Banner Health

Title: Safe Procedure		
Number: **7969**	**Version**: 3	**Original Date**: 05/31/2024
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Next Review Date: 10/15/2027		**Owner**: Martina Brooks
Approved by: PolicyTech Administrators		

Discrete Operating Unit/Facility:	**Ambulatory (Outpatient) Services**
Banner Baywood Medical Center	Banner Behavioral Health Outpatient Services
Banner Behavioral Health Hospital	Banner Health Clinics
Banner Boswell Medical Center	Banner Imaging Services
Banner Casa Grande Medical Center	Banner Imaging Services Colorado
Banner Churchill Community Hospital	Banner MD Anderson Cancer Center
Banner Del E Webb Medical Center	Banner Medical Group
Banner Desert Medical Center	Banner Sleep Center
Banner Estrella Medical Center	Banner Surgery Centers
Banner Fort Collins Medical Center	Banner Telehealth Network
Banner Gateway Medical Center	Banner Urgent Care Services
Banner Goldfield Medical Center	Banner--University Medical Group
Banner Heart Hospital	Banner--University Medical Group Phoenix
Banner Ironwood Medical Center	B--UMCS Child and Adolescent Clinic (Beh. Health)
Banner Lassen Medical Center	B--UMCT Physician Offices and Clinics
Banner McKee Medical Center	Occupational Health/Employee Health Services
Banner North Colorado Medical Center	Rural Health Clinics
Banner Ocotillo Medical Center	University of Arizona Cancer Center
Banner Payson Medical Center	
Banner Thunderbird Medical Center	
Banner--University Medical Center Phoenix	
Banner--University Medical Center South	
Banner--University Medical Center Tucson	
East Morgan County Hospital	
Ogallala Community Hospital	
Page Hospital	
Platte County Hospital	
Sterling Regional Medical Center	
Torrington Community Hospital	
Washakie Medical Center	
Wyoming Medical Center	
Wyoming Medical Center	

I. Purpose/Population:

A. **Purpose**: To standardize practices to ensure correct patient, procedure, level and laterality (when applicable) for invasive procedures performed in all acute and ambulatory settings (e.g., operating rooms, labor and delivery rooms, endoscopy and catheterization suites, medical imaging, medical office buildings, urgent care and bedside).

B. **Scope**: All procedures excluding:
- Emergency situations where the patient's condition prohibits completion of one or more safe procedure elements
- Venipuncture, arterial puncture, intravenous therapy that do not include a guidewire or introducer
- Nasogastric tube
- Urinary catheter insertion, except initial suprapubic catheterization
- Intubation
- Rectal tube insertion
- Manometry
- Capsule endoscopy
- Vaginal delivery
- Fiberoptic nasopharyngolaryngoscopy for head and neck

II. Definitions:

A. **Briefing:** Initial communication between the patient care team of any applicable special needs, equipment/instrumentation, implant availability and sterility that are needed for the surgery or procedure. Briefing will occur in person with the surgeon/proceduralist and one clinical care team member (eg. circulating nurse, primary nurse, medical assistant, technologist) at a minimum. Briefing should also include anesthesia, if applicable, and other members of the patient care team when possible. Briefing is conducted prior to induction of anesthesia/administration of sedation or prior to the start of the procedure when no anesthesia or sedation is required.

B. **Debriefing:** Post procedure communication with patient care team that includes procedure, postoperative diagnosis, specimen confirmation, wound class, estimated blood loss and if any item is intentionally retained. Must be completed by the Surgeon/Proceduralist prior to leaving the procedural area.

C. **Laterality:** The side of the patient's body in reference to the midline (i.e., left or right).

D. **Level:** The specific level of a body part that has multiple levels (e.g., level of the spine).

E. **Position:** Refers to how a patient is positioned (e.g., supine, prone) and any equipment specific to safe positioning.

F. **Primary Surgeon or Proceduralist:** A Surgeon/proceduralist with appropriate privileges and responsibility for all components of the procedure being performed, who has agreed to perform the procedure. In addition to his/her technical and clinical responsibilities, the primary surgeon or proceduralist is responsible for the planning and progress of a procedure within the scope of his/her privileges. Where the surgery or procedure involves multiple specialties, there may be more than one surgeon or proceduralist.

