

## 2007 National Patient Safety Goals

### National Patient Safety Goals

This chapter addresses the 2007 National Patient Safety Goals, requirements, and implementation expectations. This chapter has been reformatted to make it consistent with the structure of the standards in the manual. Implementation expectations have been added to each requirement and appear in the same format as elements of performance (EPs) in standards. In addition, rationales have been added to some of the requirements. Organizations providing care relevant to these goals are responsible for implementing the applicable requirements or effective alternatives. Compliance with these requirements is assessed throughout the accreditation cycle, through on-site surveys, and the Periodic Performance Review (PPR).<sup>1</sup> When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement in the same way that noncompliance with an element of performance generates a requirement for improvement at a standard. All requirements for improvement must be addressed in an Evidence of Standards Compliance (ESC) Report. Failure to resolve a requirement for improvement affects an organization's accreditation decision, which could ultimately lead to a loss of accreditation.

**The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety.** The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the goals generally focus on system-wide solutions, wherever possible.

As with Joint Commission standards, accredited organizations are evaluated for continuous compliance with the specific requirements associated with the National Patient Safety Goals. If an organization thinks that an alternative approach meets the intent of the requirement and wishes to implement such an alternative, the organization must obtain Joint Commission approval of the alternative.

The Joint Commission provides guidance on how to effectively comply with each goal's requirements. This guidance includes detailed answers to Frequently Asked Questions (FAQs), which are posted on the Joint Commission Web site (<http://www.jcaho.org>).

A broadly representative Sentinel Event Advisory Group works with Joint Commission staff on a continuing basis to prioritize and develop goals, requirements, and implementation expectations. As part of this development process, candidate goals, requirements, and implementation expectations are sent to the field for review and comment. The Advisory Group annually recommends selected existing and new goals, requirements, and implementation expectations to the Joint Commission's Board of Commissioners for review and

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<sup>1</sup> For those programs required to complete a PPR.

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approval. The Advisory Group also assists the Joint Commission in evaluating potential alternatives to goal requirements that have been suggested by individual organizations.

### **Goal 1**

#### **Improve the accuracy of patient identification.**

##### **Requirement 1A**

Use at least two patient identifiers when providing care, treatment or services.

##### **Rationale for Requirement 1A**

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. The intent for this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

##### **Implementation Expectations for Requirement 1A:**

**(M) C** 1. Two patient identifiers are used when administering medications or blood products

**(M) A** 2. Two patient identifiers are used when collecting blood samples and other specimens for clinical testing

**(M) C** 3. Two patient identifiers are used when providing other treatments or procedures

**A** 4. The patient's room number or physical location is not used as an identifier.

**(M) A** 5. Containers used for blood and other specimens are labeled in the presence of the patient.

### **Goal 2**

#### **Improve the effectiveness of communication among caregivers.**

##### **Requirement 2A**

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

##### **Rationale for Requirement 2A**

Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved patient safety.

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### Implementation Expectation for Requirement 2A

**(M) C 1.** The receiver of the information **writes** down the complete order or test result or enters it into a computer.

**(M) C 2.** The receiver of the information **reads** back the order or test result.

**(M) C 3.** The receiver of the information **receives** confirmation from the individual who gave the order or test result.

### Requirement 2B

Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

### Implementation Expectations for Requirement 2B

**A 1.** The organization develops a standardized a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

**A 2.** The list of abbreviations not to be used includes the following:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)<sup>2</sup>
- Lack of leading zero (.X mg)
- MS
- MSO<sub>4</sub>
- MgSO<sub>4</sub>

**(M) C 3.** The organization implements the “do not use” list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer.

**A 4.** Preprinted forms do not include any abbreviations identified as not to be used.

### Requirement 2C

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<sup>2</sup> **Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

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Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

### **Implementation Expectations for Requirement 2C**

**A 1.** The organization defines critical tests and critical results/values.

**A 2.** The organization defines the acceptable length of time between the ordering of critical tests and reporting the test results and values.

**A 3.** The organization defines the acceptable length of time between the availability of critical results/values and receipt by the responsible licensed caregiver.

**A 4.** The organization collects data on the timeliness of reporting critical test results/values.

**A 5.** The organization assesses the data and determines whether there is a need for improvement.

**A 6.** The organization takes appropriate action to improve and measure the effectiveness of those actions.

### **Requirement 2D**

**Not applicable**

### **Requirement 2E**

Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.

### **Rationale for Requirement 2E**

The primary objective of a “hand off” is to provide accurate information about a patient’s care, treatment, and services, current condition and any recent or anticipated changes. The information communicated during a hand off must be accurate in order to meet patient safety goals.

In health care there are numerous types of patient hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a patient, physicians transferring on-call responsibility, temporary responsibility for staff leaving the unit for a short time, anesthesiologist report to post-anesthesia recovery room nurse, nursing and physician hand off from the emergency department to inpatient units, different hospitals, nursing homes and home health care, critical laboratory and radiology results sent to physician offices.

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### **Implementation Expectations for Requirement 2E**

**(M) C 1.** The organization's process for effective "hand off" communication includes: Interactive communications allowing for the opportunity for questioning between the giver and receiver of patient information.

