General Information

Policy Name:	Verification of Patient - Side & Site
Category:	Surgical Services
Applies To:	All Units: This policy/procedure 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 special procedure units, endoscopy suite or interventional radiology suites.
Key Words:	Side, Site, Verification, Identification, Marking, Time, Out, Implants
Associated Forms & Policies:	Medical Staff Bylaws Consents (P0535) Chain of Command (P1162) Occurrences (Significant), Reporting of (P1302) Patient Identification (P0635) Sensory Impaired & Limited English Proficient Persons Services (P0226) Perioperative Nursing Plan (Doc #3350) Pre Procedure Verification Checklist (Doc #5713A)
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Policy

This policy/procedure applies to all operative and other invasive procedures that fall under the definition of surgery (see definition section) and that expose patients to more than minimal risk, including procedures done in settings other than the operating room such as special procedure units, endoscopy suite or interventional radiology suites.

Certain routine "minor" procedures such as venipuncture, peripheral IV line placement, insertion of nasogastric tube, or Foley catheter insertion are not within the scope of this policy/procedure. However, most other procedures that involve puncture or incision of skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies and closed reductions for major dislocations or fractures requiring moderate or deep sedation are within the scope of this policy/procedure.

Additionally, this policy/procedure is intended to apply to those anesthesia procedures performed prior to a surgical procedure (e.g. regional block-brachial plexus) or independently (e.g. spinal facet blocks).

Crouse Hospital staff and physicians will provide a standard procedure with multiple checks in the system to minimize the risk of wrong patient, site, side or procedure during surgery/procedure. The process is a coordinated effort between the patient, the attending surgeon/proceduralist (to include Endoscopist) of record, the nurses and the rest of the surgical/procedure team including anesthesiologists/CRNA and anyone else

assisting in any way. The process requires all persons involved in the patient's care to confirm patient identification, proposed procedure, including side/site. Never assume the task has been correctly performed by another individual.

Patients with physical or cognitive barriers to hearing or to understanding the surgical/procedural process must have whatever aids or support necessary to facilitate understanding. This may include an interpreter and/or guardian in attendance with them at the time consent is obtained and the surgical site is marked. For more information on Interpretative services: Refer to Sensory Impaired & Limited English Proficient Persons Services (P0226))

Patient identification is verified by requesting the patient to state his/her full first and last name, or in the case of a child, the parent/guardian.

Note: Asking the patient to affirm his/her name such as "Are you John Doe?" is not acceptable.

A second identifier, the date of birth, is requested for all instances of patient identification. Additional information such as physician name may be requested. If the patient is unable to provide this information, a family member, guardian or significant other may supply it. (Refer to Patient Identification (P0635))

Procedure

I. Scheduling:

The scheduling of inpatients and outpatients for all operating room procedures, Interventional Radiological, Endoscopy or non-OR procedures is done through the appropriate computer system (E.g. ORMIS, IDX, etc.) or log.

The scheduling of a procedure for both OR and non-OR procedures must include:

A. Patient identification using the patient's full first and last name and date of birth.

B. Entire procedure, exact site, level, digit, and side/laterality (including spelling out "Left", "Right" and "Bilateral" – no abbreviations other than C-Cervical, T-Thoracic, L-Lumber, S-Sacral when identifying spinal levels (e.g. L4-5) are accepted.

C. Specific information on implant/implant system and/or equipment.

D. Specific information on removal of device.

E. Information on harvest and donor sites.

F. The Surgical Registrar or the person responsible for accepting requests to schedule procedures must verify the information provided by the surgeon/physician. The information is verified with the physician/physician designee scheduling the procedure in a mutually agreed upon way (e.g. "read back", fax or email). This "read back" is documented in either the computer system or on the log. Areas other than surgical registrar accepting an add-on must read back procedure for verification and document that read back on the add-on form or log.

G. At the completion of that phone call, the Surgical Registrar initiates a phone call to the second surgeon's office. At that time, the Surgical Registrar confirms procedure, side and site WITHOUT prompting. The office is asked to state the procedure, including side and site.

