St. Elizabeth HEALTHCARE	**Administrative Clinical Policy/Procedure**

Title: **VERIFICATION OF PROCEDURES TO BE PERFORMED**

	Page 1 of 8
Approved By: **Garren Colvin, EVP/COO**	Policy No.: **ACLIN-V-01**
	Originated: **01/01/11**
Responsible Parties: **Alicia Humphrey, Director Outpatient Surgery** **Tracie Shelton, Director Patient Safety & Accreditation**	Revised: **11/06/13**
	Reviewed: **11/06/13**

Interdisciplinary Review: **Perioperative Services, Radiology, Maternal/Child Health, Special Services, Risk Management, Cancer Care, Clinical Coordination Committee, Patient Care Committee**

POLICY: Verification of correct patient, correct site and correct procedure will be performed according to the guidelines set forth in this policy for inpatients and outpatients having procedures for which consent is required. Each member of the procedure team will participate in this process. If there is question or doubt regarding the type of procedure, procedural site, or identity of the patient, each team member has a responsibility to question any other team member.

PURPOSE: Identification of correct patient, correct site and correct procedure prior to initiating invasive procedures is an important patient safety initiative instrumental in preventing wrong site surgeries/procedures.

NOTE: If the patient is unable to give consent when required at any point in the verification process, consent is to be obtained pursuant to the most current version of Patient Services/ Administrative Clinical Policy *Consent to Surgical, Diagnostic and /or Therapeutic Procedures.* If the patient is unable to respond at any point in the verification process, response should be sought from any legally authorized representative present. If no legally authorized representative is present, the staff involved should utilize all available information and take all steps reasonably necessary to complete the verification process.

PROCEDURE:

A. Verification of Procedures to Be Performed

1. All relevant documents, equipment, and studies are to be available prior to the start of the procedure.
   a. These documents, equipment, and studies are to be consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and as applicable, any implants.
   b. Any missing information or discrepancies must be addressed before starting the procedure.
2. Verification of correct person, correct site, and correct procedure occurs at the following times:
   a. At the time the procedure/surgery is scheduled.
   b. At the time of preadmission testing and assessment.

c. At the time of admission or entry into the facility for a procedure, whether elective or emergent.
d. Before the patient leaves the pre-procedure area or enters the procedure room.
e. Immediately prior to the start of the procedure, as a Time Out.
f. Anytime the responsibility for care of the patient is transferred to another member of the procedural care team (including anesthesia care providers.)
g. With the patient involved, awake and aware, if possible.
h. Correct diagnostic and radiology test results (e.g. radiology images and scans, or pathology and biopsy reports) that are properly labeled.
i. Any required blood products, implants, devices and/or special equipment for the procedure.

3. Prior to administration of local medication, perform a Time-Out.
   a. Include: specific medication name and dose, patient identification, procedure and site, appropriately marked.
   b. Document in the Additional Time-Out column in Epic
   c. This Time-Out applies to patients receiving local medication prior to the prep and drape; i.e. prior to the Final procedural Time-Out.

B. Verification of Procedure by the Pre-Procedure RN/designated team member (e.g. SDS, Holding Area)

1. While looking at the patient ID wristband, the RN/designated team member asks the patient to state his/her name and date of birth.
2. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member confirms that the patient name as address-o-graphed/pre-printed on the consent is in agreement with the ID band and patient statement.
3. While looking at the Consent for Surgical/Procedural Treatment form, the RN/ designated team member asks the patient to state the procedure to be performed and the procedure site.
4. While looking at the procedure as listed in the computerized patient record, the RN/ designated team member confirms that the procedure as listed in the computerized patient record, the Consent for Surgical/Procedural Treatment form, and the patient's statement are all in agreement.
5. The physician is contacted to resolve any discrepancy in the verification of patient identification, procedure(s) or site(s). A manager will be contacted to assist with resolution of any discrepancy, if necessary.
6. The patient is given the Consent for Surgical/Procedural Treatment form to sign. (See reverse side of Consent form for details on completing the consent.)
7. For procedures requiring site marking, the individual performing the procedure will do the site marking.

a. The site marking will be done using the initials of the individual performing the procedure as the mark and/or a temporary unique site identification bracelet to indicate laterality.
b. The mark must be visible after the patient is prepped and draped.
c. When the procedure involves more than one site, all procedural sites are marked. (See Patient Services Policy # ACLIN-M-01*Marking of Surgical / Invasive Procedure Sites(s)* for site marking details)

8. The RN/designated team member completes computerized documentation in the Pre-Op Verification section of the Pre-Op Assessment Checklist or as appropriate to the specialty department where the procedure is performed.