G. **Qualified Practitioner or Designee:** Any licensed independent practitioner (LIP) with sufficient training to conduct a delegated component of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities. A licensed practitioner who has been credentialed/approved to perform surgery/procedure and has been determined to have appropriate licenses, qualifications, training and experience to safely perform specified non-critical component(s) of a procedure under the appropriate supervision of a surgeon or proceduralist consistent with this policy and, as applicable, any other practice agreements, supervisory arrangements, protocols or

other written guidelines (Banner Health, Regulatory or Accreditation organizations) intended for the guidance of the practitioner.

H. **Retained Foreign Object (RFO):** Any item or foreign object that is unintentionally left inside a patient after surgery or invasive procedure.

   At the completion of the procedure is defined as any time after the documented end of the procedure (e.g., once the surgical incision is closed, endoscope/instrument removed, etc.), even if the patient is still in the procedural area or in the operating room under anesthesia. This definition is based on the premise that a failure to identify and correct an unintended retention of a foreign object prior to that point in the procedure represents a system failure, which requires analysis and redesign. It also places the patient at additional risk by extending the procedure, time under anesthesia, need for additional procedures, etc.

I. **Site:** The specific anatomic location as indicated by description of the body part(s) and level or digit to be subjected to procedure (e.g., shoulder, knee, hip, back, abdomen, chest, disc level).

J. **Patient Care Team:** May consist of an RN, technologist, anesthesiologist and/or CRNA or CAA, LPN/LVN, medical assistant, surgeon/proceduralist, qualified practitioner or designee.

K. **Time Out:** Safety-check conducted immediately prior to start of procedure to verify correct patient, procedure, site, laterality with applicable identification of marking, level, fire assessment (if applicable), administration of appropriate antibiotic, dose and redosing interval, timing of safety stop if applicable, patient/safety/equipment concerns, correct procedural site, and level(s) (if applicable). All members of the patient care team must be present for the time out.

L. **Invasive Procedure:** Procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice. They do not include the use of instruments such as otoscopes for examinations.

M. **Non-invasive Procedure:** A procedure done without incising the skin, mucous membrane and connective tissue or placing an instrument through a natural body orifice, but that may destroy, modify, or mark tissue or anatomical structures. Examples may include radiation therapy, closed reduction, nuclear medicine injections, etc.

N. **Safety Stop:** An additional stop that will take place during procedures involving unilateral ureteral intervention immediately prior to device/implant deployment/placement and will include all the members of the Patient Care Team and radiology (when applicable) to confirm anatomical marking(s).

III. Policy:

A. This policy is applicable to all areas in which procedures are performed. All members of the patient care team, including the patient, have a role in ensuring correct patient, procedure, and procedural site/side.

B. Procedural consent may be obtained in the medical office building, scanned into electronic medical record (EMR) and must be available prior to procedure. The key components of the Safe Procedure Policy are patient identification, briefing, time out, debriefing and are to be performed in the patient care team's presence.

C. The Surgeon/Proceduralist/Qualified Practitioner or designee participating in the procedure will, when applicable, mark the procedural site and /or level.
   1. The surgeon/proceduralist may delegate site marking to a qualified practitioner or who is being supervised by the surgeon/proceduralist, familiar with the patient, and will be present and participating in the procedure.
   2. The Surgeon/Proceduralist/Qualified Practitioner or designee will mark their initials at the site with an indelible marker or on the anatomical diagram when site marking is contraindicated or not physically possible.

3. All applicable procedure sites involving multiple anatomic locations/levels and/or laterality must be marked, at the procedure site or on an anatomical diagram excluding:
    a. Procedures in which target organ is not associated with laterality (i.e., endoscopies, laryngoscopy, anal/rectal, vaginal, and cystoscopy-based procedures without laterality).
    b. Ultrasound guided procedures such as paracentesis, thoracentesis, and central venous catheter insertion may utilize alternative site marking methods such as skin depression marking.
4. If it is not possible to mark the surgical site (e.g., ureteral stent with cystoscopy; dental extraction, intra-oral abscess drainage, tonsillectomy, oophorectomy with vaginal approach, all infants, casts), or if the patient refuses site marking, site will be marked on an anatomical diagram which will accompany the patient to the procedural area and be utilized during the time out in place of the physical site marking.

