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|---|---|
| **Policy #:** | 03.60.000 |
| **Issued:** | January 2009 |
| **Reviewed/ Revised:** | 1/2009, 9/2011, 9/2014, 12/2015, 6/2016, 3/2017, 1/2018, 8/2018, 9/2018, 12/2021, 9/2022, 5/2025 |
| **Section:** | Clinical Care/Patient Rights |

# Universal Protocol (Time Out)

## Purpose:

To describe Boston Medical Center's (BMC) "Time Out" requirements for all invasive procedures, regardless of the location within the hospital or ambulatory site where the procedure is to be performed.

## Policy Statement:

BMC recognizes that pre-procedure verification is an ongoing process throughout the continuum of care, beginning with the decision to perform a procedure, up to and including the final pause just before the start of the procedure.

Prior to the start of any invasive procedure, BMC staff will verify that the correct patient has entered the operating room/procedure room, the correct procedure is to be performed, the correct site/side/level/multiple structures (if applicable) have been identified and marked, the availability of correct implant/tissue and any special equipment or special requirements needed for the procedure, and the existence of written documentation of informed consent.

## Application:

All invasive procedures performed at BMC in the operating room, procedure room or at patient bedside.

## Exception:

Life threatening emergencies where performing a Time Out may jeopardize patient survival or outcome.

## Procedure:

***Before entering the Operating Room, Procedure Room or at Patient Bedside***

**1. PATIENT VERIFICATION (Correct Patient)**

1.1. Verification of correct person, procedure and the correct site/side/level/multiple structures (if applicable) should occur:

1.1.1. at the time the surgery/procedure is scheduled,

1.1.2. at the time of admission to the facility, and

1.1.3. at any time the responsibility for care of patients is transferred to another caregiver.

1.2. Verification of the correct patient includes:

1.2.1. Asking the patient his/her two unique patient identifiers (see below)

1.2.2. Comparing the BMC I.D. band with a document with the name and medical record number (See *Policy #03.33.000 - Patient Identification*)

| Location | Patient Identifier Examples |
|---|---|
| Inpatient<br>Observation Unit<br>Emergency Department | Patient's full name and medical record number |
| Outpatient<br>Outpatient Procedural Areas | Patient's full name and date of birth |
| Home Care Patient | Patient's full name and address |

**Examples of Patient Identification**

| Proper Patient Identification | Improper Patient Identification |
|---|---|
| What is your full name? | Is your name Jane Doe? |
| What is your date of birth? | Were you born 1/1/1911? |
| What is your address? | Is your address 1 Boston Medical Center Place? |

1.3. **Note:** If a patient regularly uses another name that is different from their legal name, the name regularly used may appear in the medical record in quotes and ALL CAPS next to the legal name (i.e.: Optime, Francine "PETER"; Johnson, Donald "DONNA"; Smith, Mary "REBECCA"; Lopez, Michael "JAMES"). A patient's legal name will be typed on their patient identification band.

The regularly used name (the portion in caps and quotes in the medical record) is not considered part of the legal name and therefore only the legal name should be used for the purposes of identifying the patient during a Time Out verification. If the names on a patient's medical record and the typed identification band match, except for the regularly used name, then there is a match.

If necessary, explain to the patient that efforts will be made to address them by their regularly used name, but that their legal name must be used in the clinical setting for identity verification purposes related to a "Time Out" prior to a procedure for patient safety and policy compliance.

## 2. CONSENT

2.1. Incompetent Adult/ Minor Patient - In the case of an incompetent adult or minor patient, the verification of identification and confirmation that the informed consent process has been satisfactorily completed and consents signed is conducted with the patient's legal surrogate, consistent with BMC Policy 03.02.000, Patient Consent

2.2. The attending physician and attending anesthesiologist (if applicable) must verify that the consent forms are complete and signed, consistent with BMC Policy 03.02.000, Patient Consent.

2.3. When there are multiple physicians involved in a procedure for surgical patients, each physician is responsible for his or her own informed consent. The attending physician of record is responsible for informing the nursing staff of his/her designation as the physician of record.

2.4. No patient will enter the operating room/procedure room without documentation of written informed consent as described above.

