UMC HEALTH SYSTEM

UNIVERSITY MEDICAL CENTER

LUBBOCK, TEXAS

«PatientNumber»

«PatientName» «MotherIdentifier»

«BirthDate» «Gender» «Age»«AgeCode»

«SpecialProgramCode» «Room» «FinClass»

«DoctorName» «LabelPrintDate»

UNIVERSAL PROTOCOL CHECKLIST

(MUST BE COMPLETED AT LOCATION OF PROCEDURE)

Date: _____ Time: _____ Procedure: _____

Location: ☐ OR ☐ Cath Lab ☐ Radiology ☐ FBC ☐ Endo ☐ Other: _____

Brief

Before Anesthesia/Sedation

(Completed with patient involved, awake and aware, if possible)

Patient Identification:

(2 identifiers per P&P)

- ☐ Name
- ☐ Patient Birth Date

Other Verified Patient Identifiers:

- ☐ Medical Record Number
- ☐ Admission Date & Visit Number

Verified by:

- ☐ Patient
- ☐ Family/Guardian
- ☐ Chart
- ☐ Care Provider _____

Consents Available: (check all applicable)

- ☐ Procedure
- ☐ Anesthesia
- ☐ Blood
- ☐ Other: _____

Code Status:

- ☐ Full Code
- ☐ DNR/AND
  If DNR – Attach "ANES" band to DNR
- ☐ Band
- ☐ Care limitations

Pre-procedure tests/exams:

(check all applicable)

- ☐ H & P
- ☐ Labs
- ☐ Type/Cross (current)
- ☐ Imaging
- ☐ EKG
- ☐ Other: _____

Other:

- ☐ Allergies Confirmed

Airway/Aspiration Risk:

- ☐ Yes/equipment available
- ☐ No
- ☐ N/A

High Risk of Blood Loss:

- ☐ Yes/products available
- ☐ No
- ☐ N/A
- ☐ Patient/Caregiver Refused

Correct Site Verification: ☐ N/A

(per policy and procedure)

- ☐ Site marked prior to procedure/draping
- ☐ Site marked by team member (Physician, PA, or NP) initials with permanent marker (per policy)
- ☐ Alternate site identification process used (dual ID bands). Witness verification required per policy. ☐ N/A

Reason: _____

Witness Signature: _____

Site/Side: ☐ Right ☐ Left

- ☐ Hand/Arm ☐ Foot/Leg
- ☐ Trunk ☐ Head/Neck
- ☐ Eye ☐ Ear
- ☐ Other: _____

Correct Antibiotic Ordered:

☐ Yes ☐ No ☐ N/A

Time Out

Before Skin Incision/Procedure

(Completed with patient involved, awake and aware, if possible)

- ☐ **Sterility of supplies confirmed**
  ☐ Yes ☐ No ☐ N/A
- ☐ **Sterility of instruments confirmed**
  ☐ Yes ☐ No ☐ N/A
- ☐ **Mark visible after skin prepped and site draped?**
  ☐ Yes ☐ No (re-marked by team member)
  ☐ N/A

Prophylactic Antibiotics administered within 60 minutes of incision:

☐ Yes ☐ No ☐ N/A

Administered by: _____

Antibiotic Name: _____

Dosage: _____ Time: _____

Prophylactic Antibiotic Re-dosing Necessary:

☐ Yes ☐ No ☐ N/A

Re-dose Antibiotic Name: _____

Dosage: _____ Time: _____

(all antibiotics are given IV unless otherwise indicated)

Beta Blocker administered during the perioperative period:

☐ Yes Time given: _____ ☐ N/A

Fire Risk Assessment

Surgical site above Xiphoid?
☐ Yes ☐ No

Open oxygen source?
☐ Yes ☐ No

Available ignition source?
☐ Yes ☐ No

Surgical Fire QA

Application site of flammable germicide or antiseptic is dry prior to draping and use of electrosurgery, cautery or a laser
☐ Yes ☐ No ☐ N/A

Pooling of solution has occurred
☐ Yes ☐ No

Pooling of solution corrected
☐ Yes ☐ No ☐ N/A

Room Humidity less than 20%
☐ Yes ☐ No

Any solution-soaked materials have been removed from the surgical field prior to draping and use of electrosurgery, cautery or a laser
☐ Yes ☐ No ☐N/A

Appropriate Fire Protocol initiated based on total:

- ☐ 0-1= Low Risk
- ☐ 2=Low risk with potential to convert to High Risk
- ☐ 3=High Risk

****TIME OUT VERIFICATION:**

(must include all of the following)

- ☐ Patient Name ☐ Consent for Procedure
- ☐ Procedure ☐ Site/Side ☐ N/A
- ☐ Correct patient position
- ☐ Allergies
- ☐ Safety precautions (based on patient history)
- ☐ Essential imaging displayed ☐ N/A
- ☐ Availability of correct implants ☐ N/A
- ☐ All necessary equipment
- ☐ All medications verified and labeled
- ☐ Antibiotic irrigation solutions available ☐ N/A
- ☐ Confirmation of team members present by name
- ☐ Confirmation of prophylactic antibiotic and/or re-dose antibiotic
- ☐ Beta Blocker Administered ☐ N/A
- ☐ Post-Op Block Planned (Anesthesiology & Surgeon) ☐ No

PROCEED WITH PROCEDURE

Debrief

Before Patient or Physician Leaves Procedure Area

Nurse Verbally Confirms:

- ☐ Procedure name recorded after final verification with physician
- ☐ Counts correct (per policy)
  ☐ Yes ☐ No ☐ N/A
- ☐ Specimens collected & labeled per policy, orders placed
  ☐ Yes ☐ No ☐ N/A
- ☐ Equipment issues identified/ corrected per policy
  ☐ Yes ☐ No ☐ N/A

Active Participation by:

_____

☐ ↑Physician ☐ N/A

_____

☐ ↑PA/NP ☐ N/A

_____

☐ ↑Nurse ☐ N/A

_____

☐ ↑Technologist ☐ N/A

_____

☐ ↑Anesthesia Care Provider ☐ N/A

_____

☐ ↑Other ☐ N/A

Signature of person(s) filling out form:

	Section:	**I**	**II**	**III**
_____		☐	☐	☐
_____		☐	☐	☐
_____		☐	☐	☐

*** Indicates time out verification was performed by all the following applicable team members: Anesthesia providers, circulating nurse, technician, and other active participants who will participate in the procedure once it begins. Other activities are suspended with focus on active confirmation. All team members use interactive verbal communication and are able to express concerns about any portion of the verification.*