
National "Time Out" Day: Preventing Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery

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"Time out", a strategic pause prior to starting any procedure for review of key parts of that procedure with all participating personnel, was established to enhance communication in operating rooms and prevent errors. The National "Time Out" Day is a once a year campaign to raise awareness of errors occurring in the surgical arena. It has been created by the Association of periOperative Registered Nurses (AORN), and backed by The Joint Commission, to increase mindfulness of safe practices that lead to optimal results for patients undergoing surgery and other invasive procedures.

The "time out" is an effective tool in supporting both patient safety, and the surgical teams' ability to speak up for safe habits in operating suites. The Joint Commission and AORN both urge health care organizations to pledge to conduct a safe and effective "time out" for every patient, every time. This annual National "Time Out" Day brings appreciation to the value of taking a time out, but it is important to acknowledge that wrong site, wrong procedure and wrong patient surgeries are even now occurring daily in the U.S. These errors are accurately referred to as never events. They are errors that should never occur and show grave underlying safety problems.

Site marking is a core component of The Joint Commission's Universal Protocol to prevent never events. The Universal Protocol also specifies use of "time out" prior to all procedures. It was initially designed for operating room procedures, but "time out" is now required before any invasive procedure, such as bronchoscopy or colonoscopy. The "time out" is the last thread of protection prior to an adverse event occurring. All members of the surgical team must be entirely engaged.

Communication issues are consistently revealed as a prominent underlying factor leading to never errors. Accordingly, the entire team is held responsible for following the proper "time out" procedures. Team members should feel empowered to speak up if they see something that could result in a never error. Comprehensive efforts to improve surgical safety have incorporated timeout principles into surgical safety checklists.

For your cases involving surgical procedures, Krug Consulting's legal nurse consultants can review the "time out" documentation and checklist. Where the relevant images properly labeled? Was all equipment available in the room? Where the sterilization indicators confirmed? Was the antibiotic within 1 hour before incision?

Krug Consulting was founded by Sandra Krug, RRT, CRNA Legal Nurse Consultant.

AREAS OF PRACTICE: Nursing Malpractice, Personal Injury, Product Liability, Toxic Tort and Environment, Worker's Compensation and Workplace Injury, Criminal Negligence, Health, Illness or Injury-related Legal action, Risk Management, Nursing Home Abuse, Fraud and Abuse Compliance and HIPPA, Elder Law

info@LNCKRUG.com

5910 Post Blvd #110296, Bradenton, FL

# COMPREHENSIVE SURGICAL CHECKLIST

Blue = World Health Organization (WHO) Green = The Joint Commission - Universal Protocol 2016 National Patient Safety Goals Teal = Joint Commission and WHO

| PREPROCEDURE CHECK-IN | SIGN-IN | TIME-OUT | SIGN-OUT |
|---|---|---|---|
| **In Preoperative Ready Area** | **Before Induction of Anesthesia** | **Before Skin Incision** | **Before the Patient Leaves the Operating Room** |
| **Patient or patient representative actively confirms with registered nurse (RN):** | **RN and anesthesia professional confirm:** | **Initiated by designated team member:**<br>All other activities to be suspended (except in case of life-threatening emergency) | **RN confirms:** |
| Identity ☐ Yes<br>Procedure and procedure site ☐ Yes<br>Consent(s) ☐ Yes<br>Site marked ☐ Yes ☐ N/A<br>by the person performing the procedure<br>**RN confirms presence of:**<br>History and physical ☐ Yes<br>Preanesthesia assessment ☐ Yes<br>Nursing assessment ☐ Yes<br>Diagnostic and radiologic test results ☐ Yes ☐ N/A<br>Blood products ☐ Yes ☐ N/A<br>Any special equipment, devices, implants ☐ Yes ☐ N/A<br><br>Include in Preprocedure check-in as per institutional custom:<br>Beta blocker medication given ☐ Yes ☐ N/A Venous thromboembolism prophylaxis ordered ☐ Yes ☐ N/A<br>Normothermia measures ☐ Yes ☐ N/A | Confirmation of the following: identity, procedure, procedure site, and consent(s) ☐ Yes<br>Site marked ☐ Yes ☐ N/A<br>by person performing the procedure<br>Patient allergies ☐ Yes ☐ N/A<br>Pulse oximeter on patient ☐ Yes<br>Difficult airway or aspiration risk<br>☐ No ☐ Yes (preparation confirmed)<br>Risk of blood loss (> 500 mL)<br>☐ Yes ☐ N/A<br># of units available _____<br>Anesthesia safety check completed<br>☐ Yes<br><br>**Briefing:**<br>All members of the team have discussed care plan and addressed concerns ☐ Yes | Introduction of team members ☐ Yes<br>**All:**<br>Confirmation of the following: identity, procedure, incision site, consent(s) ☐ Yes<br>Site is marked and visible ☐ Yes ☐ N/A<br>Fire Risk Assessment and Discussion<br>☐ Yes (prevention methods implemented)<br>☐ N/A<br>Relevant images properly labeled and displayed ☐ Yes ☐ N/A<br>Any equipment concerns ☐ Yes ☐ N/A<br>**Anticipated Critical Events**<br>**Surgeon:** States the following:<br>☐ Critical or nonroutine steps<br>☐ Case duration<br>☐ Anticipated blood loss<br>**Anesthesia professional:**<br>Antibiotic prophylaxis within 1 hour before incision ☐ Yes ☐ N/A<br>Additional concerns ☐ Yes ☐ N/A<br>**Scrub person and RN circulator:**<br>Sterilization indicators confirmed ☐ Yes<br>Additional concerns ☐ Yes ☐ N/A<br>**RN:**<br>Documented completion of time out ☐ Yes | Name of operative procedure:<br>_____<br>Completion of sponge, sharp, and instrument counts ☐ Yes ☐ N/A<br>Specimens identified and labeled ☐ Yes ☐ N/A<br>Equipment problems to be addressed ☐ Yes ☐ N/A<br>Discussion of Wound Classification<br>☐ Yes<br>**To all team members:**<br>What are the key concerns for recovery and management of this patient?<br>_____<br>_____<br>_____<br>_____<br>**Debriefing with all team members:**<br>Opportunity for discussion of<br>– team performance<br>– key events<br>– any permanent changes in the preference card<br>June 2016 |

The Joint Commission does not stipulate which team member initiates any section of the checklist except for site marking. The Joint Commission also does not stipulate where these activities occur. See the Universal Protocol for details on the Joint Commission requirements.

AORN