

Enhanced Time Out: An Improved Communication Process



PATRICIA E. NELSON, MSN-Ed, RN, CNOR

ABSTRACT

An enhanced time out is an improved communication process initiated to prevent such surgical errors as wrong-site, wrong-procedure, or wrong-patient surgery. The enhanced time out at my facility mandates participation from all members of the surgical team and requires designated members to respond to specified time out elements on the surgical safety checklist. The enhanced time out incorporated at my facility expands upon the safety measures from the World Health Organization's surgical safety checklist and ensures that all personnel involved in a surgical intervention perform a final check of relevant information. Initiating the enhanced time out at my facility was intended to improve communication and teamwork among surgical team members and provide a highly reliable safety process to prevent wrong-site, wrong-procedure, and wrong-patient surgery. *AORN J* 105 (June 2017) 564-570. © AORN, Inc, 2017. <http://dx.doi.org/10.1016/j.aorn.2017.03.014>

Key words: *surgical safety checklist, The Universal Protocol, wrong-site surgery, culture of safety, time out.*

Creating an enhanced time out is one strategy to improve communication among surgical team members and to help prevent wrong-site, wrong-procedure, and wrong-patient surgery. The Joint Commission classifies wrong-site, wrong-procedure, and wrong-patient surgeries as sentinel events that should be prevented to reduce risk to patients and to improve safety practices during invasive surgical procedures.¹ Sentinel events are patient safety incidents that result in “death, permanent harm, [or] severe temporary harm and intervention required to sustain life.”¹ Sentinel events require immediate investigation and response by health care organizations.¹ A seminal study on sentinel events supported by the Agency for Healthcare Research and Quality (AHRQ) estimated that wrong-site, wrong-procedure, and wrong-patient surgeries occur in approximately 1 of 112,994 surgical procedures in the OR, not including incidents in other procedural areas that may increase the prevalence of these mistakes.² The summary data of sentinel events reviewed by The Joint Commission indicated that

between 2004 and 2015, there were 1,215 reports of wrong-site, wrong-procedure, or wrong-patient surgery, and these were the most frequently reported sentinel events.³ According to the AHRQ Patient Safety Network, wrong-side surgery may be the most frequently reported type of wrong-site surgery.⁴ The statistics from the AHRQ Patient Safety Network and The Joint Commission indicate the severity of the problem of wrong-site, wrong-procedure, or wrong-patient surgery and the need for health care organizations to develop safety protocols to address this problem.^{1,3,4}

BACKGROUND

To combat the incidence of wrong-site, wrong-procedure, and wrong-patient surgery, several regulatory bodies and organizations formed their own protocols to ensure a safe patient care environment. The Joint Commission developed The Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery in 2004 to help hospitals improve their

<http://dx.doi.org/10.1016/j.aorn.2017.03.014>

© AORN, Inc, 2017

safety practices regarding preoperative verification of the patient, preoperative verification of the surgical site, surgical site marking, and a time out before the surgical intervention.^{5,6} The Universal Protocol followed the American Academy of Orthopaedic Surgeons' 1998 report, which cited a 25% chance that orthopedic surgeons will operate on the wrong site at some point in their careers.^{5,7} This report eventually led to the "Sign Your Site" campaign that advised orthopedic surgeons to initial the surgical site before beginning the surgical intervention.⁸ In 2008, the World Health Organization formulated a surgical safety checklist⁹ to improve basic clinical processes and patient outcomes and to address the serious ramifications of surgical errors and their negative effects on patients and the health care industry.¹⁰ The World Health Organization updated the surgical safety checklist in 2009. The checklist includes three components: the phase before induction, the phase before skin incision, and the phase before the patient leaves the OR.⁹

Although the surgical safety checklist is a useful reminder for perioperative staff members to adhere to safety protocols, it does not resolve every safety issue. It does help to encourage interaction among team members and promote a culture of safety.¹⁰ A cross-sectional study by Haugen et al¹¹ on surgical team members' perceptions of near-miss experiences and their attitudes toward time out protocols concluded that routines to prevent wrong-site, wrong-procedure, and wrong-patient surgery varied significantly among medical professionals. Varied practices can affect surgical team members' communication and their adherence to safety protocols. A 2013 prospective controlled intervention study measured the effects of the World Health Organization surgical safety checklist on OR personnel's perceptions of safety culture. The results indicated that introducing the checklist had a minimal effect on patient safety culture.¹⁰ However, a review by Ragusa et al⁵ on the effectiveness of surgical safety checklists at improving patient safety found that protocols can improve patient safety, although checklists have not been proven to reduce wrong-site surgery.

According to the AHRQ Patient Safety Network, poor communication is a major contributing factor in wrong-site, wrong-procedure, and wrong-patient surgery.⁴ They concluded that additional factors, such as production pressure and rushed time outs, can also contribute to these errors.⁴ Distractions and interruptions during critical phases of a procedure can also contribute to errors in the OR. A study by Feuerbacher et al¹² tested surgical residents during a simulated surgery by initiating four distractions and two interruptions during the procedure. The residents made major surgical errors in 8 of 18 simulated procedures with distractions and interruptions but only one major surgical error when there were no distractions or

interruptions. To address the problem of distractions and interruptions, personnel in some ORs have initiated the "no interruption zone," a quiet time when the surgical team is required to stop all conversations and unnecessary activities. This quiet time can be initiated during critical phases of a procedure such as the time out.¹³

In 2009, the Centers for Medicare & Medicaid Services began refusing to reimburse hospitals for any cost associated with a preventable event such as wrong-site, wrong-procedure, or wrong-patient surgery.^{4,14-16} This refusal to reimburse hospitals was a major impetus for health care institutions to address patient safety concerns regarding wrong-site, wrong-procedure, and wrong-patient surgery.

USING A SURGICAL SAFETY CHECKLIST

My facility is part of a comprehensive academic health care system in the New York metropolitan area and is one of the largest health care providers in the United States. We use a two-tiered surgical safety checklist that moves with the patient from the preoperative area to the OR and is archived in the OR. One side addresses the preoperative preparation of the patient, and the other side addresses intraoperative safety processes. The preoperative portion of the checklist is divided into five sections that specified perioperative team members must complete in the preoperative area and confirm they have completed by checking the designated boxes.

The preoperative admitting nurse completes the first section, which addresses verification of the patient's

- identity,
- allergies,
- availability of blood,
- nursing assessment,
- isolation precautions, and
- organ transplant status.

The anesthesia care provider completes the second section, which includes

- preanesthesia evaluation,
- obstructive sleep apnea assessment, and
- airway assessment.

The surgeon completes the third section, which includes confirmation that the following items are complete or have been verified:

- the patient's history and physical examination,
- the preoperative surgeon's plan of care,
- the patient's diagnosis,
- the surgical consent form,

Download English Version:

<https://daneshyari.com/en/article/5566926>

Download Persian Version:

<https://daneshyari.com/article/5566926>

[Daneshyari.com](https://daneshyari.com)