

***Wrong-Site, Wrong-Sided,  
Wrong-Patient, Wrong  
Procedure Surgery***

***Patient Safety Conference  
NYS Department of Health  
Albany, NY May 2007***

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FACS***

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Surgery***

***Albert Einstein College of Medicine***

***Chief Orthopaedic Spine Surgery***

***Sound Shore Medical Center of Westchester***

***Board of Councilor of the American Academy  
of Orthopaedic Surgeons***

***Member of the Board of Directors of the New  
York State Society of Orthopaedic  
Surgeons***

# *Wrong-site surgery*

*Devastating Problem*

*Affects*

*Patient*

*Surgeon*

*Institution*



# *Wrong-Site Surgery*



*Results from:*

*Poor preoperative planning*

*Lack of Institutional controls*

*Failure of the surgeon to exercise due care*

*Mistake in communication between patient and surgeon*

# *Wrong-site surgery*

*Not just an orthopaedic problem that occurs because the surgeon operates on the wrong limb*

*It is a system problem that affects other specialties as well*



# *Wrong-site surgery*

*While the number of reported orthopaedic surgery cases is not high relative to the total number of orthopaedic professional liability insurance claims, a retrospective study of a sample of insurers across the country provides evidence that 84% of cases involving wrong-site orthopaedic surgery claims resulted in indemnity payments over a ten year period, compared to all other types of orthopaedic surgery claims where indemnity payments were made in 30% of orthopaedic surgery claims during this same period*

*AAOS Advisory Statement 2007*

# *Recommendations for Eliminating Wrong-Site Surgery*

*“Sign Your Site”  
initiative by AAOS  
started in 1997*

*Voluntary effort  
within the AAOS  
fellowship since  
1998*

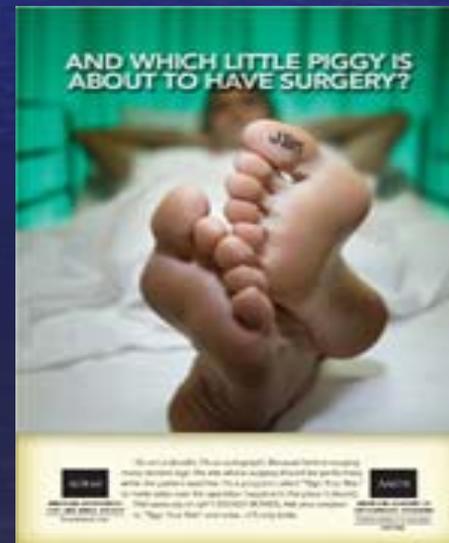
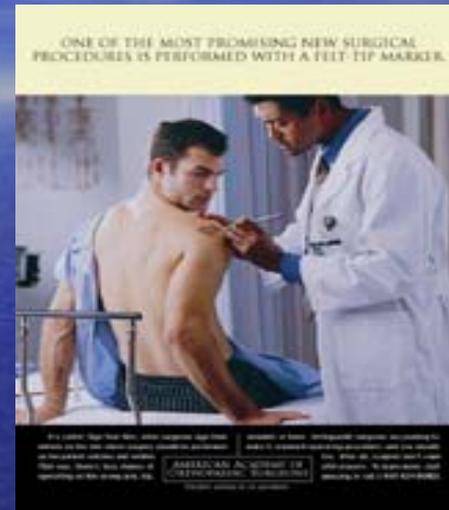


# *Wrong-site surgery*

*By 2000, 77% of orthopaedic surgeons were aware of the program*

*Over 50% had instituted a program*

*However, this was a voluntary effort, and Institutions developed different, sometimes conflicting methods of implementing the program*



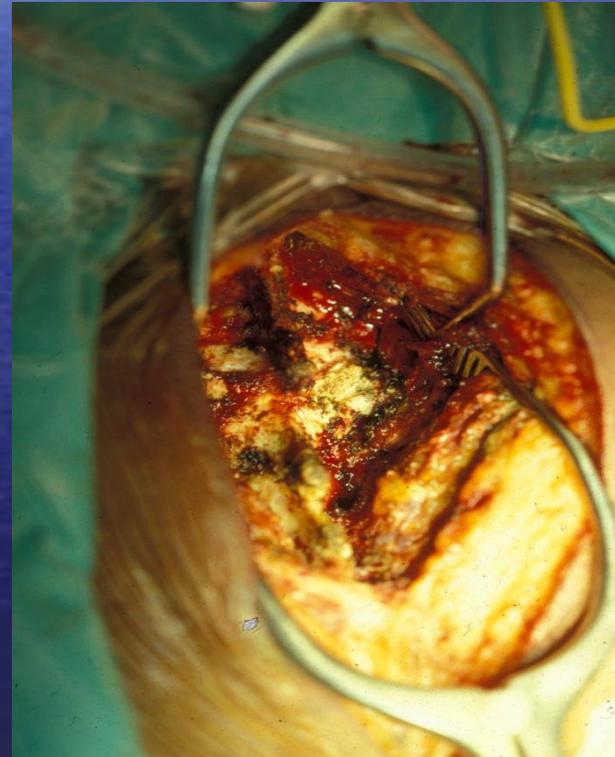
# *Wrong-site surgery*

*2000 Survey  
1 in 5 orthopaedic  
surgeons will have  
an occurrence of  
wrong-site  
surgery in his or  
her career*



