Site Identification and Patient/Procedure Verification Policy for Surgical and Other Invasive Procedures

Administrative Policies & Procedures

General Description

Purpose:
To ensure the correct patient, procedure, and site are verified prior to any patient undergoing an inpatient or outpatient surgical or other invasive procedure, including those performed in a special procedures unit, endoscopy unit, interventional radiology suite, or at the bedside.

Scope:
All departments or patient care areas of Meridian Hospitals Corporation, including Jersey Shore University Medical Center, Ocean Medical Center, Riverview Medical Center and K. Hovnanian Children’s Hospital.

Definition:
Invasive Procedure – Involving the puncturing or incision of the skin, insertion of an instrument, or insertion of foreign material into the body. Includes invasive procedures that may be performed for diagnostic or treatment-related purposes.

Policy:
For all operative and other invasive procedures that expose patients to more than minimal risk, a pre-procedure verification process will be conducted, procedure site /side marked, as applicable and time-out performed immediately prior to starting the procedure to verify the correct patient, procedure, side and site.

Procedures for non-OR settings including bedside procedures, will follow the same pre-procedure verification, site marking and time-out processes as outlined in this policy. If the individual performing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent is obtained up to the time of the procedure itself, then site marking is not required. However, the requirements for pre-procedure verification and final time-out verification still apply.

Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers) at the time of, and during the procedure, verification of the correct person, correct site and correct procedure will take place.
**Inclusions:** Examples of bedside procedures that are included under this policy are listed below. While all procedures included in this policy require pre-procedure verification and a “time out”, site marking is not required for the following procedures if the physician is in continuous attendance with the patient from the time of decision to do the procedure and consent is obtained up to the time of the procedure itself.

- PICC line
- All central line insertions
- Chest tube insertion
- Other similar types of procedures (i.e., Dialysis catheter insertion)

**Exclusions:** The following routine “minor” procedures are NOT within the scope of this policy as they do not constitute more than minimal risk to the patient:

- Venipuncture
- Peripheral intravenous line placement
- Insertion of naso-gastric tube or urinary catheter
- Other routine “minor” procedures that do not constitute more than minimal risk to the patient

Procedures also excluded from this policy are:

- Electroconvulsive therapy
- Closed reduction
- Lithotripsy
- Performance of dialysis [excluding insertion of dialysis catheters]

**Procedure:**

**A. Pre-Procedure Verification Process:**

1. After the informed consent “disclosure discussion” takes place between the physician and the patient or legally authorized patient representative, written acknowledgement of informed consent must be obtained. In addition to describing the risks, benefits, and alternatives about the procedure, the informed consent form must clearly state the planned procedure(s) and the laterality of the procedure(s) where appropriate. Laterality must be spelled out (“RIGHT” or “LEFT” not “R” or “L” and not “Rt. Or “Lt.”) on the consent form.

2. Verification of the correct person, correct site and correct procedure will occur at the following times:

   - At the time the procedure is scheduled
   - At the time of preadmission testing and assessment
   - At the time of admission or entry into the facility for a procedure, whether elective or emergent
   - Before the patient leaves the pre-procedure area or enters the procedure room
   - Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers) at the time of, and during, the procedure
   - With the patient involved, awake and aware, if possible
The correct person identification process will be in accordance with Meridian Hospitals Corporation Administrative policy, *Patient Identification*, MHC-ADMIN-02-1222 to match the patient’s identity to the planned procedure.

3. Initial surgical or other invasive procedure correct person, correct site verification and correct procedure shall be completed in the Pre-Admission Testing Area (OMC and JSUMC Same Day Admissions and Outpatients), in the Same Day Surgery / Outpatient unit (RMC Same Day Admissions and Outpatients) or on the nursing unit (Inpatients) with the patient involved, awake and aware if possible. Nursing staff will document in the patient’s chart that the patient-stated information matches what is recorded in the following documents:
   - Consent Form
   - Medical Record (including History & Physical)
   - X-rays and Other Imaging Studies

Any discrepancies in the documentation must be brought to the attention of the attending surgeon / interventionalist for resolution and documented in the medical record.

4. On the day of surgery / invasive procedure, immediately prior to moving the patient to the procedure room, the pre-operative / pre-procedure nurse will:
   - Use a check list to review and verify that the following items are available and accurately matched to the patient
     - Relevant documentation (for example, history and physical, nursing assessment, and pre-anesthesia assessment)
     - Accurately completed, and signed, procedure consent form
     - Correct diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly labeled

Any required blood products, implants, devices, and/or special equipment for the procedure will be confirmed by a member of the OR / Procedure Team.

