

**Rhode Island Hospital
Standard Practice
Instruction Manual**

Subject:
Universal Protocol:
Verification of the Patient's
Identity, Procedural Site, and
Invasive Procedure Performed
Outside the OR

File Under:
Administration
Admin-153

Issuing Department:
Administration

POLICY FOR STANDARD
PRACTICE MANUAL
Endorsed by QMIC and RIH
Procedure Review Committee
Approved by MEC 12/1/04

Revised Date:
2/08

Original Date:
12/04

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Approved by:

FINAL DRAFT

Senior Vice President

I. Purpose:

Patient Safety is of primary concern for all individuals who are members of the Rhode Island Hospital Community. The following is a hospital statement of policy and process steps for the verification and documentation of the patient's identity and the intended procedure including the procedural site and, when applicable, side. It describes the hospital's site marking and the requirement for time out, which is consistent with the *Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery*TM

II. Scope:

This policy applies to all patients presenting for any invasive procedure done outside the OR that exposes the patient to any more than minimal risk, whether or not moderate sedation may be required. Certain routine "minor" procedures such as venipuncture, peripheral IV line placement, and insertion of NG tube or Foley catheter are not within the scope of this policy. However, most other 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 policy. While most such procedures are performed in specific procedural departments of the hospital where there are more detailed process steps defined (consistent with this policy), this policy covers all such procedures that are performed anywhere outside the OR, including bedside, in this hospital. *Please see addendum for further details.*

III. Policy:

- A. **CONSENT:** All procedures covered by this policy require formal written informed consent unless an emergency condition requires immediate life-saving treatment. Consent will include the patient's full name (spelled correctly), date of birth and a full description of the procedure including the site if applicable, and side (*i.e.*, left versus right or unilateral versus bilateral) (no abbreviations). Procedural site and side differentiation will be included in the plan and/or the required history and physical form or progress note.
- B. **IDENTIFIERS:** In preparation for any diagnostic or therapeutic procedure, the nurse, technologist, medical assistant (MA), procedural physician or licensed independent practitioner (LIP)—refer to department-specific procedure—will check the patient's identification band or approved identifier and, if possible, will verbally confirm the patient's identity with the patient and/or representative. Patient identifiers for adult and pediatric patients will be the **patient's name** and **date of birth**.
- C. **DOCUMENTS:** The nurse, technologist, or medical assistant (MA) in areas without nursing coverage, will verify that documentation is present in the medical chart to be used in the confirmation of correct procedure and site/site: history & physical or progress note, and signed consent form. Identifiers on all documents will match the patient's identifiers.
- D. **SITE MARKING:** In cases where laterality is involved (extremities, head or organs) or for which there is duplication or multiple levels, the procedural site must be marked in a two-stage process.
1. A nurse, technologist, or medical assistant in areas without nursing coverage, will use an approved indelible marker to mark the procedural site as close as possible to the incision site as to preserve the patient's dignity. Whenever possible, the patient should be involved in the marking process. The mark will be a straight line and should be visible when the patient is draped.
 2. The MD/LIP who will perform the procedure must verify the procedural site with the plan as documented and with radiograph(s) where applicable. Then, he/she will complete the marking of the procedural site with an approved indelible marker by placing his/her initials on the line drawn by the nurse, technologist, or medical assistant. If the line drawn by the nurse, technologist or medical assistant is not where the intended incision will be, the surgeon's initials will be the official confirmation of the surgical site. Marking must be clearly visible after the patient is draped.
- E. **TIME OUT:** Immediately prior to the procedure, there will be a "**time out**" for the verification of the patient's identity, site and procedure. All team members present will actively acknowledge the correct patient, procedure, site and side where predetermined.
- F. **DISCREPANCIES:** Any discrepancies will be resolved to the satisfaction of all team members prior to the start of the procedure and will be documented in the patient record.

IV. Procedure: Guidelines for Verification Process and Documentation

- A. In Unit locations where the patient arrives to a Pre-procedure Area, the nurse, technologist, or medical assistant independently verifies the patient identification—actively with the patient and/or representative when possible (see III. B above)—and checks for the presence of the consent, and diagnosis or indication for the procedure. This person will complete the top third of the *Invasive Procedure Verification Checklist* form and sign the first box on the form (Part A).

Before the patient is moved from the pre-procedure area and taken to the procedure area, the RN/Tech/MA transporting the patient will confirm the patient's name and date of birth and scheduled procedure to verify this information with the patient's chart. All discrepancies are resolved and documented on the patient record.

- B. In the Procedure Area or at the Bedside

1. **Initial Verification:** Using a call back method, together, the RN/Tech/MA and the Proceduralist (defined as the MD/LIP who will perform the procedure) will visually check the patient's ID band or approved identifier for name and date of birth and match this to the medical record. Additionally, using the same call back method, they will verify that the procedure, including site and side, matches the signed consent form and/or H&P or progress note. Where images are relevant, they must be properly labeled, displayed, and consulted. Where applicable, the patient's correct position and availability of any necessary special equipment also must be checked at this time. Any discrepancies must be resolved and documented in the record. The team members will sign the boxes as indicated on the form to confirm that this verification took place.
2. **Site Marking:** In cases where laterality is involved (extremities, head or organs) or for which there is duplication or multiple levels, the procedural site must be marked in a two stage process:
 - The RN/Tech/MA will use an approved indelible marker to mark the procedural site as close as possible to the incision site as to preserve the patient's dignity. Whenever possible, the patient should be involved in the marking process. The mark will be a straight line and should be visible when the patient is draped.
 - The MD/LIP who will perform the procedure must verify the procedural site with the plan as documented and with radiograph(s) where applicable. Then, he/she will complete the marking of the procedural site with an approved indelible marker by placing his/her initials on the line drawn by the nurse, technologist or medical assistant. If the line drawn by the nurse, technologist or medical assistant is not where the intended incision will be, the surgeon's initials will be the official confirmation of the surgical site. However, the option to call a second physician is always available for staff at any level who is feeling pressured to resolve a dispute without 100% comfort in the outcome. Marking must be clearly visible after the patient is draped.