H. In the event a procedure involves two surgeon's offices, the Surgical Registrar will take the information from the office scheduling the procedure and initiates a phone call to the second surgeon's office. The following information is obtained without prompting.

1. The registrar will verify the patient using two identifiers (see A).
2. The entire procedure exact site, level, digit, and side/laterality is completed as above (see B.)
3. Specific information of implant/implant system and/or equipment.

4. Specific information on removal of device.
5. Information on harvest or donor sites.
6. At the completion of that phone call, this confirmation is noted in the Scheduling system.

II. Consent Documentation for OR and non-OR procedures

Consent documentation must include:

A. First and last name, date of birth of patient and medical record number of the patient.

B. Name and description of surgery or procedure in terms that are understandable to the patient (correct site/side, level and digit with the side spelled out as “Left,” “Right” or “Bilateral”).

1. No acronyms or abbreviations (except spinal levels noted in section 1 above).
2. Specific implant/implant system to be placed or device to be removed.
3. Patient/family, guardian, healthcare agent signature and date.
4. Witness signature and date.
5. Physician signature and date.
6. If the consent is altered or illegible it must be re-done and re-signed by all parties.

III. Pre-Operative/Pre-Procedural Verification Process:

A. Verification of the correct person, procedure, site and side must occur (as applicable):

1. At the time the surgery or invasive procedure is scheduled.
2. At the time of admission or entry into the facility.
3. With the patient involved, awake and aware, if possible.
4. Anytime the responsibility for care of the patient is transferred to another caregiver or location in the pre-operative or pre-procedural process.
5. Before the patient leaves the pre-operative area or enters the procedure/surgical room.
6. In ALL clinical settings where invasive procedures are performed, including but not limited to operating room, endoscopy suites, catheterization laboratories, general and interventional radiology suites, nuclear medicine, radiation therapy clinics, intensive care units, labor and delivery areas, emergency departments, Outpatient Clinics, etc.

   Note: Benefits are realized for patients when these processes are applied in bedside procedures.

B. Day of the Procedure (MISC, POBSC, WSC)

On the day of the procedure the MISC, POBSC, and WSC will use a three person independent verification process. The attending surgeon/Endoscopist/Proceduralist, the anesthesiologist/CRNA (when applicable), and the RN must provide this verification independently of one another. Documentation is done on the operative or procedural consent. They are verifying for accuracy of the patient identification and procedure including side and site.

C. Preoperative/Pre-procedural

A pre-operative or pre-procedural verification checklist must be utilized to ensure availability and actual review of the following, prior to the start of the procedure: In the Operating Room the Perioperative Plan of Care includes the verification checklist. In areas outside the OR, the

checklist specific to the area is utilized. (E.g. Doc #5713A, Doc #3350, etc.) The completion of the Checklist is the responsibility of the RN**.**

Documentation is expected on the designated form and the form is signed with a signature, title of each individual, and date of completion. The following components of the verification process are documented on the checklist:

A relevant current patient History & Physical completed and updated timely by the surgeon/proceduralist as outlined by the Medical Staff Rules and Regulations. The History & Physical is current within 30 days and is dated per Crouse Hospital policy. **Any H & P performed GREATER than 30 days prior to surgery MUST be re-done.** A history and physical update is required at the time of or within 24 hours of admission/ operative invasive procedure.