D. A time out will be conducted by the patient care team immediately prior to the start of the procedure.
E. During the time out all non-essential activity will stop, and all patient care team members will focus on the time out. The time out should be re-initiated if all activity cannot stop due to patient care.
F. If during any phase of the procedure following the initial time out, the patient is significantly repositioned such as from supine to prone/lateral decubitus or re-draping of a patient has occurred such that the original site marking is no longer visible, a new time out will be completed. Endoscopic procedures where laterality is not involved, the patient can be placed in a prone position without a second timeout needing to be performed.
G. If the patient has multiple procedures scheduled with additional attending surgeon(s)/proceduralist, additional time outs will be conducted immediately prior to the initiation of each subsequent procedure.
H. Counts of procedural items are performed for all procedures in which the likelihood exists that a procedural item may be retained. Counts will occur at a minimum at the beginning of each case, when closing a cavity, prior to final wound closure, and whenever a member of the patient care team has concerns about the accuracy of a count. Counts should also include temporarily intentionally retained items such as surgical packing to ensure final counts are reconciled.
I. If during the briefing, time out, or debriefing a discrepancy is discovered, the procedure is paused until the discrepancy is resolved with all appropriate members of the patient care team.
J. A Safety Stop will be conducted for procedures involving unilateral ureteral intervention just prior to implant/device deployment (i.e., stent)

IV. Procedure:

Safe Procedure Process:

A. <u>Patient Identification:</u>
    1. All patients are correctly identified with at least two approved patient identifiers per applicable departmental/service requirements.
    2. In locations where armbands are used, all team members who interact with the patient must check the arm band and verbally confirm that the name and date of birth (DOB) are correct. Designated patient care team member will ensure the following information sources match the patient's identification band as applicable:
        a. Physician's order and History and Physical (H&P)

b. Informed consent and anesthesia consent
c. Ask the patient or the patient's representative to state the procedure (including laterality or level), in layperson's terms, he/she expects to receive

3. Imaging studies, if applicable to the procedure, are confirmed by the surgeon/proceduralist (or designee) to match the patient identification band when applicable.
4. Resolve any discrepancies in the above information sources before moving the patient to the operating room/procedural area.

B. Surgical/Procedural Site Marking:
1. Before marking the site, the surgeon/proceduralist/anesthesiologist (or designee) will:
   a. Check the following to confirm the procedure, site, laterality and level(s) (if applicable):
      I. Physician's order and H&P/progress note/visit note
      II. Informed consent
      III. Imaging studies
      IV. Ask the patient or patient's representative to verify the procedure, including laterality and level(s) (if applicable).
      V. Resolve any site discrepancies before marking the site.
2. The surgeon/proceduralist/qualified practitioner will mark their initials at the site with an indelible marker. Site should be marked such that marking is visible when the patient is prepped and draped. The patient or patient's representative will verify the correct site with the surgeon/proceduralist/anesthesiologist (or designee).
3. When site marking is contraindicated the above information to be verified with the anatomical diagram.

C. Hand-Off communication to occur whenever members of the patient care team change during the course of the procedure, transitions of care and/or care locations (i.e., prior to patient leaving preop/nursing unit to operating room, PACU to floor)
1. During hand-off, at a minimum as applicable, the following are to be covered:
   a. Allergies
   b. Site and procedure
   c. Disposition of the patient post procedure
   d. Whiteboard as applicable
   e. Counts (required for permanent relief) as applicable
   f. Review medication on sterile field and ensure correct labeling as applicable
   g. Specimens or expected specimens
   h. Special equipment and supplies
   i. Any equipment or supply issues

