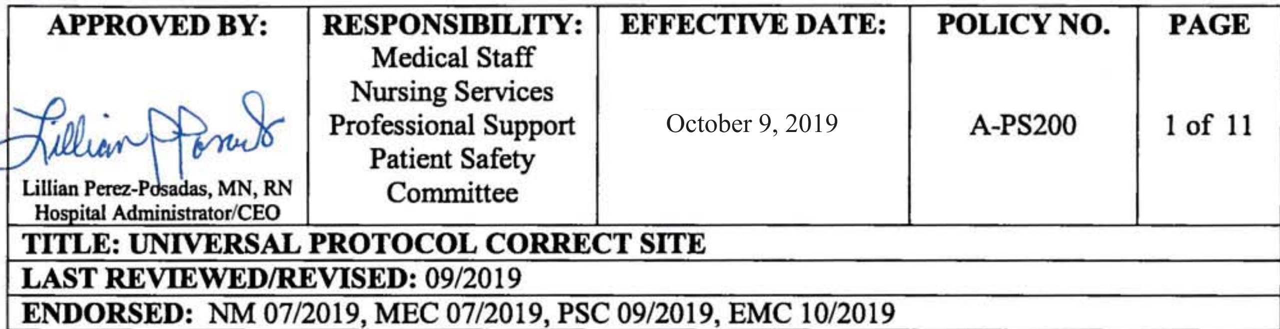
GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL



APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
Lillian Perez-Posadas, MN, RN Hospital Administrator/CEO	Medical Staff Nursing Services Professional Support Patient Safety Committee	October 9, 2019	A-PS200	1 of 11
TITLE: UNIVERSAL PROTOCOL CORRECT SITE				
LAST REVIEWED/REVISED: 09/2019				
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PURPOSE:

To ensure that patients are identified pre-operatively, surgical procedure verified and operative site correctly confirmed by the members of the surgical team. To implement steps that ensure the proper site and type of procedure correspond to the pre-procedural findings.

POLICY:

At the time of scheduling and in the pre-procedural area prior to the start of any invasive procedure, confirmation of correct site, procedure, and patient has been completed and documented in a collaborative manner by the procedural team.

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

- All patients having an invasive procedure/surgical procedure that involves laterality, multiple structures, (e.g., fingers, and toes) or multiple levels (e.g., spinal surgery), across the facility must have their site marked.

- Procedures exempt from site marking include:
    - Single organ cases (Cesarean section, Cardiac Surgery, liver procedures
    - Procedures that enter through an orifice where the target organ is not associated with laterality (e.g. endoscopies, cystoscopy, laryngoscopy)
    - In the case of teeth, the operative tooth name or teeth name(s) must be documented on the dental radiograph or dental diagram
    - Interventional procedures for which the catheter/instrument insertion site is not predetermined (e.g cardiac catherization, peripherally inserted central catheters, central lines, arteriogram).
    - Cases in which entry site for a procedure cannot be predetermined without imaging. Once the location is confirmed, the time-out will be performed prior to the start of procedure
    - Cases of a surgical emergency, a site mark maybe omitted, but surgical "time out" should be performed unless the risk outweighs the benefit

- For a procedure involving an anatomical site that has laterality, the word(s) right, left, or bilateral will be written out fully on the procedure/operating room schedule, consent, history and physical and all relevant documentation.

- For spine procedures, such as discectomy, corpectomy, laminectomy and/or spinal instrumentation procedures a spinal localization time out is required. Refer to Section IV, H.

- The following two patient identifiers, patient’s medical record number and name on the patient’s identification band will be used to verify a patient identity. When possible, have the patient state his or her full name.

- The physician/surgeon will mark the procedure/surgical site(s) with his/her initial prior to entering the procedure/operating room.

- The site **must** be marked with a disposable sterile permanent marker that must be visible after the skin prep and drape is applied.

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

- The patient should be involved in the process to the extent possible by (e.g., verbal procedure to be done and/or pointing to site/side).

- If a patient is a minor or is unable to verify the information for his or herself, the steps that are used for verification are performed with the procedural team along with the parent or legal representative.

- 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 resolution(s) to the identified discrepancy.

- The physician and/or registered nurse must document the discrepancy and resolution.