## 3. SITE VERIFICATION (MARKING THE SITE)

3.1. **Marking Exceptions:**

3.1.1. When laterality or multiple levels do not exist

3.1.2. Teeth – indicate operative tooth name(s) on documentation and mark the operative tooth or teeth on dental radiographs or a dental diagram

3.1.3. In urology cases, Extracorporeal Shock Wave Lithotripsy (ESWL) and cystoscopy cases involving laterality (ureteroscopy, retrograde or stent placement) the site will be marked with the attending surgeon's initials on the ipsilateral (same side) hand where it will remain visible after positioning

3.2. The words "right" or "left" must be spelled out in entirety on the OR/procedure schedule and consent form.

3.3. The attending physician will identify the appropriate site/side/level /multiple structures (if applicable) through review of the medical record, radiologic and other studies, and physical examination of the patient.

3.4. The site/side/level/multiple structure (if applicable) must be marked prior to the administration of narcotics/sedation or any type of anesthesia, including nerve blocks for intraoperative or postoperative analgesia.

3.5. The procedure site is marked by an attending physician or other provider who is privileged or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure.

3.6. The attending physician must mark the site/procedure site/level/multiple structures (if applicable) with the patient before the patient enters the operating room/procedure room or at the bedside where the potential for wrong site procedure exists. The patient confirms the site verification to the extent possible. Interpreter services are used when necessary. Minimally invasive and natural orifice access procedures where approach is not directly adjacent to target organ(s) will be marked and laterality noted (example: initials and left kidney visible after draping for laparoscopic left nephrectomy) at the site of first incision.

3.7. The attending physician will mark the site with a skin-marking pen (no stickers) by placing his or her initials (capital letters) with or without a line representing the incision on the correct site/side/level/multiple structures (if applicable) of the surgery.

3.7.1. If the physician's initials spell NO, he/she should write the first four letters of his/her last name.

3.7.2. Do not use the letter "X"

3.8. The patient or authorized representative should be involved in the marking of the procedure site to the extent possible. The mark should be made so it is sufficiently permanent to remain visible after completion of the skin prep including patients with pigmented skin. For premature infants/neonates, use a special neonatal marker since the traditional skin-marking pen for adults may cause a permanent tattoo. If the patient has marked him/herself, the team should explain to the patient the need for verification and re-marking.

3.9. The attending physician initials with or without a line representing the incision must be clearly visible in the field once the patient is prepped and draped. An incision will not be made if the initials are not clearly visible in the field. If the initials are not visible after the skin prep and draping, the site must be re-verified and re-marked prior to continuing. This may involve removing the drapes if necessary.

3.10. Spine surgery/procedure requires a two-stage marking process:

3.10.1. Preoperative skin marking must be done on the patient's skin at the level of the procedure (for example, cervical, thoracic, lumbar)

3.10.1.1. The skin mark indicates anterior vs. posterior and right vs. left.

3.10.1.2. Before the surgery/procedure, the attending surgeon checks the patient's records, consent form, all relevant documents, and radiologic studies, and confirms the operative/procedure site with the patient.

3.10.1.3. The pre-op registered nurse will confirm that the site is marked with the attending surgeon's/proceduralist's initials before the patient is moved into the operating/procedure room.

3.10.1.4. The circulating nurse compares the patient's site marking of planned procedure to documentation on the consent form.

3.10.2. Special intraoperative radiographic techniques with immovable markers are used for locating the exact vertebral level.

3.10.2.1. The attending physician is responsible for reviewing all films used during the procedure and will confirm that the films have been properly labeled with the patient's name.

3.10.2.2. Intraoperative radiographic films will be taken to mark the exact vertebral level (site) for spine surgery.

3.10.2.3. The attending physician will ensure that his/her initials, or radiologic marker without initials, are visible after the patient has been prepped and draped. If marking is not visible after prepping and/or draping, all drapes must be removed and the entire site verification and marking process must begin again.

3.10.2.4. For non-contiguous surgical sites (separate incisions- i.e., cervical and lumbar same case), the process will be repeated for each subsequent site.

3.10.3. Do not mark any non-operative/procedure sites unless necessary for some other aspect of care.

3.10.4. If any verification process fails to identify the correct site/side/level/multiple structures (if applicable) all activities should be halted until verification is accurate.

3.10.5. If a competent patient refuses site verification, the surgery/procedure will not be performed.

***In the Operating Room, Procedure Room or at Patient Bedside***

## 4. OFFICIAL TIME OUT VERIFICATION

4.1. The official "Time Out" takes place in the operating room/procedure room or at the bedside where the procedure is being performed.