D. Briefing:
1. Briefing will occur in person with the surgeon/proceduralist and one clinical care team member (eg. circulating nurse, primary nurse, medical assistant, technologist) at a minimum. Briefing should also include anesthesia, if applicable, and other members of the patient care team when possible.
2. Briefing may occur at any point prior to anesthesia/sedation, or prior to final procedure set up and patient positioning/prep when no anesthesia/sedation is involved.
   Elements to include as applicable:
   - ❑ Allergies
   - ❑ Consents and order (procedural, anesthesia, blood, sterilization, etc.): Obtained as applicable and complete

- ❑ Required instrumentation, supplies, implants, devices present, sterile and within expiration date
- ❑ Safety concerns
- ❑ Appropriate procedure site, side, and level marking
- ❑ Anticipated Position
- ❑ Blood product need and availability
- ❑ Availability of appropriate imaging studies
- ❑ Post procedure disposition
- ❑ Venous thromboembolism (VTE) prophylaxis modes (mechanical, chemical), timing, dose if applicable
- ❑ Procedure specific monitoring requirements and availability (e.g., EEG, SENP)
- ❑ When patient present in room:
  - ❑ Initiate introduction of team to patient
  - ❑ Verify patient name and DOB match ID band
  - ❑ Confirm site is marked and procedure matches consent
- ❑ Anesthesia plan/mode: General, regional etc.
- ❑ Fire Risk assessment shared, and interventions are in place

E. Time Out:

1. A time out will be conducted immediately prior to access, incision or instrumentation and may be initiated by any member of the patient care team. Completion of the time out will be documented by the designated patient care team member in the electronic medical record (EMR). All patient care team members must be present for and participate in the time out.
2. Elements:
   - ❑ Initiation
   - ❑ Patient name and procedure validation with consent
   - ❑ Procedure, laterality, and/or level
   - ❑ Patient-specific concerns
   - ❑ Antibiotic name, dose, time, and redosing time
   - ❑ Equipment issues/concerns
   - ❑ Visual inspection of site marking or marked anatomical diagram
   - ❑ Medications on the field with appropriate and accurate labeling
   - ❑ Fire Risk assessment shared and interventions are in place

   Surgeon/Proceduralist:
   - ❑ Safety stop timing if applicable
   - ❑ Reminder to call out when item is placed in or removed from procedural cavity, with appropriate documentation on white board if applicable

F. Debriefing:

1. Post-procedural communication with patient care team completed by the Surgeon/Proceduralist before leaving the procedural area.
2. Elements to include as applicable:
   - ❑ Procedure
   - ❑ Post Op Diagnosis
   - ❑ Confirm specimens/tissue are appropriately labeled, off field and disposition
   - ❑ Wound Class
   - ❑ Intentionally retained foreign objects
   - ❑ Safety concerns
   - ❑ Counts: Instrument, sponge and needle counts are correct
   - ❑ Appropriate radiographic imaging completed in compliance with policy when indicated
   - ❑ Disposition

- ❑ Negative Pressure Wound Therapy (NPWT), Tracheostomy, and other packing clearly labeled and identified
- ❑ For procedures involving guidewires/dilators (e.g. central venous catheter, arterial catheter, pigtail chest drainage catheter) the procedural practitioner and a patient care team member shall both verify that the guidewire and all other dilators/obturators are intact and have been removed prior to the end of the procedure
- ❑ Total IV fluids, blood products, and medications administered

Surgical Cases Only
Anesthesia Procedures (blocks/epidural/central line):

A. Anesthesia Site Marking:
1. Before marking the site of an anesthesia block the anesthesiologist/CRNA and/or CAA will verify correct patient, correct site and correct laterality by consulting source documents (informed consent for the procedure and informed consent for the anesthesia procedure) and verify with the patient or patient's representative.
2. Any site discrepancies will be resolved before marking the site.
3. The anesthesiologist, CRNA, and/or CAA will mark the site for all peripheral nerve block procedures (including femoral, interscalene, sciatic, etc.) involving laterality. The following are exceptions to the anesthesia site marking requirement:
    a. Labor epidural or spinal analgesia because they do not involve laterality.
    b. Central line placement where side is determined after induction of anesthesia.
    c. Arterial Line placement where side is determined after induction of anesthesia.
4. The anesthesiologist, CRNA, and/or CAA will mark the anesthesia procedure site with an initial.