- Signed consent.
  - The consent must be signed and dated by the patient/legal representative, surgeon/proceduralist, and a witness.
  - Consent is verified for correct patient, correct procedure, correct side, site, level or digit with the appropriate schedule/log and the H&P.
- Relevant images (e.g. films, photographs) are properly labeled and displayed. (See below D for Surgeon/proceduralist responsibility).
  - Studies, images, films or photographs are labeled with patient's first and last name, a second patient identifier, the date of study and are displayed in correct Left/Right orientation as confirmed by the RN circulator in the OR or in other non-OR areas by someone other than the primary surgeon/ proceduralist.
- Relevant Diagnostic reports or studies (e.g. ultrasound, endoscopy, etc.) are available.
- Relevant pathology reports are available.
- Blood products confirmed *
- Necessary patient specific implants and equipment are available.
- Pre-Operative medications are administered as ordered.*
- Glycemic control (time and result of fingerstick and any action taken).*
- Patient identification is verified utilizing two unique identifiers including the full first and last name of the patient and a second identifier per the Administrative Policy on Patient Identification. This information is compared to the patient identification bracelet and the medical record. Note: Second identifiers are date of birth, medical record number, or the patient account number. (For more information refer to Patient Identification (P0635).
- When the patient is able, the planned procedure is confirmed with the patient/guardian including asking the patient to state the procedure, side and site.
- When the patient is able to confirm, the patient reported procedure is compared to the schedule/log, consent and history and physical for agreement.
- The side and site marking is confirmed against the history and physical, consent and patient reporting.

* Applies to Operating Rooms only.

D. Studies, Images, Films, or photographs

The Surgeon/proceduralist is responsible for assessing what studies, images, films, or photographs are appropriate for viewing before and during surgery/procedure. If the surgeon/proceduralist determines the procedure to be High Risk, the surgeon/proceduralist should review the images together with the radiologist pre-operatively. The person reviewing the images with the surgeon/proceduralist should be documented including the name, title, and date of review in the dictated operative note or medical record progress note.

When the timeout is done at the bedside the proceduralist performing the verification will include a review of relevant reports when images are not available (reports include lab, diagnostic, pathology, radiology, and other studies.)

When intra-operative imaging studies are performed, appropriate consultation should be available for interpretation of intra-operative studies. The individual providing the consultation is noted by name and title in the dictated post operative note.

E. Marking of Surgical or Procedural Side/Site:

1. The physician/dentist/podiatrist/proceduralist doing the procedure must do the site marking using his/her own initials. Site marking must be legible and unambiguous **(See G for exceptions.)**

   Note: If the surgeon's/proceduralist's initials are "N.O.", utilize three initials.

2. **All sites involving laterality (including bilateral sites) must be marked. Examples include brain, paired organs, multiple structures such as fingers, toes, hernias, lesions, or multiple levels of the spine. See G for exceptions. The mark must be at or near the incision sites(s) so that it/they are visible after the patient is draped. (See G for exceptions.)**
3. For hand and foot surgery, the surgeon must mark the surface(s) of the digit(s) to be operated on, anterior, posterior or both based on the operative site. The involved digit **MUST BE** marked.
4. The appropriate site must be verified before any cast is split. For relevant orthopedic cases, the skin/site should be marked immediately after cast/splint is removed.
5. For surgery of the spine, pre-operative skin marking is required to indicate laterality, when appropriate. A second time out must be performed when the intra-operative imaging is done to confirm the level. This second time out must be documented on the Peri-operative Plan of Care.
6. When the site or level is not visually identifiable, the surgeon must obtain an intra-operative image, using markers that will not move, to confirm the exact level/site.
7. **DO NOT** mark any non-operative site(s).
8. The mark must be visible in the operative or procedural field after the patient is prepped and draped.
9. The mark must be made using an FDA approved marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
10. In the event of multiple surgical procedures by different surgeons, all relevant surgical sites must be marked prior to the first surgery. The surgeon marking the site must be present for and participate in the "time out" performed for each procedure he/she marks.
11. Marking must take place with the patient/family involved, awake and aware, if possible.

