Banner Health

Title: Safe Surgery Policy		
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Approved by: PolicyTech Administrators		

Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Ocotillo Medical 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
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Subcategories of Ambulatory (Outpatient) Services not selected.

Subcategories of Banner Home Care and Hospice (BHCH) not selected.

Subcategories of Post Acute Services (PAC) not selected.

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I. Purpose/Population:

A. **Purpose**: To standardize safe practices to ensure correct patient, correct procedure, and the correct procedural site/side for procedures performed in the all operating rooms and labor and delivery rooms

B. **Population**: All Patients

II. Definitions:

A. **Briefing:** Initial communication to inform the surgical team of any special needs or equipment that are needed for the surgical procedure. Briefing elements to be completed with the entire team before induction of the patient.

B. **Debriefing:** Post procedure communication with surgical team that includes Procedure, Postoperative DX, Wound Class, Blood Loss, Specimen Confirmation. Must be completed by the Surgeon prior to leaving the OR Suite.

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).

F. **Post procedure:** After incision closed, endoscope/instrument removed.

G. **Primary Surgeon or Proceduralist:** An attending physician with appropriate privileges and responsibility for the procedure being performed, who has agreed to perform the procedure. Typically, the Primary Surgeon or Proceduralist is the attending physician identified with the procedure on the OR schedule. In addition to his/her technical and clinical responsibilities, the Primary Surgeon or Proceduralist is responsible for the orchestration and progress of a procedure within the scope of his/her privileges. Where the surgery involves multiple specialties, there may be more than one Primary Surgeon or Proceduralist.

H. **Qualified Practitioner or Designee:** Any licensed practitioner 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 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 Primary Surgeon or Proceduralist consistent with this policy and, as applicable, any other practice agreements, supervisory arrangements, protocols or other written guidelines intended for the guidance of the practitioner.

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

> "After surgery or invasive procedure" is defined as any time after the documented end of the procedure (eg. 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 surgical procedure and time under anesthesia.

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

K. **Surgical Team:** Consists of the Circulating RN, Surgical tech, Anesthesia care provider and surgeon or licensed independent practitioner involved in the procedure

L. **Time Out:** Final safety-check to verify correct patient, correct procedure, and the correct procedural site, and level(s) (if applicable). The "Attending Surgeon" must be present for the Time Out.

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III. Policy:

A. This policy is applicable to all facilities that perform surgical procedures. All members of the surgical team, including the patient, have a role in ensuring correct patient, correct procedure, and correct procedural site/side.
B. Surgical Consent to be scanned in prior to surgery/procedure when and where available.
C. The key elements of the Safe Surgery Policy are Patient Identification, Briefing, Time-out and Debriefing. These elements are to be performed by all members of the surgical team.
D. The Surgeon (or designee) performing the surgical procedure will mark the site/level.
   1. The surgeon/LIP may delegate site marking to the Resident/Physician's Assistant/Nurse Practitioner who is being supervised by the surgeon, who is familiar with the patient, and who will be present when the procedure is performed.
   2. The surgeon (or designee) will mark their initials at the site with an indelible marker.
   3. All sites involving multiples (anatomic locations/levels) and or laterality must be marked (either at the surgical/procedure site or on an anatomical diagram) unless they appear in the list below:
      a. Emergency situations where the patient's condition prohibits marking
      b. Interventional cases for which the catheter/instrument insertion side is not predetermined (e.g., angiogram)
      c. Central line placement where side is determined after induction of anesthesia
      d. Venipuncture, Arterial puncture, Intravenous therapy
      e. Nasogastric Tube insertion
      f. Urinary catheter insertion
      g. Procedures that enter through an orifice where the target organ is not associated with laterality (i.e., endoscopies, laryngoscopy, anal/rectal, vaginal, and cystoscopy-based procedures without laterality).
      i. If it is not possible to mark the surgical site (e.g., ureteral stent with cysto; dental extraction, intra-oral abscess drainage, tonsillectomy, oophorectomy with vaginal approach, all infants, casts), or if the patient refuses site marking then the surgeon will mark the site on an anatomical diagram. The diagram will accompany the patient to the OR.

E. A Time Out will be conducted by the surgical team (circulator, anesthesia provider, surgical technician, and surgeon or designee) immediately prior to initiation of procedure.
F. If at any point in the verification process a discrepancy is discovered, the procedure is stopped and does not continue until the discrepancy is resolved with all appropriate members of the surgical team.
G. During the Time Out all activity will stop, and all surgical team members will focus on the Time Out.
H. If the patient is moved from supine to prone (or vice versa) following the Time Out, an additional Time Out will be necessary immediately following the repositioning and initiation of subsequent surgical procedure.
I. If the patient has multiple procedures scheduled with additional Attending Surgeon(s), an additional Time Out will be conducted immediately prior to the initiation of each additional procedure.