B. Anesthesia Time Out:
1. The anesthesiologist/CRNA and/or CAA and a RN who is a member of the perioperative team will conduct an uninterrupted Anesthesia time out.
    a. The anesthesiologist or APP will initiate the Anesthesia time out
    b. The anesthesiologist or APP and the RN will cease all other activity.
    c. The RN:
        1. Reads the following from the patient's consent for anesthesia:
            a) Patient Name
            b) Procedure
            c) Laterality of anesthesia procedure (and level) as appropriate
            d) Consent for anesthesia and any associated blocks that have been checked or written at the top of the consent form
        2. Notes position of patient.
        3. States whether he/she sees the site marking (i.e., the initial) on all peripheral nerve block procedures (including femoral, interscalene, sciatic, etc.) involving laterality.
    d. Anesthesia physician: States patient's name and the anesthesia procedure—from memory—just prior to administering the block.
    e. Anesthesia physician verifies the initial site marking for the nerve block AND verifies the presence of the surgeon (or designee) site marking at the surgical site. Any discrepancies between the site marking must be resolved prior to the nerve block.

Bedside and Ambulatory Procedures Only:
A. Minimize distractions and disruptions throughout the procedure:

1. Keep door closed
2. Place visual sign on outside of the door to indicate procedure in progress
3. Ensure surfaces being utilized in the patient room/exam room have been disinfected per facility standards prior to setting up sterile fields

B. Provide intraprocedural monitoring as appropriate and per policy

References:

AORN Guidelines for Perioperative Practice (2021) Edition reference in the "Guideline for Team Communication" Kyle, Erin, DNP, RN, CNOR, NEA-BC, ed. (2021). *AORN Guidelines for Perioperative Practice - 2021st Ed.* AORN (Association of Perioperative Registered Nurses).

Lippincott Manual of Nursing Practice – 11th Ed. (2019). Nettina, Susan M. (2019). *Lippincott Manual of Nursing Practice- 11th Edition.* Lippincott Williams & Wilkins

World Health Organization 2014. Who.int. 2021. *Patient safety: Safe surgery saves lives*. https://www.who.int/news-room/q-a-detail/safe-surgery-saves-lives-frequently-asked-questions . Retrieved 27 April 2021.

The Joint Commission Centerfortransforminghealthcare.org. 2021. *Safe Surgery*. https://www.centerfortransforminghealthcare.org/improvement-topics/safe-surgery/?_ga=2.60100264.446264788.1619563176-744566707.1619563176. Retrieved 27 April 2021.

Institute for Healthcare Improvement. Ihi.org. 2021. *Patient Safety Essentials Toolkit | IHI - Institute for Healthcare Improvement*. http://www.ihi.org/resources/Pages/Tools/Patient-Safety-Essentials-Toolkit.aspx. Retrieved 27 April 2021.

Other Related Policies/Procedures:

A. Incident Reporting, Serious and Sentinel Event Reporting (#9062)
B. Consent Guidelines for Banner Health (#7391)
C. Counts, Sharps and Instruments (#12688)
D. Patient Identification (#685)
E. Perioperative Services – Surgical Specimens (#246)
F. Procedural Sedation for Therapeutic and Diagnostic Procedures (#689)

Keywords and Keyword Phrases:

A. Patient Identification
B. Procedural Pause
C. Site Marking
D. Site Verification
E. Time Out
F. Universal Protocol

Appendices:

A. Invasive ProceduralFire Risk Assessment Workflow
B. Surgical and Procedural Site Marking Diagram

Appendix A: Invasive ProceduralFire Risk Assessment Workflow

Invasive Procedural Fire Risk Tool

Invasive Procedural Fire Risk Tool & Interventions

During the Safe Procedure Process, the Fire Risk Score and Inventions are reviewed prior to access, incision, or instrumentation.