- Once the patient has been prepped and draped and the site mark is visible, an active "time out" will be performed (*prior to an instrument being passed*) where the entire procedural team will stop all activities in order for each team member to validate the correct patient, correct site, correct procedure, correct position, correct radiological exams, and correct implants/instruments.

- Preoperative verification and "time out" will be performed for all cases, including those not involving a site mark, except in an emergency if the risks outweigh the benefits.

PROCEDURE:

I. SCHEDULING

A. The verification process for correct site procedure/surgery begins with scheduling.

B. The following information is required when scheduling as invasive/surgical procedure:

1. Correct spelling of the patient's full name

2. Date of birth

3. Procedure to be performed

4. Physician(s) name(s)

5. Implants required, if applicable
6. Facility required booking data

C. Scheduled procedures that involve anatomical sites that have laterality, the word(s) “right” “left” or “bilateral” will be written out fully on the procedure/operating room schedule, consent, history and physical and on all other relevant documentation.

D. Any discrepancies in data should be clarified with physician’s office.

II. PRE-PROCEDURE/PREOPERATIVE VERIFICATION

A. The registered nurse (radiographer, phlebotomist, etc.) will verify patient's identity by asking the patient to state his or her full name, date of birth and procedure / surgery that will be performed.

B. 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, health care proxy agent, interpreter, or legal guardian should complete the identifiers and verify site mark.

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 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.

III. SITE MARK - Completed before the patient enters the Operating/Procedure Room

A. The site will be marked with a disposable sterile permanent marker PRIOR to the patient being transferred to the procedure/ operating room by the operating physician/surgeon/proceduralist unless the anatomical site is exempted per policy guidelines

B. Placement of the mark (initials) with patient or legal representative may be on the day of procedure/surgery or prior to procedure/surgery as long as the mark(s) is visible at the time of procedure/surgery.

C. Prior to marking the site(s), the operating physician/surgeon/proceduralist verifies the patient's identity, consent(s), medical record data including history and physical, and radiographs, as applicable, to confirm accuracy.

D. The operating physician/surgeon/proceduralist asks the patient or legal representative to state the procedure(s) and site(s)/side(s) of surgery and have patient provide visual clues, if appropriate, such as pointing.

E. A site mark using the operating physician’s/surgeon’s/proceduralist’s initials will be made at or adjacent to the incision site, must be visible after the patient is prepped and draped.

1. The site will not be marked with the letter "X" or the word "No" or “YES”.

F. Adhesive markers must only be used as an adjunct to the site marking with a disposable sterile permanent marker.

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

H. The action taken and resolution of the discrepancy are to be documented by the operating physician/surgeon/proceduralist and/or registered nurse.

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

J. When confirmation of the procedure/surgical site(s) by anesthesiologist or registered nurse is completed, the team member may perform the treatment before the surgical site is marked. The patient cannot, however, be moved to the procedure/surgical suite until the procedure/surgical site(s) is marked by the operating physician/surgeon/proceduralist while the patient is awake and aware, if possible.

K. For those patients who refuse site marking or for those procedures where it is technically or anatomically impossible to mark the site, a temporary wristband shall be placed on the patient on the side of the procedure. The wristband shall contain the patient's name and a second identifier for the intended procedure and site.

L. Multiple Sides or Sites

1. If the procedure involves multiple sides/sites during the same operation, each side and site must be marked. Additionally, when two or more procedures are to be performed on the same patient, a "time out" is performed to confirm each subsequent procedure prior to the start of the specified procedure.

M. Spine surgery is a two stage marking process.

1. Preoperatively

   a. The skin is to be marked with a disposable sterile permanent marker at a level of the procedure (e.g., cervical, thoracic, or lumber).

   b. The skin mark indicates anterior versus posterior and right versus left.

2. Intraoperatively

   a. Intraoperative x-rays with immovable marker(s) will be used to determine exact location and level of surgery.

   b. X-ray(s) will be reviewed by (operating physician) for confirmation.
   (Note: Once confirmed, the surgeon should mark the site with cautery, stitch, or bone bite before removing the x-ray marker).

N. Laparoscopic surgery

The surgical site will be marked with a disposable sterile permanent marker for laparoscopic cases that involve operating on organs that have laterality. The marking must be done near the proposed site or near the proposed incision/insertion site and will indicate the correct side. The mark must be visible after draping. If it is technically impossible to be visible, an alternative method should be used.

