ELMHURST OUTPATIENT SURGERY CENTER

POLICY/PROCEDURE:	**Patient Verification, Universal Protocol and Time Out**	**EFFECTIVE DATE:**	**3/1/10**
SECTION:	**Perioperative**	**LAST REVISION:**	**07/19/10; 08/22/10; 8/10/11; 8/21/12; 2/7/13; 5/15/13; 8/15/13**

OBJECTIVES

To implement processes that ensure the patient's safety throughout the continuum of care. Fail safe measures are enacted prior to transporting the patient to the operating/procedure room, prior to the induction of anesthesia or mind-altering medications, prior to incision and prior to the physician's departure from the operating/procedure room.

The Surgical Safety Checklist shall serve as the means of documenting these measures throughout the continuum.

PLAN COMPONENTS

Patient Verification

The patient is identified using name and birth date (two patient identifiers). Verification of the correct patient, correct site, and correct procedure will occur at the following times:

- During the pre-admission phone call
- At the time of registration
- During the admission process
- Before entering the OR/procedure room
- At the start of the procedure
- Prior to administering local or regional anesthesia
- Prior to the administration of medications
- When collecting a specimen for clinical testing
- Whenever transfer of responsibility occurs

Marking the Procedure Site

- The procedure site is marked in the pre-operative area and identifies laterality, level, extremity, digit or lesion.

- The site is marked by a licensed independent practitioner (LIP) who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the LIP may delegate site marking to an individual who will be present during the procedure, is familiar with the patient, is privileged to participate in the procedure, and who will be supervised by the LIP performing the procedure. Site marking will involve the patient or the patient's legal guardian or family member, whenever possible.
- Sites will be marked with the LIP's initials, using an approved EOSC surgical marker, placed at or near the procedure or incision site. Other markings are not acceptable.
- If the surgical site involves a site with a left/right distinction that cannot be marked, a neon-colored wristband will be placed on the arm of the operative side. The LIP is responsible for writing the surgical site on the band and attaching to the correct arm.
- Patients that refuse to be marked will not be granted access to the operating/procedure room.
- The site marking must remain visible after the patient has been positioned and the surgical prep and sterile draping have been completed.

Hand-off Communication

The primary objective of hand-off communication is to provide clear, accurate information about a patient's plan of care, treatment, current condition and recent or anticipated changes. Included is the opportunity to ask and respond to questions when total care responsibility is transferred from one care provider to another.

Opportunities for reporting should include, but not be limited to, the following:

- Nursing hand-off from pre-op nurse to circulating nurse:
    - The pre-op communication board will identify each patient's assigned pre-op and circulating nurse.
    - Completion of the Surgical Safety Checklist is required prior to entering the OR/procedure room.
- Break relief/shift change:

- If the primary nurse responsible for the patient is unavailable, the inquiring nurse should speak to the Coordinator of the department to obtain necessary information.

- Nursing and anesthesiologist hand-off from OR/procedure Room to PACU.
- Nursing hand-off to ancillary departments (X-ray, CT scan).

EOSC will use the **P.A.C.E.** communication technique for hand-off reporting within the perioperative setting.

P: ***PATIENT/PROBLEM***

- The patient is recognized using NAME AND BIRTHDATE
- Physical restrictions
- Surgery or site discrepancy

A: ***ASSESSMENT/ACTION***

The review of relevant patient historical data and pre-operative assessment

- Documented History and Physical
- Verification (read/repeat back) of critical/pending lab results

C: ***CONTINUING TREATMENT/CHANGES***

Care rendered throughout peri-operative continuum including changes in patient status (level of consciousness, vital signs, pain level)

E: ***EVALUATION***

- Anticipated change of condition or treatment

If at any time during the pre-operative phase, clarification of information is necessary, verbal communication between caregivers will be implemented. The pre-op nurse can also request this interaction through documentation on the Surgical Safety Checklist or pre-op communication board.

Interruptions during any phase of interactive communication should be limited to minimize the possibility of misinterpretation of information.

The Surgical Safety Checklist is also used to review and verify the following information prior to the patient being granted access to the OR/procedure room:

- History and physical performed within 30 days of the date of surgery, signed and updated (if applicable) by the performing physician (e.g., surgeon) or another credentialed LIP who will be present during the procedure. History and physical guidelines are identified in the History and Physical Policy.
- Correct site marked, as identified under the section entitled Marking the Procedure Site above.
- Signed consent forms. The patient will be asked to sign the surgical and anesthesia consent forms while in pre-op. The pre-op nurse and OR nurse will verify that the procedure is consistent with the scheduling form, consent, H&P and patient's response. Any discrepancy will be reported to the performing physician and resolved prior to leaving the pre-op area. All consent forms will be signed by the performing physician and anesthesiologist prior to the start of the procedure.
- Implementation of mobility protocols.

