LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

CORRECT SITE UNIVERSAL PROTOCOL POLICY FOR INVASIVE/SURGICAL PROCEDURES

Purpose:

To promote patient safety by providing guidelines for verification of correct site, correct procedure, and correct patient for invasive/surgical procedure(s). This policy applies to all invasive/surgical procedures including bedside invasive procedures performed at the facility. This policy does not apply to venipuncture, peripheral IV placement, insertion of nasogastric tube or insertion of a Foley catheter.

Procedure:

I. Scheduling

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

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

1. The correct spelling of the patient’s full name;

2. Medical Record number (Date of birth is used when a medical record number is unavailable)

3. Procedure to be performed; and

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 and all relevant documentation (e.g., consents).

D. Any discrepancies in data should be clarified with the physician.

II. Pre-procedure/Preoperative Verification

A. The registered nurse, radiographer or other healthcare professional will verify patient’s identity by asking the patient
to state his or her full name, date of birth and procedure/surgery to 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 patients’ family, health care proxy agent, interpreter, or legal guardian) should complete the identifiers and verify site mark as per Hospital Informed Consent Policy.

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.

E. In an emergency situation, consent for treatment is implied, allowing treatment to proceed without obtaining written patient consent. Emergency situation is defined as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the health of the individual in serious jeopardy,
2. serious impairment of bodily functions, or
3. serious dysfunction of a bodily organ.

A. If any of the above guidelines cannot be followed, the attending physician must write a detailed explanation of the extenuating circumstances in the medical record.

III SITE MARK—Preferably, completed before patient enters procedure/operating room

A. When is a site mark required?

1. All patients having an invasive/surgical procedure that involves:
a. Laterality (right, left, etc.)

b. Multiple structures, (e.g., fingers, toes, lesions); and/or

c. Multiple levels (e.g., spine) across the facility must have their site marked

d. This includes bedside invasive procedures.

B. Procedures exempt from site marking, but these procedures must still abide by all other policy guidelines:

1. Gastroenterology endoscopic cases;

2. Tonsillectomy;

3. Hemorroidectomy;

4. Single organ cases (C-section, cardiac surgery);

5. Teeth (In the case of teeth, the operative tooth name will be documented in the patient record OR marked on the dental radiographs/dental diagram.);

6. Interventional cases for which catheter (e.g., cardiac catheterization, uldalls, central venous lines, arterial lines, pulmonary artery catheters, etc.) and instrument site is not predetermined;

7. Premature infants for whom the mark may cause a permanent tattoo, and

8. In the case of a surgical emergency, a site mark may be omitted, but a surgical “time out” should be performed unless the risk outweighs the benefit.

C. Procedures for Site Marking:

1. Prior to marking the site(s), the physician performing the procedure/surgery verifies the patient’s identify, consent(s), medical record data including history and physical, and radiographs (as applicable) to confirm accuracy.
2. The physician performing the procedure/surgery asks the patient to state the procedure(s) and site(s)/side(s) of surgery as well as point to the site(s).
   a. If the patient is a minor or unable to verify the information for his or herself, the verification process must, as possible, take place with parent, legal guardian, etc. as per informed consent policy.
   b. If a telephone site marking verification is obtained, the healthcare provider who is the witness should ask the next of kin the following questions:
      1) Identification of the person on the telephone;
      2) Affirm the relationship to the patient;
      3) What is the patient’s date of birth?
      4) What type of procedure is being performed?
      5) What procedure site(s) did the MD state would be used?

3. Preferably, the site mark is completed before the patient enters the procedure/operating room. A site mark will be made at or adjacent to the incision site, and must be visible after the patient is prepped and draped.