O. Opthalmology surgery: Refer to site marking section.

P. Dental surgery

1. Teeth do not need to be marked.

2. The tooth number(s) or tooth/surgical site will be identified on the diagram or radiograph to be included as part of the medical record and site confirmation.

3. Radiographs will be checked for proper orientation and visually confirm correct teeth or tissue charted. These must be available in the procedural room prior to the start of the procedure.

Q. Skin integrity that is not intact

1. The skin mark will not be placed on an open wound or lesion.

2. In the case of multiple lesions and when only some lesions are to be treated, the sites will be identified prior to the procedure itself.

R. Emergency procedure

1. Site marking may be waved in critical emergencies at the discretion of the operating physician, but a "time out" or pause will be conducted unless there is more risk than benefit to the patient.

S. GYN/GU procedures

1. Site marking with a disposable sterile permanent marker will occur on lateral sites (e.g., testicular/ovarian procedure/surgery)

2. When operating through a natural orifice, for example during a cysto-ureteroscopy procedure involving a single ureter which is impossible to mark and the mark would not be visible after draping; an alternative method such as an ID band may be placed on the patient.

T. Beside procedures (e.g., chest tube insertion)

As long as the person performing the procedure/surgery 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 and be documented. (Reference Attachment II).

IV. "TIME OUT" - In the Operating/Procedure Room

A. The patient enters the procedure/operating room and the preoperative nurse or radiographer will confirm identity of the patient, procedure, and site.

B. Operating physician/surgeon/proceduralist 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.

C. A verbal "time out" where all team members participating in the care of the patient must be done in the location where the procedure/surgery is to be performed. It is conducted prior to starting the procedure and ideally, prior to induction of the anesthesia process (including general/regional anesthesia, local anesthesia, and spinal anesthesia), unless contraindicated.

D. The operating physician, anesthesiologist, registered nurse, or radiographer will initiate the verbal "time out." Confirmation of the following will be made.

    1. Correct patient

    2. Correct side/site

    3. Correct procedure

    4. Correct patient position

    5. Correct radiographs

    6. Correct implants and equipment

    7. Special Requirements

E. Site marking must be visible at the "time out" for ALL team members to visualize and confirm.

F. "Time out" will be documented in medical record (See Attachments I and II). The documentation should include:

    1. Personnel present at the time out

    2. Verification of: correct patient, correct side and site, agreement on the procedure, correct patient position, correct radiographs and available correct implants and equipment.

G. At the end of the case, the site mark will be attempted to be removed in the event that the patient will be having subsequent surgical procedures (e.g., trauma).

H. Spinal Localization Time Out (after incision)

    1. An additional intra-operative time out, specifically to confirm accurate localization, will be conducted by the attending physician. During this time out, as with all other time outs, activities are suspended to the extent possible so that team members can focus on active confirmation.

2. Intra-operatively after the initial incision, but prior to diskectomy, corpectomy, laminectomy and/or spine instrumentation, radiographic confirmation of the correct level or levels must be obtained with needle or instrument at the proposed level of the procedure with the attending surgeon present. Image localization with the use of a radio-opaque marker is required.

   a. All localization films must be saved and annotated as such by the radiology technician.

3. The x-ray is compared with prior radiographic studies available for comparison to assure that surgery is performed at the appropriate level.

4. All spine procedures will have an additional "time-out" documented at the point the attending surgeon provided radiographic confirmation of the correct vertebral level.

5. Documentation of spinal localization time out will be done in the electronic perioperative record in the section labeled Spine localization Time Out with the time included.

6. The physician will document the intra-op localization time out in the dictated operative report.

7. Pertinent intra-operative events, such as durotomies, will be documented in the brief operative note and the dictated operative report.

8. Final films: In cases with spinal instrumentation, a final intra-operative film(s), without sponges, must be performed before leaving the OR and annotated as such by the Radiology Technician/Technologist.

REFERENCES:

The Joint Commission. Universal Protocol. In Joint Commission's Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Oakbrook Terrace, IL.

RESCISSION:

A-PS200, Universal Protocol Correct Site of the Administrative Manual, effective January 22, 2018.