4.2. Immediately prior to the induction of any type of anesthesia, monitored anesthesia care (MAC), regional, general anesthesia, straight local, or sedation and analgesia, the official "Time Out" including safety risk assessment (fire) will be conducted. Procedures with no ignition source being used do not require a safety risk assessment (fire).

4.3. ***Operating Room and Procedure Rooms***

4.3.1. The operating room/procedure room circulating/procedure nurse will call, conduct, and coordinate the official "Time Out" for all cases with the attending physician and the attending anesthesiologist.[1]

4.3.1.1. Fellows with attending status in the OR can be involved in the Time Out. This does not include residents, medical students, physician assistants or nurse practitioners.

4.3.2. When multiple surgeons/proceduralists are involved in a procedure, the initiating surgeon/proceduralist may perform the initial Time Out. Prior to the next surgeon/proceduralist beginning his/her procedure, another official Time Out must be conducted. All surgeons/proceduralists do not have to be present for the initial Time Out.

4.3.2.1. Active participants include the attending physician, attending anesthesiologist[2], if applicable, and designated health care staff. These individuals perform the official "Time Out" and document.

4.3.2.2. All participants must actively participate - during Time Out other activities are suspended without compromising patient safety.

4.3.2.3. The Time Out documentation is only completed in Electronic Health Record (EHR) after the official Time Out is complete.

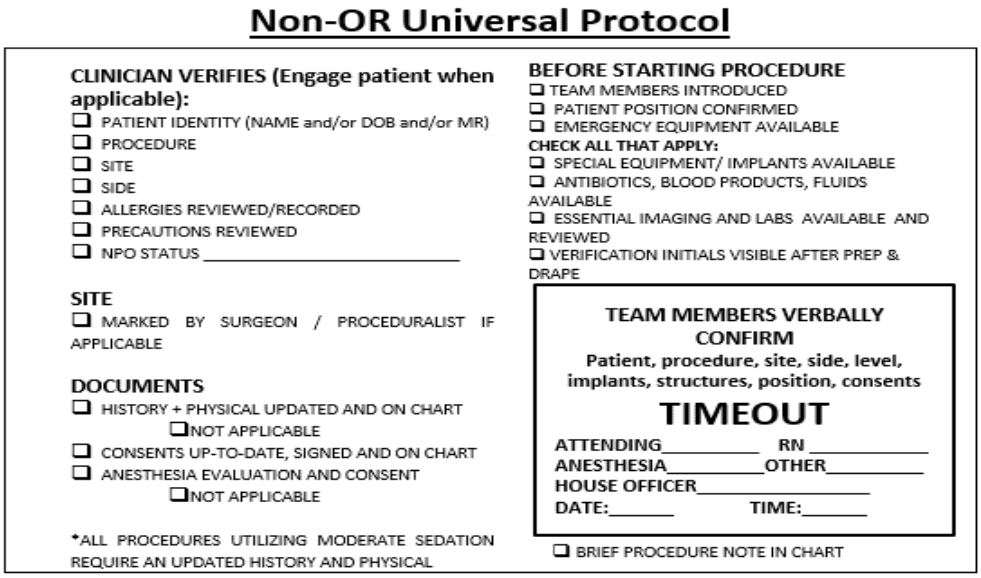
4.4. ***Non- OR Setting***

4.4.1. In non-OR setting (bedside procedures), the MD (proceduralist), RN, radiology technician, or respiratory therapist or other designated staff will call and conduct the official "Time Out". Active participants include the physician, licensed independent practitioner and/or house staff performing the procedure, anesthesiologist (if applicable) and designated health care staff. These individuals perform the official "Time Out" and initial the Time Out Documentation Sheet/Label or document in the Electronic Health Record. All participants must actively participate. During Time Out other activities are suspended without compromising patient safety. The Non-OR Universal Protocol Documentation Sticker is only signed after the official Time Out is complete.

4.4.2. The official documentation includes patient identification, surgical site verification and other initiatives that support safe surgical practice.

4.4.3. All participants must sign their initials on the Non-OR Universal Protocol documentation or document Time Out in the Electronic Health Record if available.

[1] Endoscopy Suite: The attending anesthesiologist and/or CRNA will be present during the Time Out.
[2] Endoscopy Suite: Active participants include; the attending anesthesiologist and/or CRNA.



