UNIVERSAL PROTOCOL - OPERATING ROOM

PURPOSE

This policy describes a **pre-procedure verification process to prevent surgery on the wrong patient, side, or site**. The purpose of this process is to make sure that all relevant documents and related information are:

- Available prior to the start of the procedure.
- Correctly identified, labeled, and matched to the patient's identifiers.
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.

POLICY

Licensed providers shall adhere to the following pre-procedure verification process prior to initiation of the procedure(s). This policy applies to invasive procedures performed in the operating room. This process is a shared responsibility and is conducted by the surgical care team in cooperation with the patient whenever reasonably possible.

PROCEDURE

There are four key components that must be followed:

1. The pre-operative/pre-procedure identification of the patient
2. The verification of the planned surgery/procedure including the side, site, and level
3. The marking of the site
4. The initiation of the time-out prior to the incision or entrance into body orifice

1. Pre-operative/Pre-procedure Identification of the Patient

All providers (physicians, nurses, and anesthesia providers) **MUST** verify the identity of the patient. The following must match:

a. Ask the patient to state his/her name and date of birth (if possible)
b. Information on patient's electronic medical record (Name, Medical Record Number, Date of Birth)
c. Information on patient's ID band (Name, Medical Record Number, Date of Birth)

Any discrepancies must be resolved before proceeding with the surgery.

2. Surgery/Procedure Verification

All providers (physicians, nurses, and anesthesia providers) **MUST** verify the planned procedure, operative site, side, and level. The following must match the patient and/ or be available prior to start of surgery:

a. Patient's active participation and expectations as to procedure, site, side, and level (if possible)
b. Site marked if applicable (See below)
c. Informed consent (accurately completed and signed)
d. Relevant documents (H&P, pre-anesthesia assessment, nursing assessment)
e. Images and other relevant diagnostic test results
f. Any required implants or special equipment
g. Any required blood products

Any information found missing or a discrepancy is discovered; the surgery is postponed until the information is clarified and/or corrected.

3. **Site Marking**

All procedures involving incision or percutaneous puncture or insertion will have the intended site marked. A physician involved in the surgery should mark the intended site.

Marking of the site should:

a. Occur before the patient enters the operating room
b. Consider laterality (right vs. left), surface (flexor vs. extensor), level (spine) or specific digit or lesion
c. The site must be marked with the word 'YES"
d. Be with an ink sufficiently permanent to remain visible after skin prep and sterile draping
e. Involve the patient's participation whenever possible

Procedures/sites **exempt** from marking include:

a. Surgical sites technically or impractical to mark (tonsillectomy, hemorrhoidectomy, etc.)
b. Sites with obvious wound or lesion
c. Single organ procedures (C-sections, cardiac surgeries, appendectomy)
d. Surgeries involving premature infants for whom the mark may cause a permanent tattoo
e. Interventional cases for which catheters/instrument insertion site is not predetermined
f. Dental procedures involving teeth.
g. Patient refusal

For these situations, the documentation must accurately describe the intended procedure and side/site description.

For spinal surgical procedure a two (2) stage marking process should occur:

First Stage (occurs preoperatively):

a. General level marked preoperatively (i.e., cervical, thoracic, or lumbar area)
b. Mark must also indicate anterior vs. posterior, left vs. right

Second Stage (occurs intraoperatively):

a. Further precision marking should occur intraoperatively using standard intraoperative radiographic marking techniques.

4. **Time-Out**

A time out will be performed immediately prior to the incision or entrance into body orifice.

A time-out is a final ***verbal*** confirmation of the patient's identification, planned surgery/procedure, and correct side/site. It should involve the participation of the entire operative team including physicians, nurses, anesthesia providers, and OR technicians. Active participation of the patient is not required during the time-out.

Any team member can initiate the time-out immediately prior to incision or entrance into body orifice**.** During the time-out, all activities should cease, to the extent possible without

compromising patient safety, so that all relevant members of the team are focused on the active confirmation of the correct patient, procedure, site, and other critical elements.

The time-out should **VERBALLY** address the following:

- Correct patient identity.
- Confirmation that the correct side and site are marked.
- An accurate procedure consent form.
- Agreement on the procedure to be done.
- Correct patient position.
- Relevant images and results are properly labeled and appropriately displayed.
- Confirmation on the need to administer prophylactic antibiotics
- Confirmation on the need for fluids for irrigation purposes
- Safety precautions based on patient history or medication use.
- Blood availability.

VERBAL confirmation that each of the above is correct or in agreement must be vocalized among all participants.

The surgical procedure **SHOULD NOT PROCEED** if discrepancies are discovered. They **MUST** be resolved before proceeding with the surgery or procedure.

The circulating nurse and anesthesia provider must verify that the identification band and electronic medical record match prior to tucking the arms.

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.

In an **emergency situation**, every attempt should be made to follow each of the above components. ***At a minimum***, the patient's identification **should be confirmed** by comparing the patient's identification (ID) band with the patient's demographic and/or other documentation.

Documentation

The DHS Standardized Final Surgical Time Out (Attachment 5) shall be used for every surgical procedure to document the process described above. This form will be completed to ensure that all relevant documents are available and correct and must be completed in its entirety. The team members shall document the "TIME OUT". This form is used in addition to other required documentation and does not replace the Preoperative Checklist.

REFERENCES

Joint Commission Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery (www.jointcommission.org/patientsafety/universalprotocol)
Title 22, Division 5, Chapter 1, Article 3, 70223, d
Surgical Safety Checklist (Form ----- Rev. 6/09)
Pre-operative Checklist (Form #49, Rev 5/07)
WHO Surgical Safety Checklist (www.who.int/patientsafety/safesurgery)

REVISION DATES

August 13, 2013; August 13, 2018; March 01, 2023