**Name of Policy:** Universal Protocol Policy-Procedural Verification/Time Out

**Policy Number:** 3364-100-53-05

**Department:** Hospital Administration

**Approving Officer:** Chief Executive Officer - UTMC

**Responsible Agent:** Chief of Staff

**Scope:** The University of Toledo Medical Center and its Medical Staff

**Effective Date:** 8/1/2017

**Initial Effective Date:** 5/11/2005

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(A) **Policy Statement**

Pre-procedural/operative verification, correct site marking, and “time out” for appropriate invasive procedures will be performed consistently and will be congruent with the Universal Protocol.

(B) **Purpose of Policy**

The purpose of this policy is to ensure patient safety by establishing consistent guidelines for performing **PRE-PROCEDURAL VERIFICATION, CORRECT SITE MARKING**, and performing a “TIME OUT” for invasive and surgical procedures performed in the Operating Room and in all inpatient and outpatient clinical areas where procedures are performed. The intent of the policy is to prevent wrong-patient, wrong-site, wrong-procedure surgery / procedures.

The definition of surgical or other invasive procedures for application of Universal Protocol are located in Addendum 1.

(C) **Procedure**

**PRE-PROCEDURAL VERIFICATION PROCESS**

This is an ongoing process of information gathering and verification. It is done beginning with the determination to do the procedure, continuing through all settings and interventions up to and including the time-out immediately prior to the procedure. Elements of this process include:

1. Correctly identify patient using two patient identifiers.
2. All relevant documents and studies are available and reviewed and are consistent with each other, with patient’s expectation, with all team members understanding of the intended patient, procedure, site, and as applicable implants.
3. Missing information and discrepancies must be addressed before starting procedure.
4. Availability of needed equipment is verified.

**MARKING THE PROCEDURAL/OPERATIVE SITE(S)**

1. The attending surgeon / proceduralist who is ultimately accountable for the procedure and will be present when the procedure is performed will mark the site.
2. For education and collaboration purposes, others may assist in the site marking process as follows:

   - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
- A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.

The above individuals may mark the site, but in all cases when this occurs the attending physician will mark the site as well.

3. The site(s) is to be marked prior to moving the patient to the operating room or procedure area if the procedure is performed in an area with a holding area.

4. Sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. This includes all cases involving right/left distinction, multiple structures (such as fingers/toes), multiple levels (such as spinal procedures) and skin/subcutaneous lesions.

Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

4. Marking the surgical/invasive site(s) must take place with the patient involved, awake, and aware if possible.

5. Invasive/Surgical site(s) should be marked using a surgical marker with the marker’s initials. Do not mark with an X.

6. Marking(s) must be visible after the patient is prepped and draped at the time of the incision.

7. Alternative process: When it is technically or anatomically impossible or impractical to mark the site (i.e. mucosal surfaces, perineum, teeth, premature infants and where marking might permanently discolor the skin), or a patient refuses site marking, the UTMC form with anatomic diagrams will be used to mark the correct site. The form will be signed, timed and dated by the attending surgeon/proceduralist. The site marking on the diagram will be confirmed by the team at the time out prior to incision.

Exceptions to site marking:

1. Cases in which individual performing procedure is in continuous attendance with patient from time of decision to do the procedure until the conclusion of the procedure.

2. Life and death emergencies.

3. External beam radiation when tattooing is in place.

4. All interventions where the operative site is not pre-determined.

"TIME-OUT" IMMEDIATELY BEFORE STARTING THE PROCEDURE

1. A time-out is to be performed immediately before the procedure in the location where the surgery/invasive procedure will be done, immediately before starting the surgery/procedure “prior to incision”, or just before initiation of the procedure.

2. Multiple procedures/surgeries require a “time out” prior to the start of each procedure.

3. The surgeon/proceduralist of record or the nurse is responsible for initiating the time out. The “time out” must involve the entire procedural/surgical team, involve active communication and be documented in the medical record.