# *Wrong-site surgery*

*JCAHO tracking of wrong-site surgery as part of Sentinel Events monitoring 1/95 to 9/03 there were 278 incidents reported, of which 35% involved orthopaedic surgery*



# *Wrong-site surgery*

*As of end of 1/04*

*Wrong-site surgery  
was the 3<sup>rd</sup> highest  
sentinel event*

*Accounting for more  
than 12% of all  
sentinel events  
reviewed by JCAHO  
since 1995*



# *National Importance of Wrong-site surgery*

*Overall incidence was sufficient that JCAHO decided to make surgical site identification one of its quality goals beginning in 2003*

*Summit convened in May 2003 to develop a "Universal Protocol" to avoid wrong-patient, wrong-procedure and wrong-site surgery*

*AAOS, as the only U.S. professional medical association with a formal site marking policy, played a significant role in the summit*

# *Wrong-site surgery*

*Never before had such a strong national emphasis been placed on the need for surgical site marking and a preoperative verification process as major components of a systems solution to help eliminate the incidence of wrong-site, wrong-patient, wrong-procedure surgery*



# ***Canadian Orthopaedic Association***

***1994 to 1996 Educational Program***

***To help eliminate wrong-site surgery  
Reported that the number of known  
wrong-site surgery claims in Canada  
has subsequently dropped  
dramatically***

# *Influence on this thought process on my training*

*Table 15.1. Failures of Spine Surgery*

Preoperative errors

Wrong patient

Wrong diagnosis

Intraoperative errors

Wrong level

Wrong operation

Wrong syndrome

Incomplete surgery

Complications (immediate/local)

Postoperative failure

Complications

Arachnoiditis

Change of symptoms or recurrence of symptoms

*Ian Macnab, Backache, 1977*

Anyone doing any volume of spine surgery, especially microsurgery, will admit that at one time or another, they have been in at the wrong level. When embarking on a spine surgical career, admit immediately that wrong level exposure will be a constant problem and routinely plan the operative exposure to prevent the occurrence. All of the residents in our program are taught that the three most common errors in limited spine surgical exposures are:

1. Wrong level exploration,
2. Wrong Level Exploration!
3. WRONG LEVEL EXPLORATION!!

*Ian Macnab, Backache, 1977*

# *Universal Protocol*

*JCAHO implementation beginning July 1,  
2004*

*Enhance patient safety*

*Preoperative surgical site marking became  
mandatory in U.S. hospitals and surgical  
centers*

*JACHO's adoption of the elimination of  
wrong-site, wrong-patient, wrong-  
procedure surgery as a National Patient  
Safety Goal*

# *Universal Protocol*

*All accredited organizations are required to use a preoperative verification process and a surgical site marking process*

*Critical access hospitals*

*Hospitals*

*Health care networks*

*Office-based surgical practices*

*Must implement to maintain JACHO accreditation*

*American Academy of  
Orthopaedic Surgeons (AAOS)  
Advisory Statement*

*A unified effort among surgeons,  
hospitals and other health care  
providers to initiate preoperative and  
other institutional regulations can  
effectively eliminate wrong-site  
surgery in the United States*

# *Effective methods of eliminating wrong-site surgery*

*Surgeon, in consultation with the patient, places his or her initials on the operative site using a permanent marking pen and then operating through or adjacent to his or her initials*



# *Effective methods of eliminating wrong-site surgery*

*Spinal surgery done at the wrong level can be prevented with an intraoperative X-ray that marks the exact vertebral level (site) of surgery*



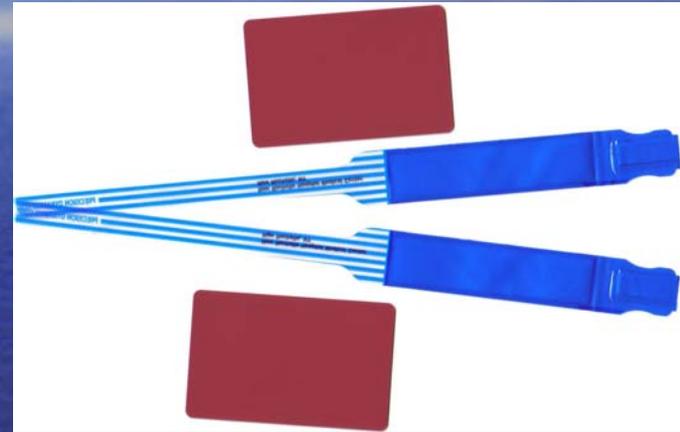
# *Effective methods of eliminating wrong-site surgery*

*Once patient in operating room, the surgical team should pause to take a "time-out" to communicate about the specific patient and procedure*