**(M) C 2.** The organization's process for effective "hand off" communication includes: Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.

**(M) C 3.** The organization's process for effective "hand off" communication includes: A process for verification of the received information, including repeat-back or read-back, as appropriate.

**A 4.** The organization's process for effective "hand off" communication includes: An opportunity for the receiver of the hand off information to review relevant patient historical data, which may include previous care, treatment and services.

**(M) C 5.** Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

### **Goal 3**

**Improve the safety of using medications.**

#### **Requirement 3A**

**Not applicable**

#### **Requirement 3B**

Standardize and limit the number of drug concentrations used by the organization.

#### **Rationale for Requirement 3B**

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. The development of standardized and redundant systems has been shown to decrease errors and improve outcomes.

#### **Implementation Expectations for Requirement 3B**

**A 1.** Standardize the drug concentrations used by the organization.

**A 2.** When more than one concentration of a drug is necessary, the number of concentrations are limited to the minimum required to meet patient care needs.

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### **Requirement 3C**

Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

### **Implementation Expectations for Requirement 3C**

**A 1.** Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 look-alike/sound-alike drug combinations selected from the tables of LASA drugs posted on the Joint Commission website).

**A 2.** Review the list of look-alike/sound-alike drugs used by the organization at least annually.

**A 3.** The organization takes action to prevent errors involving the interchange of these drugs.

### **Requirement 3D**

Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

### **Rationale for Requirement 3D**

This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or other solutions in unlabeled containers are unidentifiable. This unsafe practice neglects basic principles of medication management safety yet has been routine in many organizations with respect to medications transferred to the sterile field.

### **Implementation Expectations for Requirement 3D**

**A 1.** Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

**A 2.** Labeling occurs when any medication or solution is transferred from the original packaging to another container.

**A 3.** Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

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**(M) C 4.** All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

**A 5.** No more than one medication or solution is labeled at one time.

**A 6.** Any medications or solutions found unlabeled are immediately discarded.

**(M) C 7.** All original containers from medications or solutions remain available for reference in the perioperative/procedural area until the conclusion of the procedure.

**A 8.** All labeled containers on the sterile field are discarded at the conclusion of the procedure.

**(M) C 9.** At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

**Goal 4**  
**Not applicable**

**Goal 5**  
**Not applicable**

**Goal 6**  
**Not applicable**

**Goal 7**  
**Reduce the risk of health care-associated infections.**

**Requirement 7A**  
Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

**Rationale for Requirement 7A**  
Compliance with the CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of healthcare associated infections.

**Implementation Expectation for Requirement 7A**  
**(M) C 1.** Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines<sup>3</sup>.

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<sup>3</sup> Organizations are required to comply with all 1A, 1B, 1C CDC recommendations.

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### **Requirement 7B**

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

### **Rationale for Requirement 7B**

A significant percentage of patients who unexpectedly die or suffer major permanent loss of function have healthcare associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo a root cause analysis. The root cause analysis should attempt to answer the questions (1) why did the patient acquire an infection and, (2) given the fact of the infection, why did the patient die or suffer permanent loss of function?

### **Implementation Expectations Requirement 7B**

**(M) C 1.** The organization manages all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection as sentinel events (that is, conducts a root cause analysis).

**A 2.** The root cause analysis addresses the management of the patient before and after the identification of infection.

## **Goal 8**

**Accurately and completely reconcile medications across the continuum of care.**

### **Requirement 8A**

There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

### **Rationale for Requirement 8A**

Patients are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.

### **Implementation Expectations for Requirement 8A**

**(M) C 1.** The organization, with the patient's involvement, creates a complete list of the patient's current medications at admission/entry.

**(M) C 2.** The medications ordered for, administered to, or dispensed to the patient while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

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### **Requirement 8B**

A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the organization.

### **Implementation Expectations for Requirement 8B**

**(M) C 1.** The patient's accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization

**(M) C 2.** The next provider of service checks the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.

**(M) C 3.** The complete list of medications is also provided to the patient on discharge from the organization.

## **Goal 9**

**Reduce the risk of patient harm resulting from falls.**

### **Requirement 9B**

Implement a fall reduction program including an evaluation of the effectiveness of the program.

### **Rationale for Requirement 9B**

Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate, its patients' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, walking aids, assistive technologies and protective devices assessment and environmental assessments.

### **Implementation Expectations for Requirement 9B**

**A 1.** The organization establishes a fall reduction program.

**(M) C 2.** The fall reduction program includes an evaluation as appropriate to the patient population, settings and services provided.

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**A 3.** The fall reduction program includes interventions to reduce the patient's fall risk factors.

**(M) C 4.** Staff receive education and training for the fall reduction program

**(M) C 5.** The patient and patient's family is educated on the fall reduction program and any individualized fall reduction strategies.

**A 6.** The fall reduction program is evaluated to determine the effectiveness of the program. (Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.)

