

# UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE AND WRONG PERSON SURGERY

Specific to Ambulatory Care, Critical Access Hospital,  
Disease-Specific Care, Hospital and Office-Based Surgery

**Universal Protocol 1: The organization fulfills the expectations set forth in the Universal Protocol.**

## **REQUIREMENT 1A:**

- Conduct a pre-operative verification process as described in the Universal Protocol.
  - **Implementation Expectations:**
    1. Verification of the correct person, procedure, site, as applicable, should occur:
      - ◆ At the time the surgery/procedure is scheduled
      - ◆ At the time of admission or entry into the facility
      - ◆ Anytime the responsibility for care of the patient is transferred to another patient caregiver
      - ◆ With the patient involved, awake and aware, if possible
      - ◆ Before the patient leaves the preoperative area or enters the procedure/surgical room
    2. Review the following, prior to the start of the procedure (a preoperative verification checklist may be helpful):
      - ◆ Relevant documentation (i.e., H&P, consent)
      - ◆ Relevant images, properly labeled and displayed
      - ◆ Any required implants and special equipment

## **REQUIREMENT 1B:**

- Mark the operative site as described in the Universal Protocol.
  - **Implementation Expectations:**
    1. Make the mark at or near the incision site. Do NOT mark any nonoperative site(s) unless necessary for some other aspect of care.
    2. The mark must be unambiguous (i.e., use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous).

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| SUBJECT: ASSESSMENT PRIOR TO INDUCTION<br>OF ANESTHESIA/SEDATION | REFERENCE #2309  |
|  | PAGE: 1<br>OF: 1 |
| DEPARTMENT: AMBULATORY CARE SERVICES                             | EFFECTIVE:       |
| APPROVED BY:   | REVISED:         |

**PURPOSE:**

The purpose of this policy is to provide optimum patient care through a comprehensive preanesthesia evaluation, ensuring that the patient is hemodynamically stable to receive administration of anesthetic agents.

**POLICY:**

- It is the policy of the Anesthesia Department to reassess all patients immediately before the delivery of anesthetic agents.
- All patients will also have a preanesthesia evaluation prior to a surgical and/or invasive procedure in those instances where anesthesia services are requested.

**PROCEDURE:**

- The patient will be evaluated by the anesthesiologist/anesthetist prior to provision of anesthesia services, with the results of the evaluation documented on the preanesthesia evaluation record.
- If an evaluation is performed by one anesthesiologist/anesthetist, but anesthesia will be administered by another anesthesiologist/anesthetist, a re-evaluation is required by the anesthesiologist/anesthetist providing anesthesia to the patient.
- All patients requiring anesthetic agents will be evaluated immediately prior to induction:
  - It is understood that the term "immediately prior to induction" means the patient will be re-evaluated **right before** moderate or deep sedation and **right before** anesthesia induction.
  - Baseline vital statistics shall be reassessed immediately prior to induction and documented as the first recording of blood pressure, pulse, respiratory rate and temperature on the Anesthesia Record. Status of the patient's airway and response to pre-procedure medications should also be assessed. Further assessment may be performed at this time according to medical staff policy and the needs of the patient.
- Documentation of above noted evaluations/re-evaluations is required by the anesthesiologist/anesthetist providing anesthesia services. A note will be made on the preanesthesia evaluation record or on the anesthesia record.

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| SUBJECT: ANESTHESIA AWARENESS        | REFERENCE #2310        |
| DEPARTMENT: AMBULATORY CARE SERVICES | PAGE: 1<br>OF: 4       |
| APPROVED BY:                         | EFFECTIVE:<br>REVISED: |

## **DEFINITIONS:**

- Anesthesia:
  - For the purpose of this policy, anesthesia consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
- Anesthesia Awareness:
  - Anesthesia awareness is defined as a situation that takes place when a patient, **under general anesthesia**, becomes aware of some or all events during surgery or an invasive procedure and has direct recall of those events.