# *Effective methods of eliminating wrong-site surgery*

*Time-out should include confirmation of the patient's identity, correct procedure, site, equipment and implants/devices as applicable*



# *Effective methods of eliminating wrong-site surgery*

*All members of the team (including the surgeon, assistant surgeon, anesthesiologist, circulating nurse, and scrub nurse) should participate in the time-out to communicate with other members of the team and to raise any questions or concerns*



# ***New York State Surgical and Invasive Procedure Protocol (NYSSIPP)***

***Developed by the Procedural and Surgical  
Site Verification Panel (PSSVP)***

***Reviewed lessons learned from the analysis  
of occurrence codes 911 and 912 reported  
to the New York Patient Occurrence  
Reporting and Tracking System  
(NYPORTS) from 2003 to 2006***

***New York State Surgical and  
Invasive Procedural Protocol  
(NYSSIPP)***

***PSSVP also***

***Reviewed the Joint commission on  
Accreditation of Healthcare  
Organizations' (JCAHO) database of  
reviewable sentinel events***

***Reviewed the clinical literature as well  
as the collective experiences of the  
panelists***

# ***NYSSIPP***

***Represents a consensus of the panel on the current best practices in the area of preventing wrong-patient, wrong-site, wrong-side and wrong invasive procedures***

***It is the intent of the panel that implementation of NYSSIPP will be adapted to the setting and the procedure***

# ***NYSSIPP***

***The document identifies participants in the procedure as members of the “surgical team” but it is intended to include proceduralists, endoscopists and anyone assisting in any way in a procedure***

State of New York  
Department of Health

Office of Health Systems Management  
Division of Primary and Acute Care Services

New York State  
Surgical and Invasive Procedure Protocol

for

Hospitals ~ Diagnostic and Treatment Centers  
Ambulatory Surgery Centers ~ Individual Practitioners

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
Commissioner of Health

Hon. George E. Pataki  
Governor – State of New York

September 2006

# NYSSIPP

## NEW YORK STATE SURGICAL AND INVASIVE PROCEDURE PROTOCOL

### A. SCHEDULING

#### Scheduling must include:

1. Entire procedure, exact site, level, digit, and side/laterality (including spelling out "Left", "Right" and "Bilateral" – no abbreviations other than C-Cervical, T-Thoracic, L-Lumbar, S-Sacral *when identifying spinal levels* – e.g. L4-5).
2. Specific information on implant/implant system and/or equipment.
3. Specific information on removal of device.
4. Information on harvest and donor sites.
5. The Operating Room (OR), or the person responsible for accepting requests to schedule procedures, must verify the information provided by the surgeon/physician. The information should be verified in a manner agreed to by both the institution and physicians (read-back, fax, e-mail, etc).

### B. CONSENT DOCUMENT

#### Consent documentation must include:

1. First and last name, date of birth of patient and medical record number of the patient.
2. Name and description of surgery or procedure in terms that are understandable to the patient (correct site/side, level and digit with the side spelled out as "Left", "Right" or "Bilateral").
3. No acronyms or abbreviations (except spinal levels noted in section A above).
4. Specific implant/implant system to be placed or device to be removed.
5. Patient/family/guardian/health care agent signature and date.
6. Witness signature and date.
7. Physician signature and date.
8. If the consent is altered or illegible it must be re-done and re-signed by all parties.

### C. PRE-OPERATIVE/PRE-PROCEDURAL VERIFICATION PROCESS

#### Verification of the correct person, procedure site and side must occur (as applicable):

1. At the time the surgery or invasive procedure is scheduled.
2. At the time of admission or entry into the facility.
3. With the patient involved, awake and aware, if possible.
4. Anytime the responsibility for care of the patient is transferred to another caregiver or location in the pre-operative or pre-procedural process.
5. Before the patient leaves the pre-operative area or enters the procedure/surgical room.
6. In ALL clinical settings where invasive procedures are performed, including but not limited to endoscopy suites, catheterization laboratories, interventional radiology suites, intensive care units, labor and delivery areas, emergency departments, etc. There are recognized benefits to applying this to all bedside procedures.

John M. Olsewski, M.D., F.A.C.S., F.A.A.O.S., P.C.  
Orthopaedic Spine Surgery

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of Surgery \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Hospital: \_\_\_\_\_

Insurance: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Surgical Procedure/Levels: \_\_\_\_\_

with-- ANESTHESIA SPECIAL REQUESTS: \_\_\_\_\_ Hypotensive Anesthesia \_\_\_\_\_ Wake-up T

APPROXIMATE LENGTH OF SURGERY: \_\_\_\_\_ Units of Blood \_\_\_\_\_

Instrumentation to be used: \_\_\_\_\_

Cell Saver: \_\_\_\_\_ Spinal Cord Monitoring \_\_\_\_\_

Surgical Assistance Requested from Dr. (or group) \_\_\_\_\_  
for \_\_\_\_\_

Brace Post-Op: No Yes Type: \_\_\_\_\_ Approx. time in brace \_\_\_\_\_

PRE-OP CHECKLIST:

