UNIVERSAL PROTOCOL

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Cross Referenced: HRMC Surgical Services	**Origin: Administration**
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SCOPE

Applies to all Providers, nursing staff and technicians in the inpatient and outpatient areas, that are involved with invasive procedures/surgical procedures.

PURPOSE

The purpose of this policy is to establish guidelines that prevent the occurrence of a wrong site, wrong side, wrong procedure and/or wrong person procedure and eliminate the risk through communication with the patient/family and healthcare team prior to the start of any invasive procedure/surgery.

DEFINITIONS

I. Wrong Site Procedure: The Joint Commission defines wrong site procedure as a procedure on the wrong patient or wrong body part.

II. Invasive Procedure: A procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body. Invasive procedures include anesthesia procedures performed either prior to or during a surgical procedure.

POLICY

I. Universal protocol applies to all operative and other invasive procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room, such as a special procedures unit, emergency rooms, endoscopy unit, or an interventional radiology suite.

II. Certain routine procedures such as venipuncture, peripheral IV line placement, insertion of NasoGastric tube, or urinary catheter insertion are not within the scope of the protocol.

III. Almost all procedures that involve puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this protocol.

IV. Hackettstown Regional Medical Center (HRMC) follows the Joint Commission Universal Protocol with the goal of eliminating wrong site, wrong procedure, and wrong person surgery.

PROCEDURE

I. Preoperative Verification:

In the pre-procedure/preoperative area and prior to the start of any invasive procedure or surgical procedure, confirmation of correct site, procedure, and patient has been completed and documented in a collaborative manner by the team involved in the procedure.   Verification of the correct person, procedure, and site should occur during the following (as applicable):

A. At the time the surgery/procedure is scheduled.
B. At the time of admission or entry into the facility.
C. Anytime the responsibility for care of the patient is transferred to another caregiver.

D. With the patient involved, awake and aware, if possible.
E. Before the patient leaves the preoperative area or enters the procedure/surgical room.
F. The following patient identifiers will be used to verify a patient identity: Name, medical record number/ FIN # or date of birth.
G. The process of site verification shall be followed for all invasive procedures/surgical procedures.
H. For procedures involving an anatomical site that has laterality, the word(s) right, left, or bilateral will be written out fully on the procedure/OR schedule and all relevant documentation (e.g., consent).

II. Site Marking:

A. All patients throughout the facility having an invasive procedure/surgical procedure that involves laterality, multiple structures, (e.g., fingers and toes), laterality accessed through a natural body orifice, or multiple levels (e.g., spinal surgery), must have their site marked.
B. Procedures exempt from site marking include C-sections, gastroenterology, tonsillectomies, hemorrhoidectomy, teeth, or premature infants. In the case of teeth the operative tooth name and description will be documented in the patient record and identified on the radiograph if applicable. Marking of invasive cases for which catheter and instrument site is not predetermined (e.g., pacemaker, IVC filters) is an exception to skin marking.
C. The physician must mark the procedure/surgical site(s) with his/her initials prior to the patient entering the procedure/operating room. Exception: Eyes may be marked with a pen by either a dot over the eye or the word “yes” over the eye.
D. When applicable, the site must be marked with a permanent marker that must be visible after the skin prep and drape is applied.
E. In the event that the patient refuses to have the site marked, a member of the surgical/procedure team will fill out a temporary, paper ID band that indicates the procedure and correct site of the surgery. The band will be put on the patient’s arm corresponding to the operative side and validated with the physician.
F. The non-operative site should not be marked.
G. The patient should be involved in the process to the extent possible by verbalizing the procedure to be done and/or pointing to the site/side.
H. If the patient is a minor, the parent or guardian will confirm the site. If the patient has not signed his/her own consent, and is unable to verify the surgical site, one physician will mark the correct surgical/procedure site and a second physician or RN will act as witness. Documentation will be made in the patient’s record.

III. Time Out Immediately Before Starting the Procedure

A. Time out is the final verification of the correct patient, correct side, correct site and correct implant, as applicable, and is to be done prior to the start of any surgical or invasive procedure.

B. Once the patient has been prepped and draped and the site mark is visible, a "time out" must be verbally performed to validate correct patient, correct site, correct procedure, correct position, correct radiological exams, and correct implant/instruments, etc. are present and correct before continuing with the procedure.
C. The "time out" must be done in the location where the procedure is to be performed, before the start of the case (prior to any instrument being passed).
D. Preoperative verification and "time out" will be performed for all cases, including those not involving a site mark, except in an emergency if the benefits outweigh the risks.
E. All team members must "STOP" and participate in the time out. If this does not occur, the designated staff member who initiates the time out immediately will notify the OR Director, Charge Nurse/Manager, and Chief of Anesthesiology, Chief of Surgery, or designee.
F. If the site marking will not be visible once the patient is prepped and draped, a temporary, paper ID band that indicates the procedure and correct site of the surgery will be put on the patient's arm corresponding to the procedural/operative side and validated with the physician.
G. The "Time Out" must involve the entire procedural/operative team, can be initiated by any of the operative team members, must use active and clear communication, and must, at least include:
   a) Identification of the patient via the hospital two-identifiers, i.e. Name, medical record number/ FIN # or date of birth.
   b) Identification of the correct site and correct side
   c) Procedure to be performed, accurate procedure consent form, and proper patient position
   d) Availability of implants and any special equipment or special requirements
   e) Radiological review, if applicable
   f) Safety precautions based on patient history or medication use**.**
H. Time out applies to all invasive procedures regardless of location (i.e., all nursing units, radiology, endoscopy, labor and delivery, etc.) and must be conducted in the location where the procedure is to be done after the patient is prepped and draped and before the procedure begins.
I. The "time out" may also include SCIP (Surgical Care Improvement Project) measures: Venous thromboembolism, pre- procedural antibiotic prophylaxis, and etc.
J. Time out and site verification are documented on a Universal Protocol Checklist by the designated team member. Confirmatory time out should occur if a new surgeon arrives and is assuming primary responsibility for the case, or if the patient/operative site is re-draped. All elements of the time out protocol must be repeated.
K. If there is any discrepancy in information identified by any team member of the surgical/procedure team during the time out, the procedure must be stopped until the discrepancy is resolved.