**Non-OR Universal Protocol**

**CLINICIAN VERIFIES (Engage patient when applicable):**
- ❑ PATIENT IDENTITY (NAME and/or DOB and/or MR)
- ❑ PROCEDURE
- ❑ SITE
- ❑ SIDE
- ❑ ALLERGIES REVIEWED/RECORDED
- ❑ PRECAUTIONS REVIEWED
- ❑ NPO STATUS _____

**SITE**
- ❑ MARKED BY SURGEON / PROCEDURALIST IF APPLICABLE

**DOCUMENTS**
- ❑ HISTORY + PHYSICAL UPDATED AND ON CHART
  - ❑NOT APPLICABLE
- ❑ CONSENTS UP-TO-DATE, SIGNED AND ON CHART
- ❑ ANESTHESIA EVALUATION AND CONSENT
  - ❑NOT APPLICABLE

*ALL PROCEDURES UTILIZING MODERATE SEDATION REQUIRE AN UPDATED HISTORY AND PHYSICAL

**BEFORE STARTING PROCEDURE**
- ❑ TEAM MEMBERS INTRODUCED
- ❑ PATIENT POSITION CONFIRMED
- ❑ EMERGENCY EQUIPMENT AVAILABLE

**CHECK ALL THAT APPLY:**
- ❑ SPECIAL EQUIPMENT/ IMPLANTS AVAILABLE
- ❑ ANTIBIOTICS, BLOOD PRODUCTS, FLUIDS AVAILABLE
- ❑ ESSENTIAL IMAGING AND LABS AVAILABLE AND REVIEWED
- ❑ VERIFICATION INITIALS VISIBLE AFTER PREP & DRAPE

**TEAM MEMBERS VERBALLY CONFIRM**
**Patient, procedure, site, side, level, implants, structures, position, consents**

**TIMEOUT**

**ATTENDING**_____ **RN** _____
**ANESTHESIA**_____**OTHER**_____
**HOUSE OFFICER**_____
**DATE:**_____ **TIME:**_____

❑ BRIEF PROCEDURE NOTE IN CHART

**5. FINAL PAUSE**

5.1. A final verification is conducted immediately before making the incision or initiating the procedure. The proceduralist is responsible for calling, coordinating and conducting the Final Pause. The procedure will not start (no instruments will be passed onto the field) until there is confirmation the practitioner's initials can be seen on the field (after patient is prepped and draped) and when laterality exists.

## Responsibility:
Nursing, Licensed Independent Practitioners, House Staff

## Forms:
Non-OR Universal Protocol Sticker for Ambulatory/Bedside procedures (obtain through Materials Management)

## Attachments:
(A) Universal Protocol - Operating Room/IPP
(B) Universal Protocol – PACU

## Other Related Policies:
03.02.000 - Patient Consent
03.12.000 - Interpreter Services Department
03.33.000 - Patient Identification and Alert Bands

**Initiated by:** OR Executive Committee

**Contributing Departments:**
1) Radiology
2) Nursing
3) Endoscopy
4) Respiratory Therapy
5) Woman's Center
6) Patient Safety Risk Management
7) Regulatory Compliance
8) Interpreter Services

# Universal Protocol- Operating Room

## Upon Entering Operating/Procedure Room




**Person conducting Universal Protocol (UP) requests all activity in the room come to a complete stop; confirms visually and verbally everyone is providing their full attention before initiating next portion of the UP.**

1. **Are there contact precautions?**
2. **Introduce team members**
3. **Is the stretcher/table locked?**
4. **Are safety belts on?**
5. **Introduce patient *(confirm using name/DOB/MRN with consent, wrist band & Epic)***
6. **What procedure is being performed?**
   a. **Does this match the consent and what is in Epic? *(and imaging if applicable)*?**
   b. **Does laterality & site marking match consent and Epic?**
7. **Patient positioning?**
8. **How long is the case?**
9. **What special equipment/tissue/implants are needed?**
10. **Are there any high-risk retention items? *(bite block, vaginal or throat pack, eye shields)***
11. **Will fluoroscopy be used? *(if so, team must wear lead)***
12. **Are there blood loss concerns? *(if yes, do we need blood bank sample or cell saver?)***
13. **Is IV access adequate?**
14. **Is emergency equipment available?**
15. **What is the Fire Risk? *(over)***
16. **What is the Pulse Ox waveform and value?**
17. **Is there a difficult airway or other anesthesia concerns?**
18. **What are the temperature control measures?**
19. **What are the fluid plans?**
20. **Urinary catheter needed?**
21. **What is the prep and who will be applying it?**
22. **Are there any allergies?**
23. **What is the antibiotics plan?**
24. **Are all drugs & solutions labeled?**
25. **What is the VTE prophylaxis plan?**
26. **What is the blood pressure management plan?**
27. **Using neuromuscular blocking agents?**
28. **Any glucose control plans?**
29. **Any questions or concerns from the team?**

