the patient's medical record.

REFERENCES:

AORN. (2022). Guidelines for Perioperative Practice. Denver, CO: AORN.

AORN Sentinel Events: Preventing and Reduction wrong-patient, wrong-site, wrong-procedure events. AORN. https://www.aorn.org/education/staff-development/prevention-of-sentinel-events/wrong-site-surgery
Accessed August 10, 2022.

DHS Policy #321.005 Standardized Surgical Final Time Out

Hospital: 2022 National Patient Safety Goals Joint Commission UP.01.03.01 : A time-out is performed immediately prior to starting procedures, UP.01.02.01: Mark the procedural site, Pre-procedure verification process.

Joint Commission National Patient Safety Goals 2022.
https://www.jointcommission.org/standards/national-patient-safety-goals/-/media/131f1a35ea9743eca04b9858b73b0a93.ashx

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