Labs: \_\_\_\_\_ Routine  
\_\_\_\_\_ Other \_\_\_\_\_

X-Rays: \_\_\_\_\_ PA Lat \_\_\_\_\_ F.S. \_\_\_\_\_ L/S  
\_\_\_\_\_ Side Bending -- R or L Thoracic R or L Lumbar

\_\_\_\_\_ PFT \_\_\_\_\_ ABG

Med. Photos: \_\_\_\_\_ Pre-Op \_\_\_\_\_ Post-Op

Consults: \_\_\_\_\_ None  
\_\_\_\_\_ Medical  
\_\_\_\_\_ Cardiovascular  
\_\_\_\_\_ Other \_\_\_\_\_

Other Diagnostic Tests/Levels/Reasons: \_\_\_\_\_  
(MR & CT)

DR Scheduled \_\_\_\_\_ by \_\_\_\_\_ Notes: \_\_\_\_\_, M  
(Initial Please)

Insurance OK \_\_\_\_\_ by \_\_\_\_\_

Office Packet \_\_\_\_\_ by \_\_\_\_\_

Blood Info Sent \_\_\_\_\_ by \_\_\_\_\_

ix \_\_\_\_\_ by \_\_\_\_\_

Teach Packet \_\_\_\_\_ by \_\_\_\_\_

Consults \_\_\_\_\_ by \_\_\_\_\_

Pre-Op F/U \_\_\_\_\_ by \_\_\_\_\_

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6. In ALL clinical settings where invasive procedures are performed, including but not limited to endoscopy suites, catheterization laboratories, interventional radiology suites, intensive care units, labor and delivery areas, emergency departments, etc. There are recognized benefits to applying this to all bedside procedures.

# CONSENT FORM

(to be signed by patient wherever applicable)

ADDRESSOGRAPH

Date \_\_\_\_\_, 20\_\_\_\_ Time \_\_\_\_\_ A.M./P.M.

## PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby authorize Dr. \_\_\_\_\_ or associates or assistants of his/her choice at Montefiore Medical Center to perform upon me/the patient named above the following operation(s) and/or procedure(s): PLEASE PRINT OR TYPE, USE LAY-TERMINOLOGY & INDICATE LEVEL OF SPINAL SURGERY, RIGHT AND LEFT MUST BE WRITTEN IN THEIR ENTIRETY.  
\_\_\_\_\_
2. Dr. \_\_\_\_\_ has fully explained to me the nature and purposes of the operation(s) procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation(s), treatment(s) or procedure(s).
3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgment.
4. I further consent to the administration of such anesthesia, sedation and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health as well as benefits and alternatives associated with anesthesia, sedation and blood transfusions and these have been explained to me.
5. I further consent to disposal by hospital authorities, or possible use for research purposes, in accordance with its accustomed practice, of any tissues or parts which may be removed.
6. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

### Interpreter if required

### Patient/Relative or Guardian

SIGNATURE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

PRINT NAME AND ADDRESS \_\_\_\_\_

PRINT NAME \_\_\_\_\_

### Witness

SIGNATURE \_\_\_\_\_

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT \_\_\_\_\_

PRINT NAME \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

Physician obtaining consent \_\_\_\_\_

SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**INFORMED CONSENT DISCUSSION:** I hereby certify that I have explained the nature, purpose, benefits, risks of, and reasonable alternatives to the proposed procedure(s)/operation(s), and sedation and/or blood/blood products, when applicable. I have discussed potential problems related to recuperation, the likelihood of achieving treatment goals and the risks, benefits and side effects of reasonable alternatives, including the possible consequences of receiving no treatment. I have offered to answer any questions and fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Remarks: \_\_\_\_\_

Physician \_\_\_\_\_

SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**ATTENDING PHYSICIAN OPERATIVE SITE/SIDE VERIFICATION:** I hereby confirm that the procedure described above, including laterality, where applicable, is correct.

Attending Physician \_\_\_\_\_

SIGNATURE \_\_\_\_\_

(To be completed on the day of surgery.)