**Please feel free to speak up during the case if you are concerned about something**

## Final Pause Prior to Incision




**All activity in the room comes to a complete stop; visually and verbally confirm everyone is providing their full attention before initiating next portion of the UP.**

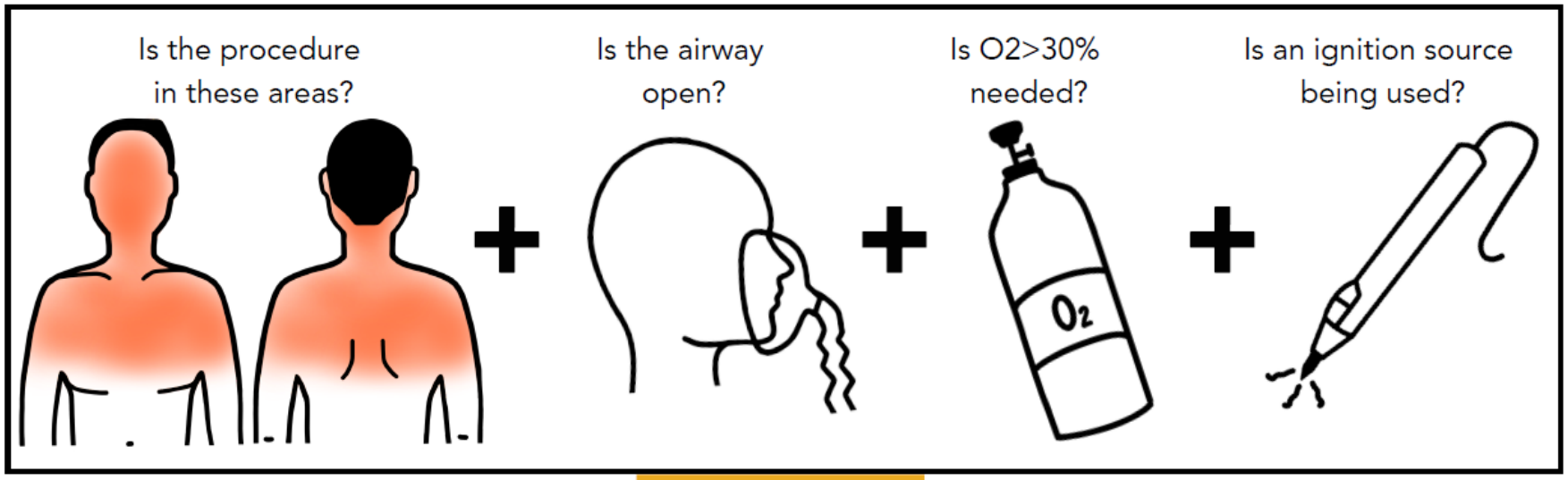
1. **Is Attending Surgeon present?**
2. **Does everyone concur about safe positioning and padding throughout the operation?**
3. **Is safety belt placed in the appropriate position? Are extremities secure?**
4. **Is site marking visible after prep and drape?**
5. **Were antibiotics given within 60 minutes of incision?**
6. **Any questions or concerns from the team?**

***If Additional Surgeons: verify patient, procedure, site, laterality, level, position, implants, special equipment & consents***

## End of Procedure Debrief

1. **What is the recovery plan & location?**
2. **Have all temporary items been removed? *(bite block, throat pack, eye shield*)**
3. **Are all counts correct?**
4. **Have the Circulating Nurse & Surgeon reconciled specimens?**
5. **Surgeon confirms diagnosis, procedure, & Wound Classification**
6. **Any final concerns?**

# Safety Risk Assessment (Fire)




**Are ALL of these present?**

**NO** → **Standard Risk**

**YES** → **High Risk**

# Universal Protocol - IPP

## Start of Operation

### UPON ENTERING OPERATING ROOM

- DISCUSS PPE, PRECAUTIONS
- CONFIRM STRETCHER AND TABLE LOCKED FOR TRANSFER

### ONCE PATIENT IS ON TABLE

#### PATIENT AND TEAM:

- APPLY SAFETY BELT(S)
- INTRODUCE PATIENT: CONFIRM NAME, DOB, AND MRN WITH LABELS AND WRISTBAND
- INTRODUCE ALL TEAM MEMBERS