12. A special purpose wrist band (SPWB) must be used for patients:
    - Who refuse marking.
    - Problematic surgical sites to mark (e.g. perineum or anus) or when marking can be done only after shaving a patient's head, prior to a neurosurgical/cranial procedure.
    - In neonates as marking may cause a permanent tattoo.
    - Duoderm initialed by the surgeon is utilized as the initials marking the surgical site for neonate laser eye surgery.
13. When the SPWB is utilized:
    - The RN confirms pt. Identification, procedure including side and site per policy.
    - The RN transcribes the procedure written on the operative consent on to the SPWB.
    - The RN then asks the surgeon to confirm and initial the SPWB.
    - The surgeon will then place the SPWB on the patient's wrist – on the intended anatomical side. **Example:** Place SPWB on left wrist for left oophorectomy.
14. Final verification of the site mark must take place during the "time out."
    - When utilizing a SPWB during the timeout the RN will visualize and read from the SPWB along with the operative consent.
    - In the event the SPWB will not be visible or accessible during the timeout:
        - The RN will remove the band once the patient has been anesthetized
        - The RN will utilize the SPWB along with the operative consent to confirm procedure side and site during timeout.
15. Spinal block for pain management or epidural does not require an intra-operative marker if fluoroscopy is used. However, it does require skin marking.
16. If a small mark is necessary, such as near the eye in Pediatric Ophthalmology cases, a dot near the eye constitutes the site marking. A special purpose wrist band may also be utilized.

    Note: If the patient arrives at the hospital with the site marked by him/her, the surgeon's/ proceduralist's initials must still be added to the surgical/procedural site.

F. Patient Refusal to Allow Marking:

Should the patient be unable to participate in the marking process or refuse to have the surgical/ operative/procedural site marked, this will be noted on the consent form in the verification portion section which is signed, dated, and timed by the surgeon/proceduralist.

G. Exceptions to Site Marking:

1. Single organ cases, which do not involve laterality (e.g. hysterectomy, appendectomy).
2. Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g. cardiac catheterization).
3. Dental cases, where the operative tooth number or name(s) can be indicated on documentation or the operative tooth (teeth) including laterality can be marked on the dental radiographs or dental diagram.
4. Endoscopic or other procedures done through a midline orifice.
5. Situations in which a primary pathology itself is plainly visible (single laceration).
6. When the operative pathology has been identified by real time imaging in the immediate pre-operative period such as for frameless stereotactic neurosurgical procedures or micro-calcifications in a breast biopsy.

7. Life threatening emergency when any delay in initiating the surgery/procedure would compromise the safety or outcome of the patient (e.g. ruptured aortic aneurysm).
8. When movement of a patient to create a marking would compromise the safety or outcome of the procedure (e.g. movement of a patient with an unstable spine fracture).

Note: A practitioner is NOT exempt from the site-marking requirement when he or she is in continuous attendance with the patient (from the time of the decision to do the procedure through the conduct of the procedure). The requirement for "time out" applies as well. This is based on reports of wrong-sided procedures being done despite the continued presence of the person performing the procedure from time to decision to completion of the procedure.

H. "TIME OUT" Immediately Before Starting the Procedure.

The purpose is to conduct a final verification of the correct patient, side/site, procedure, and as applicable, implants. The time out is a standardized procedure, and documentation indicates the procedure was followed in its entirety without deviation.

- The time out must be conducted in the location where the procedure will be done, after, the patient is prepped and draped and immediately before starting the procedure. This applies to all invasive procedures, including peripheral nerve blocks, performed in all settings.

  Note: For Peripheral Nerve Block:
  - Anesthesia will not perform a peripheral nerve block until after the surgeon has marked side and site.
  - The completed operative consent for surgery must be in the room. The block RN must ask the patient to state the site and side of surgery (with visual responses as appropriate such as pointing) and compare to the operative consent.
  - Area to be blocked must be completely uncovered.
  - The block RN will not dispense the block needle to the anesthesiologist until side and site verification is complete.
- All work ceases during the time out to allow all members of the team to focus on the time out. Note: For instances when the procedure is being performed without assistance it is strongly advised to enlist an observer or assistant to participate in the time out.
- It must involve the entire surgical/procedural team.
- The team must use active verbal communication including the surgeon verbally stating the procedure to be done and the participants in the time out must be documented.

NOTE: During the Time Out, the surgeon/proceduralist will state the procedure, including the side and site – the OR RN circulator will be reading from the operative consent and comparing to procedure stated by the surgeon.

In the event, the request is made for the OR RN circulator to state the procedure, including side and site as written on the operative consent – the surgeon will then repeat this information back, aloud.