DATE \_\_\_\_\_

TIME \_\_\_\_\_

# NYSSIPP

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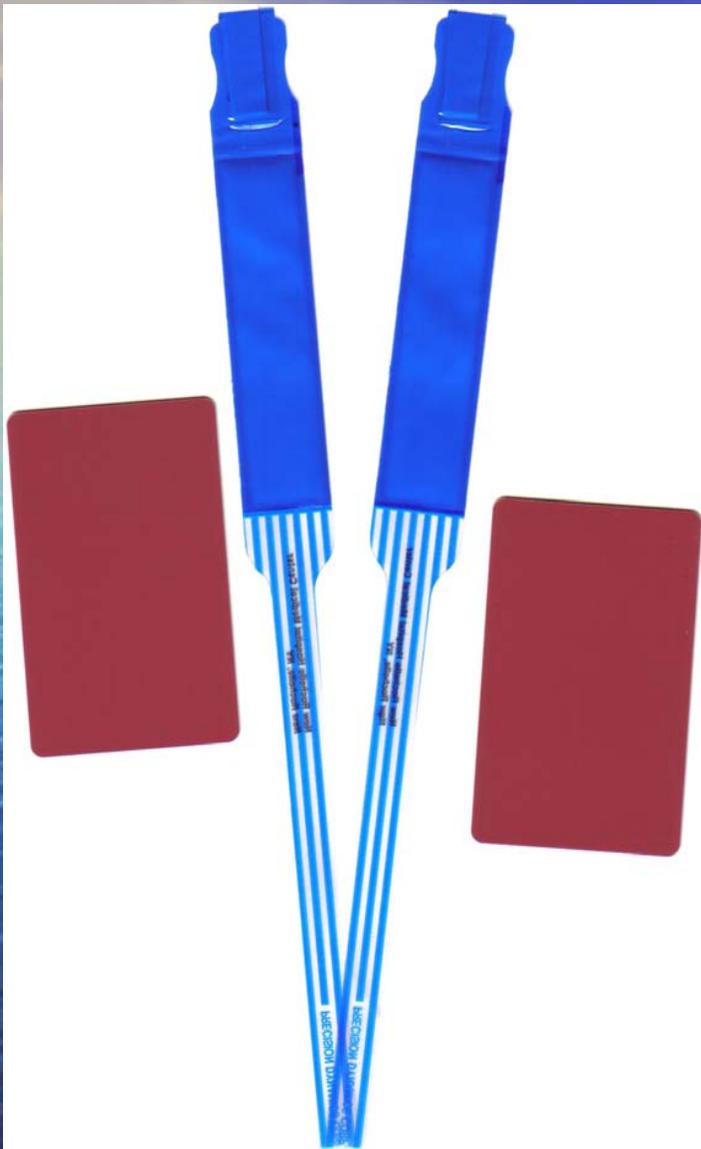
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## Pre-Operative Checklist

DATE \_\_\_\_\_

Addressograph

	Floor Nurse	Circulating Nurse
1. Patient Identiband in place Full Name, D.O.B., M.D. ( <i>legible</i> )		
2. Operative consent completed, witnessed and signed <input type="checkbox"/> by Pt. <input type="checkbox"/> next of kin <input type="checkbox"/> HCP If not by patient reason why _____		
3. Level of consciousness: <input type="checkbox"/> alert <input type="checkbox"/> sedated <input type="checkbox"/> confused <input type="checkbox"/> unresponsive <input type="checkbox"/> other		
4. Advanced Directives: Living will <input type="checkbox"/> YES <input type="checkbox"/> NO Health Care Proxy <input type="checkbox"/> YES <input type="checkbox"/> NO DNR <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> suspended <input type="checkbox"/> continued		
5. Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> others _____		
6. Dentures removed: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		
7. NPO since: _____		
8. Implants: <input type="checkbox"/> YES <input type="checkbox"/> NO where _____		
9. Skin integrity assessed: <input type="checkbox"/> YES <input type="checkbox"/> NO		
10. OR Notified of Specific Isolation Precautions: <input type="checkbox"/> YES <input type="checkbox"/> NO		
11. Labs <input type="checkbox"/> YES <input type="checkbox"/> NO H & P <input type="checkbox"/> YES <input type="checkbox"/> NO ( <i>Local Patients H &amp; P only</i> ) Chest X-Ray <input type="checkbox"/> YES <input type="checkbox"/> NO EKG <input type="checkbox"/> YES <input type="checkbox"/> NO Tye & Screen <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Blood Available <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		
12. Pre-op: TPR & BP _____ Height & Weight _____ Voided _____ Time _____		
13. Jewelry removed: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> placed in safe <input type="checkbox"/> given to family <input type="checkbox"/> taped		
14. <input type="checkbox"/> Hair Spray / Gel		