If there is missing information or a discrepancy, this must be resolved prior to initiation of the procedure.
   - Verify the correct person, correct site and correct procedure with the patient involved, awake and aware, if possible and compare the patient’s response with the above documents.
   - If the patient’s response and the above documentation are in concordance, the nurse will then document on the pre-procedure checklist or nurse’s notes that the patient confirmed the site identification.
   - If the patient is unwilling to verify the above information, the nurse will notify the operating physician / interventionalist. This refusal will be documented in the patient record.
   - If the patient is not capable of verbalizing their correct identity, correct site and/or correct procedure, a family member or significant other will be asked to verbalize the information as above.
   - If a family member or significant other is unavailable or unwilling to verify the correct person, correct site or correct procedure, the nurse will notify the operating physician / interventionalist. This will be documented in the patient record.
• If the patient and the above documentation are **NOT** in concordance, the nurse will contact the surgeon / interventionalist who must verify the correct patient, correct site or correct procedure on the informed consent before the patient leaves the pre-operative / pre-procedure area.

• In the unusual circumstance that a patient is not seen in a pre-procedure or holding area and a procedure is being done under local anesthesia, the patient, physician and circulating nurse will confirm the correct person, correct site and correct procedure in the procedure room and the circulating nurse will document this confirmation process.

• If there is missing information or a discrepancy, this must be resolved prior to initiation of the procedure.

B. Marking the Procedure Site:

1. Site identification marking must be performed by the operating physician / interventionalist before the patient is moved to the location where the procedure will be performed. The marking must take place with patient involved, awake and aware, if possible. Any patient undergoing an inpatient or outpatient surgical or other invasive procedure where Right / Left distinction applies must have the side marked as “Correct” or “C”.

2. For all cases involving multiple structures (such as fingers or toes), the correct site and total number of structures must be marked for each of the areas involved in the procedure (i.e., C-3 for 3 toes).

3. If it is not feasible for the person performing the procedure to mark the site, the procedure site must be marked by a licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or nonsurgical invasive procedure. This individual will be involved directly in the procedure and will be present at the time the procedure is performed.

   If the person marking the site is not the operating physician / interventionalist, the operating physician / interventionalist must personally initial the correct site(s) as confirmation prior to the patient being anesthetized. The confirmation must take place in the holding room and must be separate and distinct from the final “Time Out” process.

4. **The mark must be positioned to be visible after the patient has his or her skin prepped, is in his or her final position, and sterile draping is completed.**

5. Marking may be done with a standard surgical marking pen, so as not to cause permanent staining after the procedure. If a skin prep is required, marking will be done prior to the prep and must remain visible after the prep. Re-marking with a sterile marker may be done at the request of the operating physician / interventionalist.

6. The mark is to be made directly on the patient’s skin as near to the incision / puncture site as possible. Marking tape and attaching the tape to the patient or other similar marking methodologies are not an acceptable alternative(s).

7. For spinal surgery, a two stage mark process is required. First, the general level of the procedure (cervical, thoracic, or lumbar) must be marked pre-operatively as above. If
the approach involves an anterior versus posterior, or right versus left, then the mark must indicate this. Then, intraoperatively, the exact interspace(s) to be operated on should be precisely marked using standard intraoperative radiographic marking technique.

8. For facial or eye surgery, the surgeon will mark “C” over the correct side. Post-procedure post anesthetic care staff will attempt to remove any facial site identification marks.

9. For teeth, indicate the operative tooth name(s) and universal number on documentation and mark on dental radiograph or dental diagram. The dental documentation, images and/or diagrams are available in the procedure room before the start of the procedure.

10. All patients undergoing a procedure (either laparoscopic or an open procedure) on internal organs that are paired or “sided” will be marked. For laparoscopic procedures if the target is for organs that are paired, site marking is required to indicate the intended side, even though the site of insertion of the instrument is in the midline. The mark must be positioned to be visible after the patient is prepped and draped.

For any procedure performed in the prone position, the person performing the procedure shall mark the correct side so that the mark(s) will be visible to the procedure team. If identical bilateral procedures are to be done, both sides should be marked “Correct” or “C” (if facial surgery, both sides should be marked “Correct” or “C” and numbered as 2).