- The time out is initiated in the OR by the circulating RN.
- In non-OR areas the time out is initiated and conducted by the proceduralist who can be assisted by the observer or assistant.
- Verification of the Patient Identification bracelet and chart takes place by the RN as the patient is brought into the room and before the "time out". The "time out" requires that all

participants agree on the information and does not require checking the Patient Identification bracelet at that time.

Time Out: The Time Out verifies the following:

- Correct patient identification, compared against the chart, utilizing the first and last name of the patient and a second unique identifier.
- Correct procedure to be performed and proper patient position
- Correct side(s) and site(s), level and digit.
- Correct site is marked and the mark is visible.
- Availability of special equipment/required implants/blood products as appropriate.
- Relevant images and results are properly labeled and appropriately displayed.
- Any red flags for anyone.

Time Out Documentation:

The above information must be confirmed with the medical record and should be documented on the Perioperative Plan of Care by the circulating RN along with the identification of all those who participated.

Additional Confirmatory "Time Out":

Additional Confirmatory "Time Out" should be undertaken if a new surgeon/proceduralist arrives and is assuming primary responsibility for the case, or if the patient/operative site is re-draped. The name of the patient and the procedure should be verified during this second timeout and documented per policy on the Peri-operative Plan of Care in the OR or the Procedural Checklist in all other areas.

Radiological Review:

All surgeons/proceduralists performing the operation/procedure are responsible for determining that the images to be displayed are relevant to the surgery/procedure and actively review them in the location where the procedure is to be performed immediately before the incision is made. A second team member, not the primary surgeon/proceduralist, confirms that the image belongs to the patient (utilizing the first and last name of the patient and a second identifier) and that the image is displayed in the correct orientation using markers on the image. In the OR the circulating RN confirms the images are for the correct patient and are in the correct orientation. In non OR areas, a second person (the RN) other than the proceduralist is responsible for confirming this.

The surgical/procedural team confirms the site and side of the lesion as part of the "time out."

For spinal cases in which an intra operative image is used to determine the spinal level, a second "time out" must be performed to review the image and correlate with intra-spinal markers.

For procedures performed outside of the OR:

The person(s) performing the procedure(s) must conduct and document on the appropriate procedural check list the "time out" confirming all of the above information with another person including who participated, when possible.

For surgical procedures:

Instruments/equipment are not offered until after the "time out" is performed.

I. Resolution Of Disagreement Or Discrepancy:

The surgery/procedure is stopped if there is any disagreement or discrepancy in information identified by any member of the surgical/procedural team. The team includes all individuals responsible for any part of the verification process from scheduling to completion of procedure. The discrepancy or disagreement must be resolved before proceeding to the next step. This information includes but is not limited to information about the patient or surgery/procedure to be performed or any disagreements regarding the patient, site, surgery/procedure or implant/equipment provided it is medically appropriate. The delay must not compromise the patient's safety or result in clinical deterioration.

Note: All "near misses" will be reported to quality Improvement via an occurrence report. A "near miss" is defined as a difference or discrepancy in the understanding or documentation of the intended procedure or site occurring between members of the surgical/procedural team, (including the scheduler), the patient, the family, the Health Care Proxy or legal guardian and this discrepancy was corrected before the procedure occurred (including wrong patient, wrong surgery/procedure, wrong side, wrong site, wrong implant or equipment)