AMS / Floor Nurse Signature \_\_\_\_\_

Circulating Nurse \_\_\_\_\_

9149 HS-02 • PBF (42034) 12/22/05



# NYSSIPP

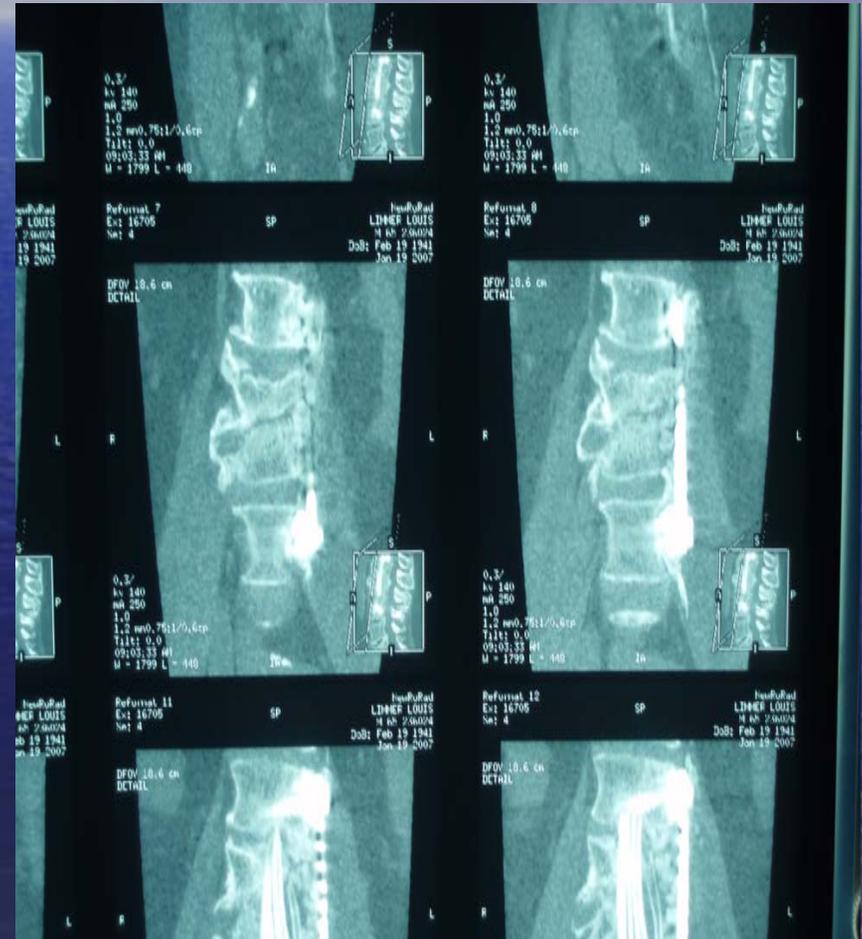
**A pre-operative or pre-procedural verification checklist must be utilized to ensure availability and actual review of the following, prior to the start of the procedure:**

1. Relevant documentation: History & Physical, signed consent and any other documents required by the organization as part of the pre-operative evaluation process. The consent must be signed by the patient/legal representative, and surgeon.
2. Relevant images, properly labeled and displayed including photographs.
  - In "High Risk" procedures (as determined by the surgeon), the images should be reviewed by the surgeon and radiologist together pre-operatively.
  - Someone other than the primary surgeon confirms the name, date of the study and "Left-Right" orientation.
  - The surgeon is responsible for assessing what films/images are appropriate for viewing before and during the surgery.
  - When intra-operative imaging studies are performed, appropriate consultation should be available for interpretation of intra-operative studies.
3. Relevant diagnostic reports or studies (ultrasound, endoscopy, etc.).
4. Relevant pathology reports.
5. Necessary patient-specific implants and special equipment.
6. Confirm identity using two (2) identifiers, confirm procedure and site marking if appropriate.

## **D. MARKING THE OPERATIVE/PROCEDURAL SITE**

1. The physician/dentist/podiatrist doing the procedure must do the site marking using his/her own initials. Site marking must be legible and unambiguous (see exceptions). Note: If the surgeon's initials are "N.O.", utilize three initials.
2. All sites involving laterality (e.g. brain) and/or paired organs, multiple structures (fingers, toes, hernias, lesions) or multiple levels (spine). Make the mark at or near the incision site(s) so that it/they will be visible when the patient is draped. (See following exceptions).
3. For hand and foot surgery, the surgeon must mark the surface(s) of the digit to be operated on, anterior, posterior or both.
4. The appropriate site must be verified before any cast is split. For relevant orthopedic cases, the skin/site should be marked immediately after cast/splint is removed.
5. For surgery of the spine, pre-operative skin marking is required to indicate laterality, when appropriate. A second time out must be performed when the intra-operative imaging is done to confirm the level.
6. When the site or level is not visually identifiable, the surgeon must obtain an intra-operative image, using markers that will not move, to confirm the exact level/site.
7. Do NOT mark any non-operative site(s).
8. The mark must be visible in the operative field after the patient is prepped and draped.
9. The mark must be made using an FDA approved marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.

# *Radiology Centers need to be made to understand that not all Offices nor all OR's are equally equipped*



***Radiology Centers need to realize that  
not all Offices nor all OR's are the  
same***



*Helping the surgeons comply with these necessary regulations*

*NYSSOS requests that Administrators and Radiology Chiefs involve the surgeons and surgical staff in these major decisions*