3. **Time Out:** Immediately prior to the procedure, there will be a “**time out**” for the verification of the patient's identity, site and procedure. All team members present will actively acknowledge the Proceduralist's verbal statement of correct patient, procedure, site and side where predetermined. The RN/Tech/MA will initial the form to confirm that the time out verification was performed immediately prior to the start of the procedure.

During the time out, any member of the team who disagrees has an obligation to verbalize their concern. A discrepancy at any point in time must stop the case from proceeding until resolved. All team members must agree on the resolution(s) to the identified discrepancy. The Proceduralist (one who performs the procedure) must document any discrepancy and resolution of the discrepancy in the patient record.

C. Variation in Verification Procedure

If the patient refuses site marking, it must be documented on the bottom of the form. If the procedure is done in such an emergent situation that the verification steps are not completed and signatures are not on the form, the top lines for Planned Procedure, Date, Time, and Unit Location must be completed, rationale noted, and the form faxed to Quality Management (ext. 4-4416) for review by the Medical Director of QM.

V. Exceptions

1. *Emergency*

In cases in which there is a possibility of loss of life or limb or injury to the patient and that require a variation from the policy, such variation will be documented in the record. When an emergency situation precludes the complete verification process, a copy of the form should be faxed as soon as possible to Quality Management, extension 4-4416.

2. *Emergency Department*

Patients unable to provide identifying information, who experience conditions requiring emergent care, will receive care prior to identification when such care is necessary to stabilize the patient's condition (e.g., unidentified patient/minor arriving unresponsive in ED or not accompanied by anyone who can identify the patient).

3. *Marking Exemptions*

There is no need to mark the following: single organ cases, interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., central line insertion), teeth (but documentation must indicate operative tooth name), and premature infants (marking may cause a permanent tattoo).

4. *Continuous Presence*

Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient, when indicated, through to the conduct of the procedure, may be exempted from the site marking requirement. The requirement for a time out for final verification still applies.

5. *Obvious Wounds and Lesions*

In general, site marking is not required if there is 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, then the sites to be treated should be marked.

6. *Marking vs. Time Out*

Even if site marking is not required (laterality or multiple structures or levels not involved), the other requirements for a pre-procedural verification process and a "time out" still apply.

7. *Patient Rights*

The patient always has the right to refuse site marking. The hospital responsibility is to provide the patient with information to understand why site marking is appropriate and desirable and the implications of refusing the site marking. Then the patient can make an informed decision. Refusal must be noted on the *Invasive Procedure Verification Checklist*.

8. *Ambulatory Settings*

Patients in some ambulatory settings do not wear an ID band. Only in those cases, it is allowable to use an approved identifier (*i.e.*, a hospital photo). The remainder of the verification process is unchanged.

9. *Bedside Settings*

Site marking pens and forms for documentation of verification will be available on the unit at the nursing station, unless provided by the visiting procedural unit. Forms also may be printed from the Intranet on the Medical Tab.

Refer to:

- *Admin-85, Standard Practice Manual: Guidelines for Moderate Sedation and Analgesia for Procedures Outside of the Operating Room at RIH.*
- *Admin-37, Informed Consent Policy*
- *Individual Procedural Department Procedures for Patient ID Verification*
- *Admin-156, General Policy for Patient Identification and Verification*

ADDENDUM

Lists here are an attempt to clarify and state examples of procedures that are included in and excluded from the scope of this policy. The lists are not meant to be comprehensive.

These types of procedures **require** the verification process as described in this policy:

- Insertion of a new foreign body into the patient's body, whether retained or not, not through an existing orifice
- Insertion of a tube into the larynx or pharynx (or below) but not including NG/OG, FEES (Fiberoptic endoscopic evaluation of swallowing), or Intubation.
- Insertion of a needle into the body for other than peripheral IV/blood draw (*e.g.*, aspirations, biopsies, PICC lines, and brachial/femoral A-lines)
- Injection of a medication into the body, not through standard delivery—IV, IM, SQ, ID (*e.g.*, intrathecal, joint, Botox)
- Any procedure requiring sedation
- Terminal extubation for organ procurement after cardiac death

Procedures that are **exempt** from the entire verification process as described in this policy*:

- Removal of a foreign body that was placed/is externally visible from the patient's body
The verification process including marking is required for a patient with multiple sites of service/treatment.
- Exchange of one foreign body for another (*e.g.*, line change over a wire)
The verification process including marking is required for a patient with multiple sites of service/treatment.
- Replacement of foreign body into hole previously created (*e.g.*, suprapubic tube, G tube)
The verification process including marking is required for a patient with multiple sites of service/treatment.
- Radial Arterial line insertion
- Intubation
- Procedures delegated to non-LIP level staff, except PICC lines
- Procedures of minimal risk: NG/OG or FEES (Fiberoptic endoscopic evaluation of swallowing), peripheral IV/blood draw, foley catheter
- Treatment/repair of a single externally obvious wound or lesion

**Patient name and DOB must be checked prior to any service or treatment.*