4. The following elements must be verbally verified during the “time out” process:
   - correct patient identity
   - correct site and side (site(s) marking is visible)
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- correct surgery/procedure to be performed (informed consent document matches the intended procedure)
- correct patient position
- correct implants and equipment availability
- correct imaging data reviewed
- Prophylactic antibiotics have been infused within the appropriate time frame when applicable.

*IF DISCREPANCIES OCCUR, THE SURGERY/PROCEDURE WILL NOT TAKE PLACE UNTIL THE DISCREPANCIES ARE RESOLVED.*

Documentation

Documentation for all applicable procedures and operations must include pre-procedure/operation verification process, site marking, and time out process. Documentation must include the following:

1. Verification of correct patient using two patient identifiers.
2. Verification of correct imaging studies and implant.
3. Verification of correct equipment including emergency equipment.
4. Site marked if applicable.
5. Verification of “time out” process.

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**Approved by:**

Daniel Barbee, RN, BSN, MBA  
Chief Executive Officer - UTMC  
Date 5 Sept 2017

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**Review/Revision Date:**

6/25/2008  
5/27/2009  
6/22/2011  
6/1/2014  
8/1/2017

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**Review/Revision Completed By:**

Surgical Services Administrator  
Chief of Staff

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**Next Review Date:** 8/1/2020

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**Policies Superseded by This Policy:**
ADDENDUM I

DEFINITION OF SURGICAL OR OTHER INVASIVE PROCEDURES FOR APPLICATION OF UNIVERSAL PROTOCOL

NOTE of CLARIFICATION: This list is not all inclusive but is representative of the more common invasive procedures. All invasive procedures require pre procedure verification and a time out, not all procedures require site marking if sidedness, level, multiple structures or lesion specificity is not an issue.

1. Surgical or other invasive procedures are those involving a skin incision or puncture including insertion of an instrument or foreign material into the body. These procedures expose patients to more than minimal risk and may be preformed in settings other than the operating room such as a special procedures unit, endoscopy unit, or interventional radiology suite and include, but are not limited to:
   a. open surgical procedures
   b. percutaneous aspiration of body fluids through the skin (e.g., arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis, suprapubic catheterization, and needle biopsy);
   c. biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin, bone marrow);
   d. cardiac procedures (e.g., cardiac catheterization, cardiac pacemaker implantation, angioplasty, stent implantation, intra-aortic balloon catheter insertion);
   e. central vascular access device insertion (e.g., Swan-Ganz catheter, percutaneous intravascular catheter (PIC) line, Hickman catheter);
   f. electrocautery of skin lesion;
   g. endoscopy (e.g., colonoscopy, bronchoscopy, esophagogastric endoscopy, cystoscopy, percutaneous endoscopic, transesophagelal, gastrosomy (pEG), and J-tube placements, nephrostomy tube placements);
   h. laparoscopic surgical procedures (e.g., laparoscopic colectomy, laparoscopic nephrectomy);
   i. arthrosocopy;
   j. invasive radiology procedures (e.g., angiography, angioplasty, percutaneous biopsy);
   k. laser therapy (e.g., eye, ear, nose, and throat);
   l. dermatology procedures (biopsy, excision and deep cryotherapy for malignant lesions - excluding cryotherapy for benign lesions);
   m. invasive ophthalmic procedures, including miscellaneous procedures involving implants;
   n. oral surgical procedures including tooth extraction and gingival biopsy,
   o. podiatric invasive procedures (removal of ingrown toenail, etc.);
   p. skin or wound debridement performed in an operating room;
   q. high risk chemotherapy i.e. vincristine
   r. nerve blocks
   s. interventional pain procedures
   t. injections of any substance into a joint space or body cavity;

2. Certain procedures will also be included because of their potential for patient risk and use of technology that is invasive, but does not involve a skin puncture or incision. These include but are not limited to:
   a. radiation therapy,
   b. lithotripsy
   c. vinca alkaloids.

3. Excluded Procedures
   a. venipuncture
   b. arterial blood gas
   c. intravenous therapy
   d. foley catheter insertion
   e. nasogastric and similar tubes.