### **Goal 10**

**Not applicable**

### **Goal 11**

**Not applicable**

### **Goal 12**

**Not applicable**

### **Goal 13**

**Encourage patients' active involvement in their own care as a patient safety strategy.**

#### **Requirement 13A**

Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

#### **Rationale for Requirement 13A**

Communication with patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When patients know what to expect, they are more aware of possible errors and choices. Patients can be an important source of information about potential adverse events and hazardous conditions.

#### **Implementation Expectation for Requirement 13A**

**(M) C 1.** Patients and families are educated on methods available to report concerns related to care, treatment, services and patient safety issues.

**(M) C 2.** The organization encourages patients and their families to report concerns about safety.

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### Goal 14

Not applicable

### Goal 15

The organization identifies safety risks inherent in its patient population.

#### Rationale for Goal 15

Probabilistic risk assessment has been used to assess the designs of high hazard systems such as chemical engineering plants and space initiatives. Probabilistic risk assessment looks at events that contributed to adverse outcomes. Healthcare has the ability to identify those areas of high risk potential based on previous sentinel events and other data.

#### Requirement 15A

The organization identifies patients at risk for suicide.

**Note:** *This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.*

#### Rationale for Requirement 15A

Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission's Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important first step in protecting and planning the care of these at-risk individuals.

#### Implementation Expectations for Requirement 15A

**(M) C 1.** The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.

**(M) C 2.** The patient's immediate safety needs and most appropriate setting for treatment are addressed.

**(M) C 3.** The organization provides information such as a crisis hotline to individuals and their family members for crisis situations.

#### Universal Protocol

Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

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In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
  - Active involvement and effective communication among all members of the surgical team is important for success.
  - To the extent possible, the patient (or legally designated representative) should be involved in the process.
  - Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
  - The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
  - A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
  - The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, wrong person surgery:

- Pre-operative verification process
  - Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
  - Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the "time out" just before the start of the procedure.
- Marking the operative site
  - Purpose: To identify unambiguously the intended site of incision or insertion.
  - Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
- "Time out" immediately before starting the procedure

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- Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
- Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a “fail-safe” mode, i.e., the procedure is not started until any questions or concerns are resolved.

### Universal Protocol

The organization fulfills the expectations set forth in the Universal Protocol

### UP Requirement 1A

Conduct a pre-operative verification process as described in the Universal Protocol

### Implementation Expectations

**(M) A 1.** Verification of the correct person, procedure, and site should occur during the following (as applicable):

- 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 caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.

**(M) A 2.** The following is reviewed prior to the start of the procedure:

- Relevant documentation (e.g. H&P, consent).
- Relevant images, properly labeled and displayed.
- Any required implants and special equipment.

### UP Requirement 1B

Mark the operative site as described in the Universal Protocol

### Implementation Expectations

**(M) C 1.** Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.

**A 2.** The mark must be unambiguous. (Note: for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.)

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**(M) C 3.** The mark must be positioned to be visible after the patient is prepped and draped.

**A 4.** The method of marking and type of mark should be consistent throughout the organization.

**(M) C 5.** At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). (Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).

**(M) C 6.** The person performing the procedure should do the site marking.

**(M) C 7.** Marking must take place with the patient involved, awake and aware, if possible.

### **UP Requirement 1C**

Conduct a “time out” immediately before starting the procedure as described in the Universal Protocol

### **Implementation Expectations**

**(M) C 1.** The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

**(M) A 2.** The process must involve the entire operative team, use active communication, and must, at least, include:

- Correct patient identity.
- Correct side and site
- Agreement on the procedure to be done.
- Correct patient position.
- Availability of correct implants and any special equipment or special requirements.

**(M) C 3.** The process is briefly documented, such as in a checklist (Note: the organization should determine the type and amount of documentation.)

**A 4.** The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

### **Guidelines for the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™**

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These guidelines provide detailed implementation requirements, exemptions and adaptations for special situations.

### 1. Pre-operative verification process

Verification of the correct person, procedure, and site should occur (as applicable):

- 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 caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.

A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to the start of the procedure:

- Relevant documentation (e.g. H&P, consent).
- Relevant images, properly labeled and displayed.
- Any required implants and special equipment.

### 2. Marking the operative site

- Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.
- The mark must be unambiguous (e.g., use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous).
- The mark must be positioned to be visible after the patient is prepped and draped.
- The mark must be made using a 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.
- The method of marking and type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).
- The person performing the procedure should do the site marking.
- Marking must take place with the patient involved, awake and aware, if possible.
- Final verification of the site mark must take place during the “time out.”
- A defined procedure must be in place for patients who refuse site marking.

#### Exemptions:

- Single organ cases (e.g., Cesarean section, cardiac surgery).
- Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).

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- Teeth—BUT, indicate operative tooth name(s) on documentation *OR* mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- Premature infants, for whom the mark may cause a permanent tattoo.

### 3. “Time out” immediately before starting the procedure

Must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at the least, include:

- Correct patient identity.
- Correct side and site.
- Agreement on the procedure to be done.
- Correct patient position.
- Availability of correct implants and any special equipment or special requirements.

The organization should have processes and systems in place for reconciling differences in staff responses during the “time out.”

### 4. Procedures for non-OR settings including bedside procedures.

- Site marking must be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).
- Verification, site marking, and “time out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time out” final verification still applies.