C. Verification of Procedure by the Procedure RN/designated team member (e.g. OR RN in SDS or Holding Area)

1. While looking at the patient ID wristband, the RN/designated team member asks the patient to state his/her name and date of birth.
2. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member confirms that the patient name as address-o-graphed/pre-printed on the consent is in agreement with the ID band and patient statement.
3. While looking at the Consent for Surgical/Procedural Treatment form, the RN/ designated team member asks the patient to state the procedure to be performed and the procedure site.
4. While looking at the procedure as listed in the computerized patient record, the RN/ designated team member confirms that the procedure as listed in the computerized patient record, the Consent for Surgical/Procedural Treatment form, and the patient's statement are all in agreement.
5. For procedures requiring site marking, the RN/designated team member asks the patient to show where the procedure site has been marked with the initials of the individual performing the procedure and/or with a temporary unique site identification bracelet to indicate laterality.
   a. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member confirms correct placement of the site marking and that the mark will be visible after the patient is prepped and draped.
6. The physician is contacted to resolve any discrepancy in the verification of patient identification, procedure(s) or site(s). A manager will be contacted to assist with resolution of any discrepancy, if necessary.
7. The RN/designated team member completes computerized documentation in the Pre-Op Verification section of the Pre-Op Assessment Checklist or as appropriate to the specialty department where the procedure is performed.
8. The patient does not go into the procedure room until the antibiotic is ordered and is available at the bedside.

D. Verification of Procedure upon Entering the Procedure Room (Initial Time Out)

1. The RN/designated team member asks for the attention of all team members. All activity in the procedure room stops.
2. The RN/designated team member asks the patient to state his/her name, date of birth, the procedure to be performed and the procedure site. If the patient is unable to respond proceed to the next step.
3. While looking at the patient ID wristband, the RN/designated team member reads aloud to all team members the name and date of birth as written.
4. While looking at the Consent for Surgical/Procedural Treatment form, the RN/ designated team member reads aloud to all team members the patient name as address-o-graphed/pre-printed and as written on the consent, the date of birth, the procedure to be performed, and the procedure site as written.
5. For procedures requiring site marking, the RN/designated team member shows all team members where the procedure site has been marked with the initials of the individual performing the procedure and/or with a temporary unique site identification bracelet to indicate laterality.
   a. While looking at the placement of the site marking, each team member states the location of the site.
   b. The RN/designated team member makes a statement confirming that all identifiers are in agreement.
6. The RN/designated team member confirms that the antibiotic has been ordered and is available at the bedside.
7. A manager is contacted immediately if any member of the team is not completely and actively participating in all steps of the verification process.
8. The physician is contacted to resolve any discrepancy in the verification of patient identification, procedure(s) or site(s). A manager will be contacted to assist with resolution of any discrepancy, if necessary.
9. The RN/designated team member completes computerized documentation in the Time Out – Initial section of the Pre-Incision log entry or as appropriate to the specialty department where the procedure is performed.

E. Verification of Procedure Immediately Prior to Procedure Start (Final Time Out)

1. No instrument is provided until the final Time Out is complete.
2. The physician initiates the Time Out.
3. The physician calls a Time Out, asking for the attention of all team members. All activity in the procedure room stops.
4. While looking at the Consent for Surgical/Procedural Treatment form, the RN/ designated team member reads aloud to all team members the patient name as address-o-graphed/pre-printed and as written on the consent, the date of birth, the procedure to be performed, and the procedure site as written.
5. While looking at the prepped and draped procedure site, each team member states the location of the prepped, marked, and draped site and confirms that the patient is properly positioned for the procedure.
   a. If all identifiers are in agreement, the RN/designated team member makes a statement indicating so and the procedure may begin.
6. The RN/designated team member confirms that the ordered antibiotic infusion has been initiated or completed.
   a. If the antibiotic was not given within the appropriate time frame, no instrument is provided until the antibiotic has been infusing for at least one minute prior to incision/procedure start time.
7. As applicable to the scheduled procedure, the availability of appropriate implants, and any specialty equipment or requirements is confirmed.
8. A manager is contacted immediately if any member of the team is not completely and actively participating in all steps of the verification process.
9. If any discrepancy is noted by any member of the team during the Time Out process, all activity immediately stops. The procedure is not started. A manager is contacted immediately. The procedure does not proceed until the discrepancy is resolved.
   a. When the discrepancy is resolved, the Time Out begins again at Step 1 of the Final Time Out process.
10. The RN/designated team member completes computerized documentation in the Time Out – Final section of the Pre-Incision log entry or as appropriate to the specialty department where the procedure is performed.
11. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a Final Time Out before each procedure is initiated.