J. Discovery of Wrong Patient, Wrong Procedure or Wrong Side/Site:

1. Stop the procedure.
2. Perform all components of the pre-op/pre procedure Time Out again using verbal active communication.
3. Obtain equipment, images, films or studies or the documentation of such to assist with the resolution of the discrepancy.
4. Contact OR leadership or the Nurse Manager/designee using the Chain of Command structure per the Chain of Command policy for the area.
5. Contact appropriate physicians using Chain of Command structure.
6. Report actions and resolution through the Occurrence Reporting system.
7. Act in accord with the patient's best interests and promote the patient's well being.
8. Take appropriate steps to return the patient, as nearly as possible, to the patient's pre-operative/ pre-procedure condition.
9. If after the surgery/procedure has been completed, it is determined that the surgery/procedure was performed incorrectly or at the wrong site, side, or on the wrong person, the surgeon/proceduralist should, as soon as reasonably possible, discuss the mistake/occurrence with the patient and if appropriate, with the patient's family or responsible person and recommend an immediate plan to rectify the occurrence, unless there is medical reason not to proceed. The surgeon/proceduralist may perform the desired surgery/procedure at the correct site, unless there are medical reasons not to proceed. For example, if proceeding with the surgery/procedure would materially increase the risk associated with extended length of the surgery/ procedure or if the correct site surgery/procedure would likely result in an additional and unacceptable disability.
10. The surgeon/proceduralist must advise the patient, the patient's family or the responsible person as soon as reasonably possible, of what occurred and the likely consequences including any change in health status, harm, or injury, the cause of the change and the recommended course of treatment. (See Title 10 of the New York Code Rules and Regulations Section 405.7(b)(8).

11. The above will be clearly documented by the surgeon/proceduralist/Endoscopist in the patient medical record. This can be within the dictated notes or progress notes.

K. Monitoring & Reporting All Elements for Compliance with this Policy

Routine audits are done and reported through the QI process. Audits include concurrent observational and medical record review. Reports are sent to and reviewed by the Surgical Services PI Council, "THE" meeting, and the QI Committee of the Board of Directors. Review of the process ensures that requirements for patient identification, site marking, pre-operative/pre-procedural verification and "time out" are followed consistently wherever invasive procedures are performed.

All Surgical Staff and non-OR staff will complete an annual competency that will be based on audit information related to this process. Individual performance is addressed through education and the Hospital disciplinary process when warranted. Follow-up activities must be documented.

Responsibilities of Each Team Member

Team Member	Responsibility
Scheduler/ Surgical Registrar	• Schedules the procedure into the appropriate computer system or log. • Verifies the patient using first and last name and a second unique identifier • Enters entire procedure, exact site, level, digit, and side using no abbreviations. • Enters specific information on implants and or equipment • Enters specific information on the removal of devices. • Enters information on harvest and donor sites • Verifies with the physician or physician representative the information obtained. • Stops the scheduling process if there is any discrepancy in the information provided. • Verifies the "read back" is completed. • Documents the "read back".
Anesthesiologist/ CRNA	• Verifies the identification of patient pre-operatively and pre-procedurally. • Performs the pre-op/pre-procedure verification including side and site. • Verifies the proposed procedure pre-op and pre-procedure. • Verifies surgical/procedural side and site, level or digit pre-operatively/pre-procedurally. • Marks the level for a spinal block site. • Verbally participates in the Time Out. • Stops the surgery/procedure if any disagreement or discrepancy occurs within any of the processes. • Documents the verification on the operative/procedural **consent.**
Attending of Record/ Proceduralist/	• Completes the History and Physical related to surgery/procedure including side and site.

Endoscopist	• Completes the Surgical consent including procedure, site and side, level and digit, signature, and date. • Orders appropriate pre-op/pre-procedure medications. • Verifies the Identification of patient pre-operatively/pre-procedure. • Verifies the proposed procedure, side and site pre-operatively/pre-procedurally and documents on the surgical/procedural consent • Marks the side and site pre-operatively/pre-procedurally per policy. • For a high risk surgery/procedure reviews with a Radiologist and confirms the results of relevant images pre-operatively/pre-procedurally and documents such in the dictated operative note or the medical record progress note. • Determines all relevant radiological images, films, studies, photographs to be displayed for viewing pre-operatively/pre-procedurally and during the surgery/procedure. • Compares the History and Physical, consent and patient reported information with the images, photographs, films, relevant diagnostic reports or studies and pathology reports as well as site marking for accuracy and consistency. • Ensures implants and equipment are available, accurate and consistent. • Verbally participates in the Time Out in the OR by stating the procedure.
Team Member	**Responsibility**
Attending of Record/ Proceduralist/ Endoscopist - Continued	• Conducts the Time Out in non-OR procedural areas. • Immediately prior to the incision or start of procedure assures that all components of the time out are addressed per policy. • Stops the surgery/procedure if any disagreement or discrepancy occurs within any of the verification processes. • Obtains Intra-operative consultation for interpretation of intra operative studies and confirms site markings. • Resolves all disagreements or discrepancies before proceeding with the incision • Documents the time out for non-OR procedures. • Addresses and documents any adverse events either in a dictated note or progress note.