11. If the patient refuses to allow the surgeon / interventionalist to mark the site, this will be documented in the medical record and the patient will be asked to sign the refusal note.

12. A defined, alternative process is in place for patients who cannot easily be marked under the following conditions:
   • For cases in which it is technically or anatomically impossible or impractical to mark the site (i.e., mucosal surfaces, premature infants), an alternative method for visually identifying the correct side and site is used. A temporary, unique band or other physical identifier will be placed on the side of the procedure containing the patient’s name, date of birth / medical record #, and side/site. The operating physician / interventionalist must apply the band.
   • For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or near the insertion site, and remains visible after completion of the skin prep and sterile draping.

All temporary wristbands or other physical identifiers used will be removed after the procedure is completed.

13. All efforts should be made to comply with the above marking process; however, the patient’s treatment must take precedence. If emergent treatment prevented site marking, the reason must be documented by the surgeon / interventionalist in the physician progress notes.
Exemptions:

- Midline, single organ procedures (e.g., Cesarean section, cardiac surgery)
- Endoscopies without intended laterality
- Interventional cases for which the catheter / instrument insertion site is not predetermined or where the entrance site laterality is of no consequence to the procedure (e.g., cardiac catheterization)
- An obvious wound or lesion that is the site of the intended procedure. However, if there are multiple wounds or lesions and only some of them are to be treated, and the decision and direction for which ones are to be treated is determined at some time prior to the procedure itself, then the sites to be treated should be marked as soon as possible after the decision is made
- Bilateral procedures, where there is an identical procedure, surgical team and equipment, site marking is recommended but not required
- If the individual performing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent is obtained up to the time of the procedure itself, then site marking is not required. Examples of such procedures include PICC line, Dialysis / other angio catheters and central lines. However, the requirements for pre-procedure verification and final “time-out” still apply.

C. “Time-Out” Immediately Before Starting the Procedure:

1. A final “time-out” verification will be completed in the operating or procedure room just prior to incision / procedure, with all members of the operative or procedure team present (i.e., surgeon(s), interventionalist(s), anesthesia provider(s) circulating nurse, scrub nurse, resident, operating room / interventional technician, etc.).

Whenever there is more than one procedure being performed on the same patient by separate procedure teams, there will be a time-out prior to each team commencing their procedure. This does not apply to those situations where the same team is performing multiple components during a single procedure. It does apply, however, to procedures requiring two separate consents. Two separate time-outs should occur for these situations.

2. The surgeon / interventionalist will initiate the time-out process and all of the members of the team will verbally concur with the following:
   - Correct Patient Identity
   - Confirmation that the correct side and site(s) are marked
   - An accurate procedure consent form
   - Agreement on procedure(s) to be done
   - Correct Patient Position
   - Relevant images and results are properly labeled and appropriately displayed
   - The need to administer antibiotics or fluids for irrigation purposes
   - Safety precautions based on patient history or medication use

Any team member is able to express concerns about the procedure verification.

3. During the time-out, other activities are suspended, 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.

4. If the patient’s identification, surgical / interventional procedure, side, site, etc., are NOT in concordance, the surgeon / interventionalist must resolve this issue prior to initiating the procedure and all team members must verbally concur.

5. The circulating nurse or interventional nurse / technician will ensure that this final time-out verification of the correct patient, procedure, side and site, position, relevant images and results properly labeled and displayed, need to administer antibiotics or fluids for irrigation purposes and safety precautions based on patient history or medication use is documented. The documentation will note the successful completion of the time-out and not each individual component of the time-out process on the medical record.

6. No procedure will proceed if the surgeon / interventionalist does not participate in the time-out.

D. Change in Responsibility for Care:

Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers) at the time of, and during the procedure, verification of the correct person, correct site and correct procedure will take place.

E. Non-OR Settings:

Procedures for non-OR settings including bedside procedures, will follow the same pre-procedure, site marking and time-out processes as stated above. If the individual performing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent is obtained up to the time of the procedure itself, then site marking is not required. However, the requirements for pre-procedure verification and final “time-out” verification still apply.

F. Documentation Requirements:

The completed components of the pre-procedure verification, site marking and time-out processes are documented on the medical record.

Requirements:

Approvals: JSUMC Medical Executive Committee: 2004
OMC Medical Executive Committee: 2004
RMC Medical Executive Committee: 2004
Medical Council: 2004


2008 World Health Organization (WHO) Surgical Safety Checklist