Time Out

The EOSC time out process is based on the World Health Organization's Surgical Safety Checklist and includes three components.

Step 1: Room Preparation/Prior to Patient Entry

Participating individuals: OR/procedure room staff

1. Verify all supplies, trays, instruments, implants (including tissue) are present in room. This includes any anesthesia equipment or supplies, if appropriate.
2. Verify the sterility of all trays and implants as per the *Sterility Verification Protocol.*
3. Ensure that the correct information is written on the white board or entered/loaded into all equipment monitors (e.g., GI monitor, Catalys, etc.)

Step 2: Entry into Operating Room/Prior to Induction of Anesthesia

Participating individuals: patient, OR/procedure room staff, anesthesia (surgeon may/may not be present)

1. Upon entering the operating room, the circulator will introduce the patient to those present by announcing the patient's name and procedure, including laterality.
2. Immediately prior to the induction of anesthesia, the circulator will verify with anesthesia that equipment checks are complete and all equipment is functional.

Step 3: TIME OUT - Before Injection/Block or Start of Procedure

Participating individuals: surgeon, anesthesia, OR/procedure room staff, any other individuals present for procedure

1. The circulator or surgeon should initiate the TIME OUT by making a formal announcement that the process has begun. Once the TIME OUT is announced, every team member present in the room must STOP ALL activities. The identity and role of all present in the room should be confirmed.
2. The circulator should read the patient name and procedure, directly from the CONSENT in the chart. The schedule should not be the primary source of this information, but may be compared to the consent for reference. The white board or equipment monitor is also referenced during the time out.
3. The following are addressed during the TIME OUT process:
    a. Correct patient identity.
    b. Correct side/laterality, level/digits and site are ***marked.*** For procedures involving laterality, all participants will be required to repeat back the correct laterality and digits ***before*** the process can continue.
    c. Patient allergies.
    d. Correct patient position.
    e. Relevant images and results are properly labeled/displayed.
    f. Antibiotics administered within the appropriate time frame.
    g. Anticipated critical events identified by surgeon, anesthesia, or nursing team members based on patient history or medication use (i.e.; mastectomy, allergy, MH, etc.) and appropriate safety measures to be taken.
    h. Availability of the correct type and size of implant.

4. **The circulator must receive VERBAL acknowledgement from all present before the surgery can begin. This includes the surgical tech, surgeon, surgical assistant, anesthesiologist and anyone else present and participating in the procedure.**
5. Once verbal acknowledgement is received, the circulator should document the time in the chart and the procedure may begin.

Step 4: Before Surgeon Leaves Operating Room
Participating individuals: surgeon, anesthesia, OR/procedure room circulating nurse

1. Prior to the surgeon leaving the OR/procedure room, the circulator will confirm the following:
    a. Name of procedure(s) to be recorded.
    b. Level of anesthesia provided
    c. Instrument, sponge and needle counts are correct (if applicable).
    d. Specimen labeling.
    e. Any problems with equipment or instrument used during the case that requires attention.
    f. Concerns regarding recovery or management of the patient post-operatively.

Cataract and Astigmatism Correction Procedures

Step 1: Room Preparation/Prior to Patient Entry
Participating individuals: OR/procedure room staff

1. Verify all supplies, trays, instruments, implants (including tissue) are present in room. This includes any anesthesia equipment or supplies, if appropriate.
2. Verify the sterility of all trays and implants as per the *Sterility Verification Protocol.*

3. Ensure that the correct information is written on the white board or entered/loaded into all equipment monitors (e.g., GI monitor, Catalys, etc.). The surgeon is responsible for completing the white board with the following information for all cataract cases (both traditional and laser-assisted): patient name, operative eye, implant type/size. The only exception to the surgeon writing this information on the white board is for the first case of the day. For the first case, the white board may be completed by the circulating nurse for but must be initialed by the surgeon prior to the Time Out process.

Step 2: Entry into Operating Room/Prior to Induction of Anesthesia

Participating individuals: patient, OR/procedure room staff, anesthesia (surgeon may/may not be present)

1. Upon entering the operating room, the circulator will introduce the patient to those present by announcing the patient's name and procedure, including laterality.
2. Immediately prior to the induction of anesthesia, the circulator will verify with anesthesia that equipment checks are complete and all equipment is functional.