#### OPERATION/PROCEDURE:

- CONFIRM OPERATION(S) AND DURATION
- CONFIRM LATERALITY AND SITE MARKING
- CONFIRM POSITION
- CONFIRM POST-OPERATIVE DESTINATION
- ANNOUNCE SPECIAL EQUIPMENT, PERSONNEL, STERILITY ISSUES, AND ITEMS AT RISK FOR RETENTION (BITE BLOCKS, THROAT PACKS, EYE SHIELDS, VAGINAL PACKS)
- EXPECTED BLOOD LOSS? BLOOD BANK SAMPLE OR CELL SAVER (IF APPLICABLE)?
- REVIEW IMAGING (IF APPLICABLE)

#### COMPLICATION PREVENTION:

- LIST ALLERGIES AND PRECAUTIONS
- IS EMERGENCY EQUIPMENT AVAILABLE?
- ASSESS SAFETY (FIRE) RISK (OVER)
- PULSE OXIMETRY WAVEFORM & VALUE?
- DIFFICULT AIRWAY, RISK OF ASPIRATION, PPE FOR INTUBATION, OTHER ANESTHESIA CONCERNS?
- LABEL ALL DRUGS and SOLUTIONS
- BETA-BLOCKER AND BP MANAGEMENT?
- VTE PROPHYLAXIS PLANS: HEPARIN, OTHER MEDICATIONS, BOOTS?
- ANTIBIOTIC PLANS?
- NEUROMUSCLAR BLOCKING AGENTS?
- GLUCOSE CONTROL PLANS?
- TEMPERATURE CONTROL MEASURES?
- FLUID PLANS?
- URINARY CATHETER PLANS? WHEN WAS LAST VOID? NO CATHETER IF POSSIBLE, ESPECIALLY IF OPERATION LESS THAN 4 HOURS

## Before Incision

### FINAL PAUSE

- STOP ALL ACTIVITY
- SURGEONS, NURSES/TECHS, AND ANESTHESIOLOGISTS CONCUR ABOUT SAFE POSITIONING AND PADDING THROUGHOUT THE OPERATION
- CONFIRM THAT TISSUE, IMPLANTS and SPECIAL DEVICES ARE AVAILABLE
- CONFIRM THAT PREP IS DRY
- CONFIRM SAFETY BELT PLACED IN THE APPROPRIATE SAFE POSITION
- IS SITE MARKING VISIBLE AFTER PREP AND DRAPE? RE-MARK SITE IF ORIGINAL MARK AND INITIALS ARE NO LONGER VISIBLE
- CONFIRM ANTIBIOTICS GIVEN BEFORE INCISION
- IS ATTENDING SURGEON PRESENT?
- DECIDE TIMING OF STAFF CHANGES
- ESTABLISH NEUTRAL ZONE
- RECORD INCISION TIME

### TIMEOUT FOR ADDITIONAL SURGEONS

**Review and verify patient, procedure, site, laterality, level, position, implants, special equipment, and consents**

## End of Operation

### BEFORE SURGEON LEAVES ROOM

- PERFORM SPONGE, INSTRUMENT, AND NEEDLE COUNTS
- CONFIRM ALL TEMPORARY ITEMS ARE REMOVED (BITE BLOCKS, THROAT PACKS, EYE SHIELDS, VAGINAL PACKS)
- DEVISE PLANS FOR INCORRECT COUNTS (SEE FLIPCARD)
- CIRCULATING NURSE AND SURGEON RECONCILE SPECIMENS
- SURGEON CONFIRMS FINAL DIAGNOSIS, NAME OF OPERATION(S)/ PROCEDURE(S) AND WOUND CLASSIFICATION (FLIPCARD)
- ANNOUNCE “STEPS TO EXIT”
- ANESTHETIST ANNOUNCES EXTUBATION SO THAT OTHERS IN ROOM CAN WEAR PPE (e.g., N-95 masks), IF NECESSARY
- ANESTHETIST, NURSE and SURGEON REVIEW PLANS FOR RECOVERY
- DISCUSS PLANS FOR POST-OPERATIVE ANALGESIA, INCLUDING POSSIBLE NERVE BLOCK
- CALL POST-OP DESTINATION WITH PPE, PRECAUTIONS, AND EQUIPMENT NEEDS
- DEBRIEF RE: PATIENT, TEAM, AND/OR EQUIPMENT CHALLENGES

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# IPP Safety Risk Assessment (Fire)

**PRESENCE OF ALL 3 = HIGH**

- Procedure involving head, neck, chest (front or back), or upper arm
- Open airway
- Use of ignition source

No → **STANDARD RISK**

Proceed but frequently reassess for changes in fire risk

- Avoid pooling of alcohol-based skin prep solutions
- Allow adequate drying time
- Surgeon communicates to the room prior to initial use of ignition source

Yes

Does the patient require oxygen?