F. Verification of Anesthesia Procedures by the Anesthesia Care Provider

1. In the preoperative area, for patients receiving preoperative regional anesthesia (including but not limited to epidurals, intrascalene blocks, axillary blocks), immediately prior to administration of the regional anesthetic, the anesthesia care provider places a temporary unique identification bracelet to indicate laterality and conducts a Time Out with an RN.
2. While looking at the patient ID wristband, the anesthesia care provider asks the patient to state his/her name and date of birth. The RN must also hear the patient's statement.
3. While looking at the Consent for Surgical/Procedural Treatment form, the anesthesia care provider confirms that the patient name as address-o-graphed/pre-printed and as written on the consent is in agreement with the ID band and patient statement. A statement is made informing the RN that these identifiers are in agreement.
4. While looking at the Consent for Surgical/Procedural Treatment form, the anesthesia care provider asks the patient to state the procedure to be performed and the procedure site. The RN must also hear the patient's statement.
5. While looking at the procedure as listed in the computerized patient record, the anesthesia care provider confirms that the procedure as listed in the computerized patient record, the Consent for Surgical/Procedural Treatment form, and the patient's statement are all in agreement. A statement is made informing the RN that these identifiers are in agreement.
6. For anesthesia procedures requiring site marking (e.g. anesthesia blocks), the individual performing the procedure will do the site marking.
   a. The site marking will be done using a temporary unique site identification bracelet to indicate laterality.
      i. This bracelet must be visible after the patient is prepped and draped.
      ii. The site identification bracelet will be placed on the appropriate wrist or ankle corresponding to the location and laterality of the anesthesia procedure/block. (See Patient Services Policy # ACLIN-M-01*Marking of Surgical / Invasive Procedure Site(s)* for site marking details.)
   b. When the procedure involves more than one site, all procedure sites are marked.
7. A final Time Out is conducted prior to initiating the anesthesia procedure/block.
   a. When two or more procedures are being performed on the same patient and/or additional site prepped and draped, a final time out will be performed before each procedure is initiated.
8. The physician is contacted to resolve any discrepancy in the verification of patient identification, procedure(s) or site(s). A manager will be contacted to assist with resolution of any discrepancy, if necessary.
9. The anesthesia care provider documents on the Anesthesia Record that the verification of procedure site has been performed.
10. The site identification bracelet is removed at the conclusion of the anesthesia procedure by the person who performed the procedure, and prior to initiating the surgical procedure verification process.

G. Verification of Bedside Procedures

1. While looking at the patient ID wristband, the RN/designated team member asks the patient to state his/her name and date of birth.
2. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member confirms that the patient name as address-o-graphed/pre-printed on the consent is in agreement with the ID band and patient statement.
3. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member asks the patient to state the procedure to be performed and the procedure site.
4. While looking at the MD order, the RN/designated team member confirms that the MD order, the Consent for Surgical/Procedural Treatment form, and the patient's statement are all in agreement.
5. The physician is contacted to resolve any discrepancy in the verification of patient identification, procedure(s) or site(s). A manager will be contacted to assist with resolution of any discrepancy, if necessary.
6. The patient is given the Consent for Surgical/Procedural Treatment form to sign. (See reverse side of Consent form for details on completing the consent.)
7. For procedures requiring site marking, the individual performing the procedure will do the site marking.
    a. Bedside procedures in which the individual performing 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 initiation of the procedure may be exempted from the site marking requirement.
    b. If required, site marking will be done using the initials of the individual performing the procedure as the mark and/or a temporary unique site identification bracelet to indicate laterality.
    c. The mark must be visible after the patient is prepped and draped.
    d. When the procedure involves more than one site, all procedural sites are marked. (See Patient Services Policy # ACLIN-M-01 *Marking of Surgical / Invasive Procedure Site(s)* for site marking details)
8. The RN completes computerized documentation in the Pre-Op Verification section of the Pre-Op Assessment Checklist.
9. The procedure does not begin until the final Time Out is completed. The physician initiates the Time Out, asking for the attention of all team members. All activity in the procedure room stops.
10. While looking at the Consent for Surgical/Procedural Treatment form, the RN/designated team member reads aloud to all team members the patient name as address-o-graphed/pre-printed and as written on the consent, the date of birth, the procedure to be performed, and the procedure site as written.

11. While looking at the prepped and draped procedure site, each team member states the location of the prepped, marked (if required), and draped site and confirms that the patient is properly positioned for the procedure.

12. If all identifiers are in agreement, the RN/designated team member makes a statement indicating so and the procedure may begin.
13. As applicable to the scheduled procedure, the availability of appropriate implants, and any specialty equipment or requirements is confirmed.
14. A manager is contacted immediately if any member of the team is not completely and actively participating in all steps of the verification process.
15. If any discrepancy is noted by any member of the team during the Time Out process, all activity immediately stops. The procedure is not started. A manager is contacted immediately. The procedure does not proceed until the discrepancy is resolved.
16. When the discrepancy is resolved, the Time Out begins again at Step 1 of the Final Time Out process.
17. The RN completes computerized documentation in the Pre-Op Verification section of the Pre-Op Assessment Checklist.

H. Verification of Emergency Procedures

1. When invasive procedures are performed under emergency or urgent conditions, the individual performing the procedure may be in continuous attendance of the patient from the point of decision to perform the procedure.

   a. Under those circumstances, marking the site would not be necessary.

2. The Time Out to verify the correct patient, procedure, and site would still be appropriate, unless it was such an emergency that even the Time Out would add more risk than benefit.

REFERENCES:

"Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery," The Joint Commission, National Patient Safety Goals, 2010.

"Frequently Asked Questions about the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery," The Joint Commission, 2008.

"Statement on Correct Site Surgery," 2010 AORN Perioperative Standards and Recommended Practices.