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IV. Procedure:

Safe Surgery Process:

A. Patient Identification:
1. All patients are correctly identified with at least two approved patient identifiers per applicable departmental/service requirements.
2. All clinicians who interact with the patient must check the arm band and verbally confirm that the name and DOB are correct. Preoperative and intraoperative RN will ensure the following information sources match the patient's identification band:
    a. Physician's order
    b. Informed consent and anesthesia consent
    c. Ask the patient or the patient's representative to state the procedure, in layperson's terms, he/she expects to receive
3. Imaging studies, if applicable to the procedure are confirmed by the surgeon (or designee) to match the patient identification band.
4. Resolve any discrepancies in the above information sources before moving the patient to the operating room

B. Hand-Off
1. During Handoff at a minimum the following are to be covered:
    a. Nurse to nurse handoff:
        I. Allergies
        II. Site and procedure
        III. Disposition of the patient post procedure
        IV. Whiteboard
        V. Counts (required for permanent)
        VI. Review medication on sterile field and ensure correct labeling
    b. Scrub to scrub handoff:
        I. Special equipment and supplies
        II. Any equipment or supplies issues
        III. Sterile and instrument integrity
        IV. Specimens
        V. Review medication on sterile field and ensure correct labeling

C. Surgical Site Marking:
1. Before marking the site, the surgeon (or designee) will:
    a. Check the following to confirm the procedure, site, and level(s) (if applicable):
        I. Physician's order
        II. Informed consent
        III. Imaging studies
        IV. Ask the patient or patient's representative to verify the procedure, site, and level(s) (if applicable).
        V. Resolve any site discrepancies before marking the site.
2. The surgeon (or designee) will mark their initials at the site with an indelible marker. The patient will verify the correct site with the surgeon (or designee).
3. Surgical Site Marking to be completed when the procedure involves multiples (anatomic locations/levels) and/or laterality before moving the patient into the OR.

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D. Briefing:

1. Members of the surgical team who will be present during the procedure will participate in the briefing together.
2. Briefing elements to be addressed before the induction of the patient, if applicable:

   RN:
   - ❑ Allergies
   - ❑ No expired supplies/implants
   - ❑ 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

   Surgeon (or designee):
   - ❑ Procedure site was marked in pre-op
   - ❑ Positioning
   - ❑ Expected blood loss and blood product available
   - ❑ Appropriate imaging studies are available
   - ❑ Identify if a post op ICU admission is anticipated
   - ❑ Concerns or special needs for the case

   Anesthesia Provider:
   - ❑ Anesthesia plan
   - ❑ Were Beta Blockers given if indicated

   Surgical Technologist:
   - ❑ Necessary equipment and supplies are available
   - ❑ Surgical items have sterile integrity maintained
   - ❑ Instrument integrity verification was complete
   - ❑ Meds/Fluids Identified and Labeled

   Surgeon (or designee):
   - ❑ Asks team – Does anyone have any safety concerns?

E. Time Out:

1. A Time Out will be conducted immediately prior to incision or procedure. Completion of the Time Out will be documented. The “Attending Surgeon” must be present for the Time Out.
2. Time Out elements to be addressed before the induction of the patient, if applicable:

   Surgeon:
   - ❑ Let’s start the time out!

   RN:
   - ❑ Patient’s name and procedure match consent
   - ❑ Procedure, laterality, and/or level
   - ❑ Reminder to call out when item placed in/out of cavity or surgical field for counts
   - ❑ Fire assessment shared and interventions are in place
   - ❑ SCD machine in place and turned on for DVT prophylaxis

   Anesthesia Provider:
   - ❑ Read from anesthesia record: Name, Procedure
   - ❑ Patient-specific concerns
   - ❑ Antibiotic name, does, time, and redosing time

   Surgical Technologist:
   - ❑ Procedure
   - ❑ Equipment issues or concerns
   - ❑ Visual inspection of site marking
   - ❑ Meds on the field

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Surgeon:
- ❑ Asks team – Does anyone have any safety concerns?