No → Use room air sedation

Yes

Does the patient require a FiO2 > 30% to maintain O2 saturation?

No → Administer O2 below 30% via the common gas outlet of the anesthesia machine

| Desired FiO2 | Oxygen flow for 5 L/min total | Air flow for 5 L/min total |
|---|---|---|
| 21% | 0.0 | 5.0 |
| 25% | 0.3 | 4.7 |
| 30% | 0.6 | 4.4 |

Yes

**HIGH RISK**

- **GENERAL ANESTHESIA WITH ENDOTRACHEAL TUBE, LMA, OR OTHER SUPRAGLOTTIC AIRWAY DEVICE**
- If is an airway device is undesirable or not feasible, mitigate oxygen accumulation by sealing surgical field, uncovering the face and insufflating "blow by" air at 10 L/min. Have water available on the field and anesthesia workstation.

# Universal Protocol - PACU

| Pre-Operative | Post-Operative |
|---|---|
| **PATIENT CHECK-IN** | **UPON ARRIVAL** |
| ☐ PATIENT STATES NAME AND D.O.B | ☐ $O_2$ SATURATION/VS/TEMP |
| ☐ PATIENT CONFIRMS ID BAND/CONSENT | ☐ TEAM MEMBERS INTRODUCED |
| ☐ PATIENT STATES PROCEDURE, SITE, SIDE | ☐ O.R. NURSE/SURGEON REVIEW CONCERNS FOR RECOVERY |
| ☐ PATIENT NAMES HIS/HER SURGEON | ☐ EXPECTED DISPOSITION |
| ☐ PATIENT ASKED WHEN THEY LAST ATE OR DRANK | |
| ☐ DETERMINE NEED FOR INTERPRETER | **ANESTHESIA REPORT** |
| ☐ ALLERGIES REVIEWED/RECORDED | ☐ ALLERGIES VERBALIZED |
| ☐ VERIFY WITH O.R. BOARD | ☐ PATIENT HISTORY |
| ☐ SITE MARKED, IF APPLICABLE, AND CONFIRMED | ☐ LAST O.R. VITAL SIGNS |
| ☐ H&P UPDATED AND IN CHART | ☐ DRUGS ADMINISTERED |
| ☐ CONSENT UP TO DATE/SIGNED | ☐ URINE OUTPUT/BLOOD LOSS |
| ☐ ANESTHESIA PREOP/CONSENT DONE | ☐ FLUID/BLOOD PRODUCTS |
| ☐ ANESTHESIA VERIFY/DOCUMENT ASA STATUS | |
| ☐ ANTIBIOTIC ORDERED, IF APPLICABLE | **PRIOR TO FINAL SIGN OUT** |
| ☐ VTE PROPHYLAXIS, IF APPLICABLE | ☐ PROCEDURE NOTE IN CHART |
| ☐ PRECAUTIONS IDENTIFIED | ☐ ANESTHESIA DRUG/DISCHARGE ORDERS |
| ☐ PREOP RN/CIRCULATOR HANDOFF | ☐ NEED FOR CONSULTS/X-RAYS/LABS |
| ☐ IMPLANTS, SPECIAL EQUIPMENT, BLOOD AND TISSUE AVAILABLE, IF APPLICABLE | ☐ POST ANESTHESIA PROGRESS NOTE |
| ☐ DETERMINE POTENTIAL NEED FOR UNIT BED | ☐ TIMING OF ANTIBIOTICS, IF APPLICABLE |
| ☐ CONFIRM B BLOCKER USAGE AND DOCUMENT, IF APPLICABLE | ☐ FINAL DISCHARGE DISPOSITION |
| ☐ STEROID PROTOCOL, IF APPLICABLE | |
| ☐ SIGN AND RELEASE MEDS TO BED ORDER | |

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