## **POLICY:**

The Anesthesia Department is committed to preventing and, when unavoidable, adequately managing unintended intraoperative awareness, known as anesthesia awareness. The following processes will be undertaken to identify patients at risk for anesthesia awareness, prevent the occurrence if possible, and adequately manage the occurrence if it occurs.

## **PROCEDURE:**

- All clinical staff (anesthesia and nursing staff) in Outpatient Surgery will receive education on anesthesia awareness, including identification of patients at risk, precipitating factors, prevention and management of anesthesia awareness.
  - Patients who may be at risk for anesthesia awareness are those patients who undergo abdominal, cardiac, obstetric, ophthalmologic, thoracic or trauma surgeries.
  - Precipitating factors may include:
    - Excessive use of neuromuscular blockers
    - The misuse or failure of equipment during surgery
    - Inadequate anesthesia

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| SUBJECT: "HAND-OFF" COMMUNICATION IN THE PERIOPERATIVE SETTING | REFERENCE #2404  |
|  | PAGE: 1<br>OF: 5 |
| DEPARTMENT: AMBULATORY CARE SERVICES                           | EFFECTIVE:       |
| APPROVED BY:   | REVISED:         |

**POLICY:**

- "Hand-offs" are interactive communications that allow the opportunity for questioning between the giver and receiver of patient information.
- "Hand-off" communication includes:
  - Accurate patient information regarding care, treatment and services
  - Patient's current condition and diagnosis
  - Recent or anticipated changes in the patient's condition
  - What to "watch for" in the next interval of care
- Specific examples of times when the transfer of responsibility for the surgical patient, i.e., "hand-offs", occur include, but are not limited to, the following:
  - Shift change or break relief
  - Physician to surgeon/nurse to nurse/surgical technician to surgical technician transfer of patient responsibility
  - When surgeons and nurses are transferring patient to another level of care within or outside of the organization
  - Patient care unit RN/Ambulatory Care RN report to the Holding Area RN
  - Holding Area RN reports to anesthesia, the surgeon and the Circulating RN
  - Circulating RNs report to the PACU RN and/or the patient care unit RN
  - Anesthesiologists report to the PACU RN and/or to the patient care unit RN
  - Surgical team (surgeon, nurse, surgical technologist) transfer of on-call responsibility
  - Surgeon hand-off from the perioperative area to inpatient units
  - Critical laboratory and radiology results disseminated to the surgical team

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| SUBJECT: MEDICATION RECONCILIATION/<br>VERIFICATION | REFERENCE #3001        |
| DEPARTMENT: AMBULATORY CARE SERVICES                | PAGE: 1<br>OF: 6       |
| APPROVED BY:  | EFFECTIVE:<br>REVISED: |

**POLICY:**

- \_\_\_\_\_ Facility will implement and maintain a process to obtain and document a complete list of a patient’s current medications upon admission.
- Medication reconciliation is a multidisciplinary process between Nursing, the Pharmacist and the physician with patient/family involvement.
- Medication reconciliation/verification will be performed:
  - Upon admission/entry into the facility, i.e., Urgent Care, Surgery, Direct Admits
  - When a patient is transferred or referred to another setting, service, practitioner or level of care within or outside of this organization
  - Any transition of care where new medications are ordered or existing orders are rewritten (as defined by the organization)
  - At the time of discharge:
    - Medication reconciliation at the time of discharge avoids therapeutic duplication, drug interactions and omissions of medications that may have been discontinued or placed on hold during the patient’s hospitalization.
- The nurse completing the admission assessment will obtain and document the patient’s current medications taken at home. These medications will be listed on the Medication Reconciliation/Verification Form.
  - Pharmacy consultation shall be required for:
    - Patients taking high-risk medications
    - Patients taking anticonvulsants
    - Patients taking more than \_\_\_\_ medications
    - When a patient reports abnormal doses
    - Other