4. If used, adhesive markers must only be used as an adjunct to the site marking.

5. The physician performing the procedure will definitely mark the procedure site prior to induction of anesthesia, using an indelible, hypoallergenic, latex-free, skin marker. The marking shall be clear and unambiguous. It is unacceptable to mark with an “X” or use the word “No”. It is recommended that SS be used to mark the procedure site(s).
6. Non-operative (s) will not be marked unless medically indicated (e.g., pedal pulse markings or no BP cuff).

7. A sterile indelible marker may be placed on the prep tray. In the event the site mark is removed during the surgical/procedure prep, the qualified RN or another member of the surgical team who is fully informed about the patient and the intended procedure may reapply the site mark steriley in the presence of the physician performing the procedure. The Qualified RN must be a member of the surgical team and have documented knowledge, skills and abilities to reapply the procedure site mark(s).

8. Patient Refusal Procedures for Site Marking - If a patient refuses to have the site marked, the patient’s physician will review with the patient the rationale for site marking. Documentation of patient refusal is documented in the medical record.

D. Special Site Marking Requirements:

1. Multiple sides or sites - If the procedure involves multiple sites/sides during the same operation, each side and site must be marked.

2. Spine Surgery
   a. Preoperatively, the skin is marked in the general spinal region; and
   b. Special radiographic techniques are used for marking the exact vertebral level.

3. Laparoscopic surgery - The surgical site will be marked 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.

4. Dental Surgery
   a. Teeth do not need to be marked.
b. 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.

c. Radiographs will be checked for proper orientation and visually confirm correct teeth or tissue charted.

5. Skin Integrity that is not Intact

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

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

6. Emergency Procedure - Site marking may be waived in critical emergencies at the discretion of the operating physician, but a “time out” or pause should be conducted unless there is more risk than benefit to the patient.

7. Bedside procedures (e.g., chest tube insertion, etc.)

a. If the person performing the procedure leaves the bedside at any point, the site/side must be marked prior to the procedure.

b. However, if the person performing the procedure is in continuous attendance from the time the diagnosis is made until the procedure begins and performs the following:

1) identifies the patient and confirms all data, including consent, history and physical, and radiographs, then,

2) he/she may perform the procedure without marking the site.

3) A “time out” must still occur with all parties involved in the procedure prior to the start of the procedure and must be documented in the medical record.
VI. “TIME OUT” in the procedure/operating/room/bedside/ treatment room

A. The patient enters the procedure/operating room and the nurse/radiographer/healthcare professional will confirm:
   1. identity of the patient,
   2. procedure, and
   3. site.

B. The physician performing the procedure/surgery 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” or pause must be done in the location where the procedure is to be performed, immediately before the start of the case by the entire procedure/surgical team. The patient does not have to be awake for the “time out”. Even when there is only one person doing the procedure, a brief pause to confirm the correct patient, procedure and site is appropriate. It is not necessary to engage others in this verification process if they would not otherwise be involved in the procedure.

D. Site marking must be visible at the “time out” or pause.

E. The time out requires confirmation of:
   1. Correct patient,
   2. Correct side/site,
   3. Correct procedure,
   4. Correct patient position,
   5. Correct radiographs, and
   6. Correct implants and equipment.

F. “Time out” will be documented in the medical record. The documentation should include:
1. Personnel present at the time out
2. Verification of correct patient,
3. Verification of correct side and site,
4. Agreement on the procedure,
5. Verification of the correct position, and
6. Available implants and equipment.

V. Procedure for Managing Discrepancies

A. A discrepancy at any point must stop the case from proceeding until resolved.

B. All team members and patient (if possible) must agree on the resolution(s) to the identified discrepancy.

C. The discrepancy and resolution must be documented by the physician, registered nurse, radiology technician or other appropriate healthcare professional involved in the case.

VI. Removal of the Site Mark - At the end of the case, staff should attempt to remove the site mark in the event that the patient will be having subsequent surgical/invasive procedures

VII. If any of these guidelines cannot be followed, the attending physician must write a detailed explanation of the extenuating circumstances in the medical record.

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Administrator

7/02/04
Date