Association for Radiologic & Imaging Nursing

Clinical Practice Guideline

Site Marking and Verification For Invasive and/or High Risk Procedures in Radiology

Overview:

The Safety in America group and The Joint Commission have set forth guidelines for the safe care of patients undergoing invasive procedures. The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong procedure, Wrong Person Surgery™ was developed to ensure that these guidelines become a part of our culture and practice. The key point is to ensure that the correct patient receives the properly identified intended procedure and the correct site is chosen. This outcome can almost be guaranteed when all team members take an active role in the steps of the process as outlined. The Joint Commission recommends the use of two patient identifiers in the process. Elements of the process include: scheduling; informed consent; patient identification and verification of the procedure to be performed; site marking as required; "time out" which includes final confirmation of the patient's identification, the procedure to be done and the site of the procedure when necessary; and documentation of the time out and other elements required.

Target Audience:

Radiology Nurses, Radiology Technologists, Radiologists, Radiology Residents, Medical Students

Content/Strategies:

A. Marking the Procedural or Operative Site

- The individual doing the site marking is the physician or other credentialed/privileged clinician or a physician in training who is part of the team performing the procedure.
- The patient can mark the site but only when the practitioner performing the procedure is present.
- If the patient refuses to have the site marked, an alternative process such as a drawing will be used and the patient's wishes are documented in the medical record.
- The physician uses a marker that is sufficiently permanent to remain visible after completion of the skin prep.
- The mark is placed so that it is visible on the procedure field after the site is prepped and draped. Do not mark non-procedural sites. Do not use stick-on labels.
- The site is marked with the initials of the person marking the site or an X (NOTE – although the site may be marked with an X, this is discouraged as it may be ambiguous).
- In the event of a life-threatening emergency, the site may not be marked prior to patient transport; however, the radiology team must affirm the site prior to beginning the procedure.
- In cases where the clinician performing the procedure is in continuous physical attendance with the patient at the time it is determined to do the procedure, site marking is not required. All other parts of the policy apply.

B. All key clinicians involved in the care of the patient must individually verify the patient's identity, the procedure to be performed, and the site of the procedure. This is done by reviewing the relevant documentation and diagnostic studies.

- All the clinicians present perform final verification immediately prior to the procedure, using active, verbal participation. They verbally verify patient identity, the procedure to be performed and the site of the procedure (noting the current position of the patient). Whoever is documenting the final verification must verbally verify that all relevant information such as study reports, x-ray images and any special equipment needed are present in the room prior to starting the procedure.
- Documentation in the patient's medical record reflects that identification and verification was completed. This includes the initial pre-procedure verification and the "time out".
- If at any point in the process, a discrepancy is discovered in the site marking or verification process, the clinicians involved in performing the procedure are called to the patient's bedside. The procedure is stopped and does not continue until the discrepancy is reconciled.
- In the event of a life or limb emergency situation, all of the steps may not be followed but must be documented as such in the medical record.

- Any episode of wrong patient, wrong site, or wrong procedure is immediately reported in accordance with the organization's sentinel event policy and state laws.

Examples of Procedures That May Require Site Marking

Mark all cases involving laterality, multiple structures (fingers, toes, lesions) or multiple levels (spine). In addition to pre-procedure skin marking of the general spinal region, specific intra-procedural radiographic techniques are used for marking the exact vertebral level.

1. Biopsies (where there is more than one organ or laterality is involved)
2. Chest tube placement
3. Thoracentesis
4. Discogram
5. Joint Injection
6. Vertebroplasty
7. Percutaneous nephrostomy tube placement and follow-up exams/changes
8. Extremity procedures specific to that extremity (angiogram, angioplasty, thrombolysis)

Exemptions: Cardiac catheterization and Interventional cases for which the catheter instrument insertion site is not predetermined (access site is determined using intra-procedural imaging to identify the lesion. For these procedures in which site marking is not required, the other requirements for preventing wrong site, wrong procedure, wrong person surgery still apply.

References:

The Joint Commission: Frequently Asked Questions about the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong person Surgery, Available at: (www.jointcommission.org/PatientSafety/UniversalProtocol/up_faqs.htm) September 10, 2008

The Joint Commission: Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery, Available at: (www.jointcommission.org/PatientSafety/UniversalProtocol/) September 10, 2008

Time Out: An Analysis, Dillon KA, AORN J, 01 Sept 2008, Vol. 88, No.3, pg. 437-442.

Society of Interventional Radiology (SIR): Quality Improvement Guidelines for Preventing Wrong Site, Wrong Procedure, and Wrong Person Errors: Application of the Joint Commission "Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery" to the Practice of Interventional Radiology, JVIR, August 2008, Vol 19, No 8, pg 1145-1151.

Other Resources

Safest in America Group is a collaboration of 10 hospital systems in Minneapolis, St. Paul and Rochester, Minnesota that are committed to working together to improve patient care by collaborating on process improvements. (www.safestinamerica.org)

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