Step 3a: TIME OUT - Before Start of Femtosecond Laser Procedure (if applicable)

Participating individuals: surgeon, OR/procedure room staff which includes the laser System Operator, and any other individuals present for procedure

1. The circulator initiates the TIME OUT by making a formal announcement that the process has begun. Once the TIME OUT is announced, every team member present in the room must STOP ALL activities. The identity and role of all present in the room should be confirmed.
2. The circulator reads the following information from the Catalys Treatment Plan form and/or medical record, if identified with a (*) below:
    a. Patient name and date of birth
    b. Allergies (*)
    c. Antibiotics administered within the appropriate time frame if applicable (*)
    d. Operative eye

e. Arcuate incision components including: type, axis, length and centering method

3. The System Operator and surgeon will verify the information read by the circulator with what appears on the femtosecond laser monitor. **The System Operator will be required to read back each segment of the plan to the circulator and surgeon. The surgeon must also verbally acknowledge that the information read by the circulator is what appears on the femtosecond laser *monitor*.**

4. Once verbal acknowledgement is received, the circulator should document the time in the chart and the procedure may begin.
5. If incisions are modified from the original treatment plan during the procedure, the circulator will identify this on the Catalys Treatment Plan form. The surgeon will acknowledge the modifications by signing the form.

Step 3b: TIME OUT - Before Start of Phaco Portion of Cataract Procedure

Participating individuals: surgeon, anesthesia, OR/procedure room staff, any other individuals present for procedure

6. The circulator initiates the TIME OUT by making a formal announcement that the process has begun. Once the TIME OUT is announced, every team member present in the room must STOP ALL activities. The identity and role of all present in the room should be confirmed.
7. The circulator should read the patient name and procedure, directly from the CONSENT in the chart. The schedule should not be the primary source of this information, but may be compared to the consent for reference. The white board is also referenced during the time out.
8. The following are addressed during the TIME OUT process:
    a. Correct patient identity.
    b. Correct side/laterality, level/digits and site are ***marked.*** For procedures involving laterality, all participants will be required to repeat back the correct laterality and digits ***before*** the process can continue.
    c. Patient allergies.
    d. Correct patient position.

e. Relevant images and results are properly labeled/displayed.

f. Antibiotics administered within the appropriate time frame.

g. Anticipated critical events identified by surgeon, anesthesia, or nursing team members based on patient history or medication use (i.e.; mastectomy, allergy, MH, etc.) and appropriate safety measures to be taken.

h. Availability of the correct type and size of implant.

9. The circulator must receive **verbal acknowledgement** from all present before the surgery can begin. This includes the surgical tech, surgeon, surgical assistant, anesthesiologist and anyone else present and participating in the procedure.
10. Once verbal acknowledgement is received, the circulator should document the time in the chart and the procedure may begin.

Step 3c: TIME OUT - Before Implantation of Intraocular Lens

Participating individuals: surgeon, anesthesia, OR/procedure room staff, any other individuals present for procedure

11. The circulator must receive **verbal acknowledgement** from the surgeon and scrub tech that the correct implant is being opened. The circulator will read the implant type/size from the implant box and the surgeon and scrub tech will reference the white board to confirm accuracy.
12. If the surgeon changes the lens size after the procedure has started, the box containing the intraocular lens must be visually confirmed by the surgeon prior to opening.

Step 4: Before Surgeon Leaves Operating Room

Participating individuals: surgeon, anesthesia, OR/procedure room circulating nurse

1. Prior to the surgeon leaving the OR/procedure room, the circulator will confirm the following:

   a. Name of procedure(s) to be recorded.

   b. Level of anesthesia provided.

c. Instrument, sponge and needle counts are correct (if applicable).

d. Specimen labeling.

e. Any problems with equipment or instrument used during the case that requires attention.

f. Concerns regarding recovery or management of the patient post-operatively.

Other Special Circumstances

1. For cases involving laterality, all participants will be required to **repeat back** the correct laterality and digits a second time, after prepping and draping, immediately prior to skin incision.
2. When two or more procedures are being done on the same patient by different LIPs, a time out will be performed for each procedure. This time out is done before each procedure is initiated.

AUTHORITY AND RESPONSIBILITY

All Clinical Managers/Directors/Coordinators are responsible for enforcing this policy.

EVALUATION AND IMPROVEMENT

The evaluation and effectiveness of this policy is conducted by all members of the leadership team and reported to the PCC, CRC and Board of Managers as appropriate. Included in the evaluation are recommendations for changes based on trends, incidents, exposures, best practices, regulatory standards or the results of new scientific research. The CRC or Board of Managers may also provide direction on additional measures they wish the leadership to implement in order to ensure the objectives of the policy are met.

REFERENCES

Improving Hand-Off Communication. Joint Commission Resources.

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WHO Surgical Safety Checklist, First Edition.

"Recommendations for Pre-Anesthesia Checkout Procedures (2008)". American Society of Anesthesiologists.