	Yes	No
Procedural site or incision is above the xyphoid.	1	0
Environment changed the humidity in the room OR presence of open oxygen source.	1	0
Available ignition source *(ex. electrosurgery unit, laser, fiberoptic light source) & other ignition sources (ex. battery powered coutery pens, defibrillators, drills, saws, burrs).*	1	0
Total Score:		

- ❑ **Score 1: Low Risk**
- ❑ **Score 2: Low Risk with potential to convert to High Risk**
- ❑ **Score 3: High Risk**

Invasive Procedural Fire Risk Interventions:

Score 1 – Low Risk:

- ❑ Implement standard fire safety precautions:
  1. Allow for alcohol-based prep solutions to dry completely (minimum of 3 minutes).
  2. Use standard draping procedures and avoid contact of drapes with prep solutions.
  3. Protect heat sources (use the ESU pencil holder).

Score 2 – Low Risk with potential to convert to High Risk:

- ❑ Implement standard fire safety precautions.
- ❑ Monitor and communicate potential fire risk hazards that could increase risk.

Score 3 – High Risk:

- ❑ Confirm that alcohol-based prep solutions have dissipated/dry (minimum of 3 minutes).
- ❑ Ensure appropriate techniques to minimize concentrated oxygen under the drapes (prevent tenting, use incise drape).
- ❑ Consider using the lowest concentration of oxygen needed for adequate oxygenation (<30%).
- ❑ Use the lowest possible power setting for the electrosurgical devices.
- ❑ Encourage use of wet sponges.
- ❑ Ensure sterile saline is available for fire suppression, including saline syringes.

Anesthesia Provider:

- ❑ Use the MAC circuit oxygen (initially at 30% FiO2) and fresh gas flows of at least 12 L/min.
- ❑ Document oxygen concentration flows.

References:

- **Banner Health Policy: Safe Procedure**
- **Banner Health Policy: Temperature, Humidity, and Pressure Guidelines for Critical Space**
- **AORN Guidelines for Perioperative Practice (2023)**
- **OR Manager, Volume 22 No. 1. Scoring fire risk for surgical patients. January, 2006**
- **Joint Commission SEA 68: Updated Sentinel Event Alert on surgical fire prevention for 21st century**
- **Lippincott Procedure: Fire prevention and management, OR**

Appendix B: Surgical and Procedural Site Marking Diagram

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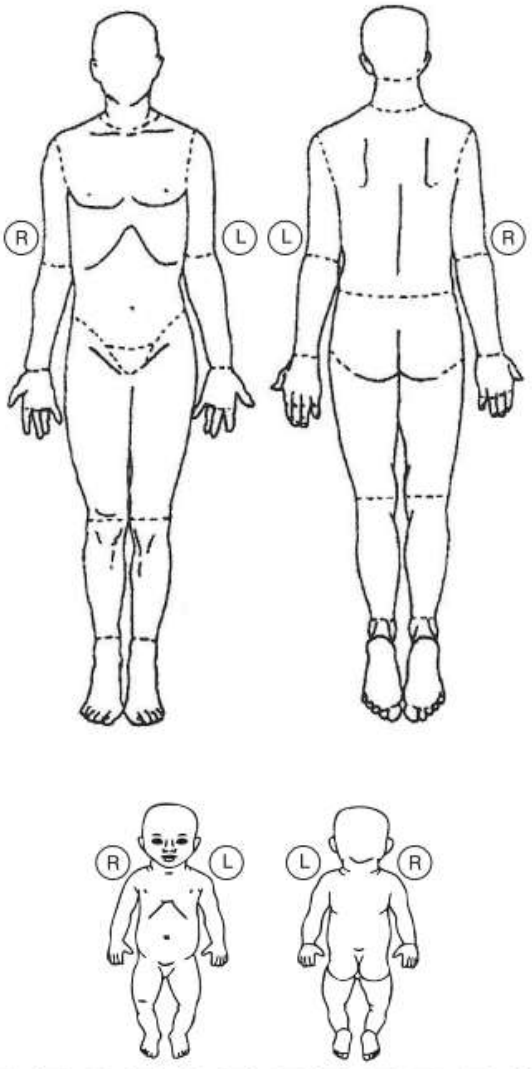
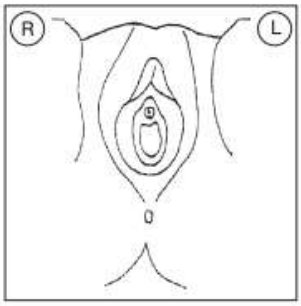
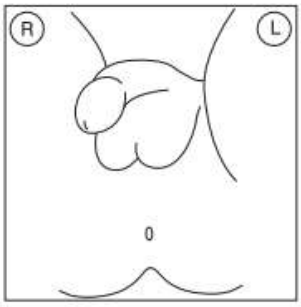
PROCEDURAL SITE MARKING DIAGRAM