ATTACHMENTS:

I. **OPERATIVE/INVASIVE PROCEDURE VERIFICATION CHECKLIST**
II. **PRE-PROCEDURE VERIFICATION CHECKLIST – INVASIVE PROCEDURES OUTSIDE THE OPERATING ROOM**

ATTACHMENT I

OPERATIVE/INVASIVE PROCEDURE VERIFICATION CHECKLIST

Hospital Location of Procedure to be Performed: _____ Operating Room
_____ Radiology
Other: ____________________________

NOT ORIGINAL

NOTE:

1. The verification process to include "timeout" is to be implemented for all operative and other invasive procedures that include puncture to the skin and insertion of an instrument or foreign material into the body including, but not limited to percutaneous aspirations, biopsies, cardiac and vascular catherizations and endoscopies. Exclusions for timeouts include minor procedures such as venipunctures, peripheral IV line placement, insertion of NG tube, or Foley catheter insertion.

2. All patients having an invasive procedure/surgical procedure that involves laterality, multiple structures, (e.g., fingers, and toes) or multiple levels (e.g., spinal surgery), across the facility must have their site marked. Procedures that are exempt from site marking: Single organ cases (e.g., cesarean section, liver procedures); procedures that enter through an orifice where the target organ is not associated with laterality (e.g. endoscopies, cystoscopy); in the case of teeth, the operative tooth name or teeth name(s) must be documented on the dental radiograph or dental diagram; interventional procedures for which the catheter/instrument insertion site is not predetermined, cases in which entry site for a procedure cannot be predetermined without imaging Note: once the location is confirmed, the time-out will be performed prior to the start of procedure); and cases of a surgical emergency, a site mark maybe omitted, but surgical "time out" should be performed unless the risk outweighs the benefit. (Reference Policy A-PS200, Universal Protocol, Correct Site of the GMHA Administrative Manual.)

VERIFICATION #1: Complete when procedure is scheduled and/or at pre-admission testing.

Name of Operative/Invasive Procedure: ____

Correct Patient Using Two Identifiers ☐ **YES** ☐ **NO** **(check one)**

Date to be performed: ____

Verbal Site Verification: ____

NOT ORIGINAL

Scheduled by: ____

VERIFICATION #2: Complete on the day of procedure.

Location: ____

Operative/Invasive Procedure to be performed: ____

Correct Patient Using Two Identifiers ☐ **YES** ☐ **NO** **(check one)**

Consent for: ____

History & Physical confirms procedure and site: ☐ **YES** ☐ **NO** **(check one)**

Relevant Images or other Pre-procedure Studies are available and interpreted: ☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**

(If NO, identify the results not available) ____

____

Patient Verbal Site Verification: ☐ **YES** ☐ **NO** (check one)

NOT ORIGINAL

Signature of Staff Verifying Correct Patient, Correct Procedure, Correct Site/Side: ____________ Date: ______ Time: ____

PATIENT ID LABEL

VERIFICATION #3: Complete in Holding or Pre-Procedure Area

NOT ORIGINAL

Procedure to be Performed: ______________________________

Consent for: ______________________________

History and Physical Confirms Procedure and Site, *when applicable*: ☐ **YES** ☐ **NO** **(check one)**

With Patient Involved, Awake, and Aware, verify: **(check one per line item)**

- Correct Patient Using Two Identifiers.........☐ **YES** ☐ **NO**
- Correct Procedure..............................☐ **YES** ☐ **NO**
- Correct Site/Side..............................☐ **YES** ☐ **NO**
- Site Marked, if applicable.....................☐ **YES** ☐ **NO** ☐ **N/A**
  NOTE: Site marking when applicable, *should* be done by the person performing the surgery/procedure.
- Any Allergies..................................☐ **YES** ☐ **NO**
- Applicable Safety Concerns.....................☐ **YES** ☐ **NO**
- Anesthetic/Sedation Plan Identified............☐ **YES** ☐ **NO**

Patient Refused Site/Side Marking: ☐ **YES** ☐ **NO** ☐ **N/A** If yes, reason ______________________________

Signature of Staff Verifying Correct Patient, Correct Procedure, Correct Site/Side: ____________ Date: _____ Time: ____

VERIFICATION #4: Final Verification and "Timeout". Complete where the procedure is to be performed just prior to starting the procedure.