# NYSSIPP

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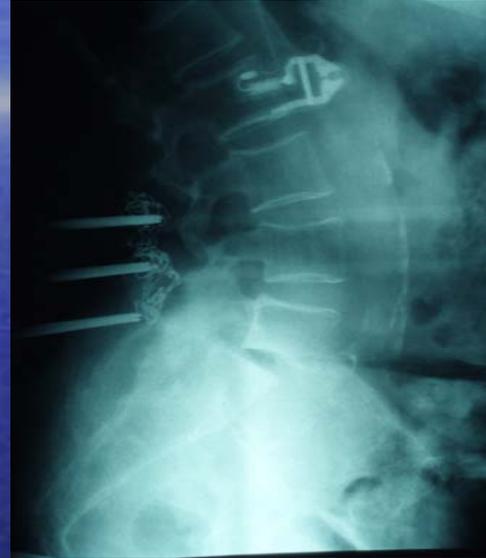
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3. For hand and foot surgery, the surgeon must mark the surface(s) of the digit to be operated on, anterior, posterior or both.
4. The appropriate site must be verified before any cast is split. For relevant orthopedic cases, the skin/site should be marked immediately after cast/splint is removed.
5. For surgery of the spine, pre-operative skin marking is required to indicate laterality, when appropriate. A second time out must be performed when the intra-operative imaging is done to confirm the level.
6. When the site or level is not visually identifiable, the surgeon must obtain an intra-operative image, using markers that will not move, to confirm the exact level/site.
7. Do NOT mark any non-operative site(s).
8. The mark must be visible in the operative field after the patient is prepped and draped.
9. The mark must be made using an FDA approved marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.