RN-OR	• Compares patient identification with surgical schedule including the procedure, site and side pre-operatively.
	• Verifies schedule and consent elements are complete per policy.
	• Verifies the Identification of patient pre-operatively
	• Verifies the identification of patient, proposed procedure, site and side pre-operatively (Surgical schedule, H&P, Consent, and patient statement.)
	  ○ Compares proposed procedure on the consent with surgical schedule including full first and last patient name, site and side.
	  ○ Confirms presence of a signed and dated consent
	  ○ Compares the attending history and physical with consent looking for agreement of patient identification, procedure, side, site, level, and digit.

	○ Verifies the history and physical are current and updated. ○ Asks the patient to state/describe the procedure they will be undergoing as they understood it including point to the side and site. Compare patient's understanding of procedure, side, and site with the surgical schedule, History and Physical and Consent. All should agree. • Verifies the procedure, side and site marking including comparison of H&P, consent and patient reporting. • Ensures the documentation of above and the following elements. • Verifies all relevant diagnostic reports and studies and pathology reports as determined by the surgeon are available. • Verifies that the requested radiological films, images, studies, or photographs are present, properly labeled and the orientation is correct. • Verifies that all pre-operative medications are given as ordered. • Verifies patient specific implants or equipment is present and available. • Verifies correct positioning including visualization of site marking. • Initiates the time out in accordance with all requirements. ○ Responsible for assuring that TIME OUT occurs, IMMEDIATELY prior to the incision, or start of procedure. ○ Assures that all components of the TIME OUT as listed on the Peri Operative Plan of Care are addressed prior to start of procedure • Stops the procedure if any disagreement/discrepancy occurs within any of the processes
Team Member	**Responsibility**
RN Non-OR (Continued)	• Compares patient identification with surgical schedule including the procedure, site and side pre-procedurally. • Verifies that the provider is credentialed in procedure listed on consent-contact the Nursing Supervisor to verify in Cactus. • Verifies schedule and consent elements are complete per policy. • Verifies the Identification of patient pre-procedurally. • Verifies the identification of patient, the proposed procedure, site and side pre-procedurally (Surgical schedule, H&P, Consent, and patient statement). ○ Compares proposed procedure on the consent with surgical schedule/log including full first and last patient name, site and side. ○ Confirms presence of a signed and dated consent. ○ Compares the attending history and physical with consent looking for agreement of patient identification, procedure, side, site, level, and digit. ○ Verifies the history and physical are current and updated. ○ Asks the patient to state/describe the procedure they will be undergoing as they understood it including pointing to the site and side. Compare patient's understanding of procedure, side, and site with the schedule/log, History and Physical and Consent. All should agree. • Verifies the procedure, side and site marking including comparison of H&P, consent and patient reporting

	• Verifies patient specific implants or equipment is present and available. • Verifies correct positioning including visualization of site marking. • Ensures the documentation of above and the following elements. • Verifies all relevant diagnostic reports and studies and pathology reports as determined by the surgeon/ proceduralist are available. • Verifies that the requested radiological films, images, studies, or photographs are present, properly labeled and the orientation is correct. • Verifies that all pre-procedure medications are given as ordered. • Stops the procedure if any discrepancy or disagreement occurs within any of the processes. • Ensures documentation of above by the proceduralist on the appropriate procedural check list.

References

NYS DOH, Surgical & Invasive Procedure Protocol for Hospitals, Diagnostic and Treatment Centers, Ambulatory Surgery Centers and Individual Practitioners: September 2006. Accessed 08/04/22.

Definitions

SPWB – Special Purpose Wrist Band

Surgery- Performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. A diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (physicians as defined in 482.12(c)(1)) who are working within their scope of practice, hospital privileges, and who meet appropriate professional standards.

Addendums, Diagrams & Illustrations

Not Applicable