IV. Procedures Performed Outside the OR

A. Persons performing the procedure must conduct and document the time out confirming all of the above information with another person when possible.

V. Discrepancy:

A. A discrepancy at any point in time **must** stop the case from proceeding until it is resolved.
B. All team members and patient (if possible) must agree on the resolution(s) to the identified discrepancy.
C. The physician and/or RN must document the discrepancy and resolution in the patient record.

VI. Documentation:

The Universal Protocol including verification and "Time Out" will be documented in the electronic medical record (EMR) in departments that utilize the EMR and all other departments will utilize the standard Universal Protocol Verification template (see Appendix A) that will be integrated into the permanent medical record. Exception: The Wound Care Center will document the "Time-Out" on the "Treatments/Procedures" form.

REFERENCES

WHO (World Health Organization)
AORN, www.aorn.org 2014 Recommendations
Joint Commission Universal Protocol www.jointcommission.org
VA National Center for Patient Safety, www.patientsafety.gov/CorrSurgFACQs.doc
The Association of Perioperative Registered Nurses (AORN), the American College of Surgeons (ACS), the American Society of Anesthesiologists (ASA), the American Hospital Association (AHA), World Health Organization (WHO) and more than 40 other professional organizations have endorsed the use of the Joint Commission Universal Protocol.

Date: ____________________ **Procedure:** ______________________________

SECTION 1: Patient Verification

Person Completing Verification of Patient ☐ Patient ☐ Other:________________

☐ YES ☐ No Patient identifiers are checked (Name, Medical Record number and/or date of birth)

☐ YES ☐ No Identifiers match ID band, consents, x-rays and/or any other relevant data.

Signature: __________________________ **Date:** ________________ **Time:** ______________

SECTION 2: Procedure/Site Verification

☐ YES ☐ No Patient states procedure to be performed and point to site.

☐ YES ☐ No Patient's informed consent describes the operative/procedural site and laterality as described by patient.

☐ YES ☐ No All relevant data in the medical record is consistent with patient response.

☐ YES ☐ No Invasive procedure schedule/operative schedule is consistent with patient response.

☐ YES ☐ N/A Invasive or surgical site is marked over or adjacent to the surgical/procedural site incision.

Signature: __________________________ **Date:** ________________ **Time:** ______________

SECTION 3: Intraoperative

☐ YES ☐ No Confirms: Patient identity, consent(s), patient position, operative procedure, laterality, and site mark.

☐ YES ☐ No Review medical record for consistency in identifying the correct surgical site or procedural site.

☐ YES ☐ N/A **(Procedural/Operating Physician)** hangs imaging studies and confirms patient identity and surgical site.

☐ YES ☐ N/A If digital x-ray images are performed and displayed on the computer monitor or taken intraoperatively, the patient identity and surgical site should be confirmed.

☐ YES ☐ N/A Implants system available.

☐ YES ☐ N/A Special equipment available.

☐ YES ☐ N/A Sterilization indicators confirmed where applicable.

☐ YES ☐ No Any Concerns?____

Signature: __________________________ **Date:** ________________ **Time:** ______________

☐ **"Time Out"** immediately before start of the procedure for final verification of correct patient, correct site, correct procedure, x-rays and displayed appropriately on the correct patient. Site mark visible after draping when applicable.

Signature: __________________________ **Date:** ________________ **Time:** ______________

Document members present for "Time Out"

MD:___________________________ Circulator:_______________ Other:_________________

Anesthesia:_____________________ Scrub:__________________ First Assist: _____________

Discrepancy : ☐Yes ☐No, if any found, describe the discrepancy and the actions taken to resolve it in notes

Procedurist Notified: ☐Yes ☐No Time:_____

Resolution:

☐ Final site/side verified by Procedurist

☐ Final site/side communicated with team by ☐ Procedurist

☐ Case Held Pending Resolution

☐ Case Cancelled/rescheduled

Other: ________________________________

Antibiotic Administration within one hour.

Administered: ☐Yes ☐No ☐N/A ☐See eMAR

Antibiotic Type: __________________

Started: Date:_____ Time: _____

Started by:______________________

Patient Label

Universal Protocol / Time Out

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