SITE MARKING DIAGRAM

Instructions:
A. **Mark directly on patient's body** – use of a diagram permitted only if: 1 – unable to mark on patient next to the incision site, 2 – for site sensitive areas, or 3 – if a patient refuses marking.
B. **Initials of the provider performing the procedure must be used to mark the site.**





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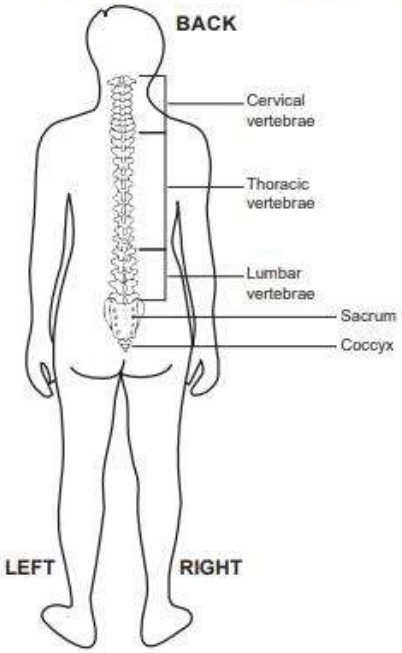
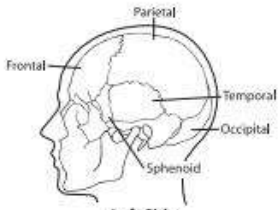
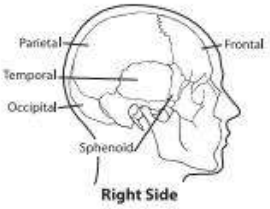
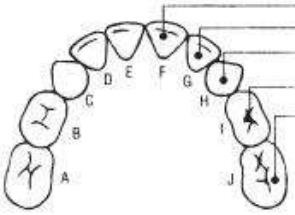
PROCEDURAL SITE MARKING DIAGRAM



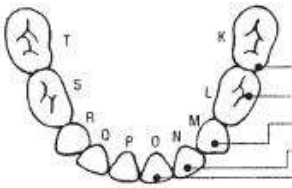




PRIMARY DENTITION

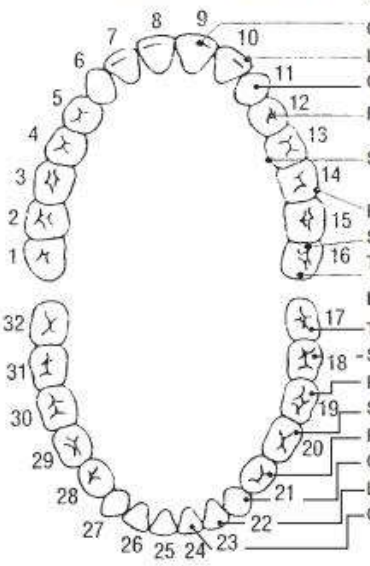


Upper Teeth	Erupt
Central incisor	8-12 months
Lateral incisor	9-13 months
Canine (cuspid)	16-22 months
First molar	13-19 months
Second molar	25-33 months



Lower Teeth	Erupt
Second molar	23-31 months
First molar	14-18 months
Canine (cuspid)	17-23 months
Lateral incisor	10-16 months
Central incisor	6-10 months

PERMANENT DENTITION



Upper Teeth
Central incisor
Lateral incisor
Canine (cuspid)
First premolar (first bicuspid)
Second premolar (second bicuspid)
First molar
Second molar
Third molar (wisdom tooth)

Lower Teeth
Third molar (wisdom tooth)
Second molar
First molar
Second premolar (second bicuspid)
First premolar (first bicuspid)
Canine (cuspid)
Lateral incisor
Central incisor

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