Another Time Out is required:
- ❑ When changing procedures and/or positioning

F. Debriefing:
1. Debriefing elements to be addressed during closing and before the surgeon leaves the operating room.

   Surgeon:
   - ❑ Procedure
   - ❑ Post Op Diagnosis
   - ❑ Confirm specimens/tissue are named and off field
   - ❑ Wound Class
   - ❑ Blood Loss
   - ❑ Manual Cavity Sweep Complete (if applicable)
   - ❑ All foreign objects removed or states number intentionally retained

   RN:
   - ❑ Verifies surgeon reported information (above)
   - ❑ Procedure field in Surginet is correct
   - ❑ Specimen labeling (read specimen labels aloud, including patient name)
   - ❑ Instrument, sponge and needle counts correct
   - ❑ X-ray complete for mis-counts/trauma/placement

   Surgical Technologist:
   - ❑ Surgical items/instruments integrity maintained
   - ❑ Negative Pressure Wound Therapy (NPWT), Tracheostomy, and other packing clearly labeled and identified

   Surgeon:
   - ❑ Asks team – Does anyone have any safety concerns?

Anesthesia Procedures (blocks/epidural/central line):

A. Anesthesia Site Marking:
1. Before marking the site of an anesthesia block the anesthesia provider [i.e., anesthesiologist or certified nurse anesthetist (CRNA)] will verify correct patient, correct site and correct laterality by consulting source documents (informed consent for the surgical 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 anesthesia provider 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 anesthesia 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 anesthesia provider will mark the anesthesia procedure site with an "A" with a circle around it.

B. <u>Anesthesia Time Out:</u>

1. The anesthesia provider together with the RN who is a member of the surgical team will conduct an uninterrupted Anesthesia Time Out.
   a. The anesthesia provider will initiate the Anesthesia Time Out
   b. The anesthesia provider 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 or not he/she sees the anesthesia provider site marking (i.e., the "A" with a circle around it) on all peripheral nerve block procedures (including femoral, interscalene, sciatic, etc.) involving laterality.
   d. Anesthesia provider: States patient's name and the anesthesia procedure—from memory—just prior to administering the block.
   e. Anesthesia provider verifies the "A" 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.

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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)

Keywords and Keyword Phrases:

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

Appendices:

A. Surgical Site Fire Risk Assessment Workflow

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Appendix A: Surgical Site Fire Risk Assessment Workflow

Surgical Site Fire Risk Assessment Workflow

1. **Fire risk assessment performed by RN during the briefing using the laminated tool below.**

Surgical Site Fire Risk Assessment Tool			
OR RN to complete Fire Risk Assessment prior to incision & communicate with the team.			
Circle	**Yes**	**No**	☐ **Score 1: Low risk**
Surgical Site or Incision above the xiphoid	1	0	**Score 2: Low risk with potential to convert to high risk.** ☐ Initiated Score 2 Protocol ☐ Converted to Score 3 & initiated High Risk Fire Protocol
Open oxygen source (patient receiving supplemental oxygen by and variety of face mask or nasal cannula)	1	0	
Available ignition source (ex, electrosurgery unit, laser, fiberoptic light source	1	0	**Score 3: High Risk** ☐ Initiated Score 3- High Risk Fire Protocol
Total Score: *If Total Score a 2 or 3* *Initiate applicable Protocol*			
Alcohol-based prep solution had sufficient time for fumes to dissipate.			☐ Yes ☐ No ☐ N/A

2. **During the briefing portion of the safe surgery process, the RN will state the fire risk score and actions needed based on score:**

Score 2- Low risk with potential to convert to high risk

- Observe alcohol based prep dry times (minimum of 3 minutes)
- Protect heat sources (ex, using the ESU pencil holster)
- Use standard draping procedures.

Score 3- High Risk

Circulating RN:

- Verifies fire triangle, including verbal confirmation of oxygen percentage.
- Ensures the appropriate draping techniques to minimize oxygen concentration under the drapes (ex. Tenting, incise drape)
- Minimize ESU setting
- Assess that sufficient time has been allowed for fumes of alcohol based prep solutions to dissipate (minimum of 3 minutes)
- Encourage use of wet sponges
- Ensure a basin of sterile saline and bulb syringe are available for fire suppression.

Anesthesia Provider:

- Ensures that a syringe full of saline is in reach for procedures conducted with in the oral cavity
- Documents oxygen concentration flows
- Uses the MAC circuit oxygen administration initially at FiO2 of .30 using fresh gas flows of at least 12 L/min.

3. **Actions implemented according to fire risk score.**

Reference: OR Manager, Volume 22 No. 1. Scoring fire risk for surgical patients. Jan, 2006.

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