NOT ORIGINAL

Operative/Invasive Procedure to be Performed: ______________________________

Consent for: ______________________________

History & Physical Confirms Procedure and Site, *when applicable*: ☐ **YES** ☐ **NO** **(check one)**

Verification Confirms: **(check one per line item)**

- Correct Patient Using Two Identifiers.........☐ **YES** ☐ **NO**
- Correct Side/Site are marked..................☐ **YES** ☐ **NO** ☐ **N/A**
- Agreement on Procedure.........................☐ **YES** ☐ **NO**
- Correct Patient Position.......................☐ **YES** ☐ **NO**
- Correct Implants Available.....................☐ **YES** ☐ **NO** ☐ **N/A**
- Correct Equipment Available & Functional.......☐ **YES** ☐ **NO**
- Special Requirements...........................☐ **YES** ☐ **NO** ☐ **N/A**

Relevant Images or Other Pre-Procedure Studies are available and interpreted:...☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Relevant Images are properly labeled and displayed:.............☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Prophylactic antibiotics administered:.........................☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Fluids for irrigation purpose prepared and labeled:............☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Medication on the field appropriately labeled:.................☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Required Blood Products, Implants, and Devices are available:..☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**
Fire Risk Prevention Implemented:..............................☐ **YES** ☐ **NO** ☐ **N/A** **(check one)**

Physician Performing Procedure: ______________________________

Anesthesia Name: ______________________________

NOT ORIGINAL

Circulating RN Name: ______________________________

Scrub Name: ______________________________

Signature/Title of Healthcare Team Member Calling "Timeout" ______________________________

Timeout called at ____:____:____ (Time) on ______________ (Date)

***If at any time during this process, there is a discrepancy of information, call for a "HARD STOP"-all activity ceases until information is reconciled.**
**** An additional checklist will be used to document the verification process should the responsibility for care of the patient be transferred to another caregiver (including the anesthesia provider) during any major section of the verification processes 1-4.**

Operative/Invasive Procedure Verification Checklist

PATIENT ID LABEL

ATTACHMENT II

Pre-Procedure Verification Checklist
Invasive Procedures Outside the Operating Room

If at any time during this process, there is a discrepancy of information, call for a "HARD STOP"- all activity ceases until information is reconciled.

NOT ORIGINAL

Pre-Procedure-Verification

1. Patient identification verified using two indicators ………………………………………………… ☐
2. Accurate and complete informed consent verified ……………………………………………… ☐
   PROCEDURE: ____
3. Site marked, as appropriate*, by person performing the procedure with initials …………………… ☐

*Refer to Policy No. A-PS200, Universal Protocol, Correct Site policy for site marking exclusions.

- Multiple Site(s) marked and identified in the informed consent …………………………….. ☐
- Diagram marked by person performing the procedure if unable to mark on patient ……… ☐
  - Site was not marked due to:
    - ( ) Site marking not required per policy
    - ( ) Refused by patient

Health Care Provider Signature: ____________________ Date: ____________ Time: ______

Pre-Procedure—Communication

1. Team communicated completed …………………………………………………………………. ☐
   - Team reviewed relevant case information including:
     - --Images and diagnostic/pathology/lab reports ……………………… Yes ( ) N/A ( )
     - --Anticipated equipment is available …………………………………… Yes ( ) N/A ( )
     - --Antibiotics or fluids for irrigation ………………………………………. Yes ( ) N/A ( )
     - --Position ………………………………………………………………….. Yes ( ) N/A ( )
     - --Additional safety precautions, e.g. allergies ………………………….. Yes ( ) N/A ( )

Just Prior to Procedure (Time Out)

1. Person performing the procedure initiated the time-out verbally …………………………………… ☐
2. All other activity ceased ……………………………………………………………………………….. ☐
3. 2nd health care provider verbally verified: ☐

Correct Patient Using Two Identifiers………	☐ YES	☐ NO	
Correct Side/Site are marked………………	☐ YES	☐ NO	☐ N/A
Agreement on Procedure……………………	☐ YES	☐ NO	
Correct Patient Position……………………	☐ YES	☐ NO	
Correct Implants Available…………………	☐ YES	☐ NO	☐ N/A
Correct Equipment Available………………	☐ YES	☐ NO	
Special Requirements………………………	☐ YES	☐ NO	☐ N/A

4. Person performing the procedure verbally ☐
   - Verified procedure including side/site ……………………………………………………..

Health Care Provider Signature: ____________________ Date: ____________ Time: ______

Pre-Procedure Verification Checklist
Invasive Procedures Outside the Operating Room

PATIENT ID LABEL

Guam Memorial Hospital Authority
Page 1 of 1
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