# *Intraoperative marking film in spine surgery – 2<sup>nd</sup> “time-out”*



# *Problems with intraoperative imaging*



# *Problems with intraoperative imaging*

*Obesity*

*Osteopenia*

*Revision surgery*

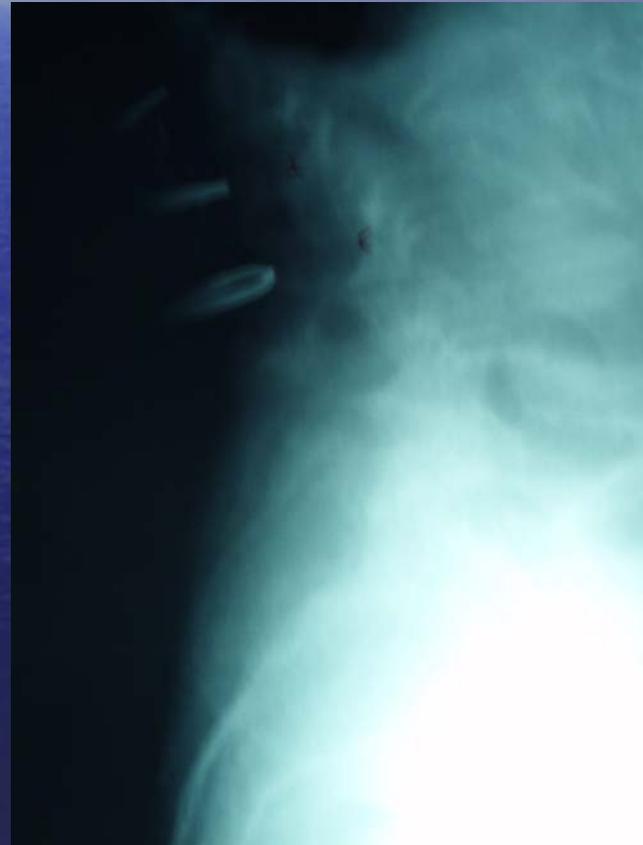
*Landmarks gone*

*Experience of  
radiology  
technician*

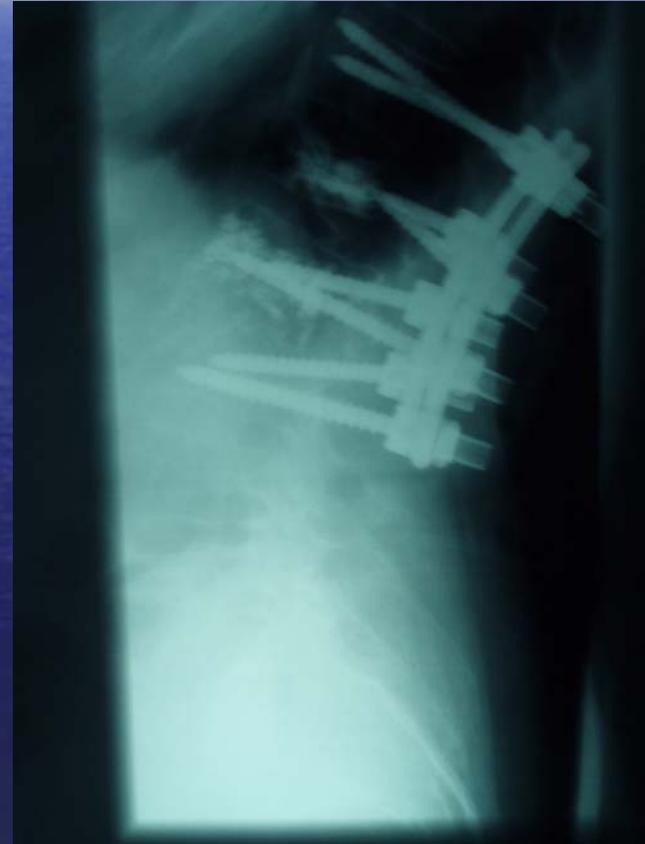
*Quality of radiology  
equipment*



# *Problems with intraoperative imaging*



# *Problems with intraoperative imaging*



# NYSSIPP

10. In the event of multiple surgical procedures by different surgeons, all relevant surgical sites must be marked prior to the first surgery. The surgeon marking the site(s) must be present for and participate in the "time out" performed for each procedure he/she marks.
11. Marking must take place with the patient/family involved, awake and aware, if possible.
12. If a smaller mark is necessary, such as near the eye in Pediatric Ophthalmology cases, a dot near the eye constitutes the site marking. A special purpose wristband is also an option.
13. A special purpose wristband must be used for patients:
  - who refuse marking,
  - a neonate (as marking may cause a permanent tattoo),
  - problematic surgical site(s) to mark (e.g. perineum or anus) or when marking can be done only after shaving a patient's head prior to a neurosurgical/cranial procedure.
  - The first and last name of the patient, a second identifier, the anatomical site and name of the procedure must be written on the special purpose wristband.
14. Final verification of the site mark must take place during the "time out".

## E. EXCEPTIONS TO SITE MARKING

1. Single organ cases, which do not involve laterality (e.g., hysterectomy, appendectomy).
2. Spinal block for pain management or epidural does not require an intra-operative marker if fluoroscopy is used. However, it does require skin marking.
3. Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).
4. Dental cases, where the operative tooth number or name(s) can be indicated on documentation or the operative tooth (teeth) including laterality can be marked on the dental radiographs or dental diagram.
5. Endoscopic or other procedures done through a midline orifice.
6. Situations in which the primary pathology itself is plainly visible (single laceration).
7. When the operative pathology has been identified by real time imaging in the immediate pre-operative period such as for frameless stereotactic neurosurgical procedures or microcalcifications in a breast biopsy.
8. Life threatening emergency when any delay in initiating the surgery would compromise the safety or outcome of the patient (e.g. ruptured aortic aneurysm).
9. When movement of a patient to create a marking would compromise the safety or outcome of the procedure (e.g. movement of a patient with an unstable spine fracture.)

*NOTE: A practitioner is NOT exempt from the site-marking requirement when he or she is in continuous attendance with the patient (from the time of the decision to do the procedure through the conduct of the procedure). The requirement for "time out" applies as well. This is based reports of wrong-sided procedures being done despite the continued presence of the person performing the procedure from time to decision to completion of the procedure.*



*Anterior access vascular surgeon, spine surgeon also present; two posterior surgical sites for spine surgeon*



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# NYSSIPP

## F. "TIME OUT" IMMEDIATELY BEFORE STARTING THE PROCEDURE

**Purpose: To conduct a final verification of the correct patient, site/side, procedure and, as applicable, implants.**

The "time out" must be conducted in the location where the procedure will be done, after the patient is prepped and draped and just before starting the procedure. This applies to all invasive procedures performed in all settings. All work should cease during the "time out" to allow all members of the team to focus on the "time out". For instances when the procedure is being performed without assistance, it is strongly advised to enlist an observer or assistant to participate in the "time out". It must involve the entire operative/procedural team, use "active communication", and be documented. The "time out" is a standardized procedure, and documentation indicates the procedure was followed in its entirety without deviation.

**"Time out" includes the following:**

1. Identification of the patient using 2 patient identifiers, such as, name (first and last) and a second identifier as determined by the organization.
2. Identification of the correct site and side(s).
3. Procedure to be performed and proper patient position.
4. Availability of correct implants and any special equipment or special requirements.
5. Verification of the wristband and chart takes place as the patient is brought into the room and before the "time out". The "time out" requires that all participants agree on the information and does not require checking the wristband at that time.
6. Radiological review, when germane to the case (see below).

*The above information should be confirmed with the medical record and should be documented along with the identification of those who participated in the "time out".*

**Additional Confirmatory "Time out"** should be undertaken if a new surgeon arrives and is assuming primary responsibility for the case, or if the patient/operative site is re-draped. The name of the patient and the procedure should be verified during this second "time out".

**Radiological Review:** The surgeon performing the operation is responsible for determining that the images to be displayed are relevant to the surgery. A second team member confirms that the image belongs to the patient (first and last names and second identifier) and that the image is displayed in the correct orientation, using markers on the image. The team confirms the site and side of the lesion as part of the "time out".

- For spinal cases in which an intra-operative image is used to determine the spinal level, a second "time out" must be performed to review the image and correlate with intra-spinal markers.

**Procedures Performed Outside the OR:** The person(s) performing the procedure must conduct and document the "time out" confirming all of the above information with another person when possible.

**For Surgical Procedures:** Instruments/equipment are not offered until after the "time out" is performed.

 the procedure if there is any discrepancy in information identified by any member of the surgical team. Resolve the discrepancy or disagreement before proceeding.

# *All work stops for the "time out"*



# NYSSIPP

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**Stop** the procedure if there is any discrepancy in information identified by any member of the surgical team. Resolve the discrepancy or disagreement before proceeding.

# *Thank You*



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