Two Takes on the "Time Out"

The practice of holding a "time out"—pausing for final verification of a patient's identity, procedure, and operative site—has been widely cited as one strategy to prevent wrong patient, wrong site, and wrong procedure errors in surgery and other invasive interventions. The time out can be a useful defense against these types of errors, as illustrated in several reports submitted to PA-PSRS in which time outs highlighted potential patient identification problems. These reports represent success stories for the time out practice.

Other reports we have received document problems in implementation that may limit the theoretical benefits of this safety practice. However, these stories, too, hold lessons that may help other facilities promote and execute this practice more effectively.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) includes the use of a time out immediately prior to surgeries and "other invasive procedures that expose patients to harm" in its Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™. [Ed. Note: The JCAHO Universal Protocol was previously addressed in the June 2004 *PA-PSRS Patient Safety Advisory*, under the headline "Patient Safety News."] This protocol, which became mandatory for all JCAHO-accredited facilities on July 1, 2004, requires that the time out:

> [B]e 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…and must, at the least, include:

- Correct patient identity

- Correct site and side

- 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."[1]

JCAHO is not the only organization to advocate the use of the time out practice. The American College of Surgeons (ACS) suggests that members of the surgical team conduct a final verification process to ensure that the patient, procedure, and site are correctly identified. Further, ACS suggests that all activities be halted until verification is accurate.[2] The Association of periOperative Registered Nurses (AORN) also advocates the time out procedure in its position statement on correct-site surgery.[3] VHA, a national alliance of not-for-profit hospitals and health systems, incorporates the time out practice in its safety program "7 Absolutes to Avoid Surgical Site Errors."[4]

The Success Stories

Case #1: An elderly patient undergoing repair of a hip fracture was prepped for a *right*-sided procedure, consistent with the consent, history and physical, and a consultation report. During the time out, the surgical team determined [*method unspecified*] that the patient had a *left* hip fracture, which was then confirmed by x-ray. The procedure was performed on the correct side.

Case #2: Prior to performing an angiography, the team conducted a time out and found an unspecified error on the patient's wrist band. A nurse familiar with the patient was called to the radiology department to positively identify the patient. A new, corrected wrist band was placed on the patient before the procedure began.

Two Takes on the "Time Out" (Continued)

Case #3: An adolescent patient was brought to interventional radiology for a lumbar puncture. During a time out, the team discovered that the birth date on the patient's wrist band was incorrect. The procedure was halted while the correct birth date was confirmed with the patient's parents. The error was corrected and a new wrist band applied prior to beginning the procedure.

These reports are "success stories" because the healthcare providers seem to have executed the time out procedure very well. The time out in the first case clearly prevented a wrong-side surgery. In neither case 2 nor 3 had they been about to perform a procedure on the wrong patient; the only aspect of the verification process noted as problematic is the wrist band. Yet, in both cases the clinical team took the safe course in halting the procedure until all information used in the verification process was in agreement.

It is also interesting to note that the facility in the third case performed a time out before a lumbar puncture, which is not universally viewed as an invasive procedure. While the time out is typically performed prior to surgeries and other invasive procedures to prevent patient identification errors, these are not the only clinical situations where patient identification is a problem. For example, during one month, PA-PSRS received twice as many reports involving the wrong patient, side, site, or procedure in relation to radiology/imaging as in relation to surgeries/invasive procedures.

One might ask why something as common as wrist band errors would bring to a halt procedures where all other sources of verification—including presumably the members of the clinical teams themselves—were in agreement. While on its face this question seems reasonable, consider the counter-argument. How many opportunities would there have been to check these patients' identities before they reached the sites of their procedures? How many times must someone have failed to look at their wrist bands, or looked but failed to notice the errors, or noticed the errors but failed to correct them? The fact that these errors were not caught earlier during medication administration and/or diagnostic testing appropriately made these clinical teams confirm their patients' identities and correct the errors.

A number of other reports recount the time out procedure successfully identifying errors or omissions in documentation used in the verification process,

failure to obtain or document consent, and failure to mark the operative site.

Tips for Performing the "Time Out"

- Performing immediately before the procedure begins
- Performing in the same location where the procedure will be performed
- Performing with the patient and clinical team in the same positions as during the procedure
- Performing after marking the operative site
- Involving all members of the clinical team
- Using active communication (i.e., not assuming silence means assent)
- Using all available documentation (e.g., patient wrist band, history and physical, OR schedule, patient consent, results of imaging or other diagnostic studies)
- Holding the procedure until all forms of verification are in agreement
- Documenting the results of the time out, including how any discrepancies were resolved

Sources: JCAHO[5, 6] and ECRI

The Cautionary Tales

Case #1: A patient presented for cystoscopy and replacement of a stent in the *left* ureter. The OR team completed a final time out before beginning the procedure. During the procedure, an unspecified feature of the patient's anatomy caused the surgeon to assume the patient's consent (and presumably other documentation) had been in error, and she inserted the stent in the *right* ureter. With the patient in recovery, the surgeon contacted her office and confirmed that the *left* had been the correct side. The patient was brought back to the OR, the stent placed earlier was removed, and a stent was placed correctly in the left ureter.

The problem in implementing the time out procedure in this case is that the surgeon ignored the results of the time out, which presumably ended with all members of the surgical team concurring with the available documentation that this was a left-sided procedure. When the surgeon encountered contradictory evidence about the correct side for this procedure in the form of some anatomical feature of the patient, she weighed the evidence of the pre-operative documentation and the surgical team's time out against the evidence provided by the patient's anatomy. Presumably, the latter evidence seemed the more compelling at the time, and the procedure proceeded incorrectly.

Two Takes on the "Time Out" (Continued)

During a time out, if any single element of the verification process is inconsistent with the others, some clinical teams will halt the procedure until the error is corrected. Though the time out had been completed and the procedure was in progress when the surgeon encountered the contradictory evidence, it may have been possible for the surgeon to pause long enough to contact her office from the OR during the procedure rather than after it. Further, the fact that the surgeon implicitly discounted the evidence reviewed during the time out may indicate that documentation errors are so frequent that clinicians are predisposed to doubt their veracity.

Case #2: A 45-year-old female patient presented for surgery for release of "trigger thumb." Prior to conducting a time out, the surgeon made an incision at the site for a carpal tunnel release. Another clinician alerted the surgeon to the error. After suturing the incorrect incision, the team stopped to perform a time out, and then proceeded to perform the scheduled operation.

Clearly, the problem in implementing the time out in this case is that the surgeon made an incision *before* performing the time out. It is not clear whether this was a lapse or an intentional violation. The systems lesson in this case is less about the technical details of the time out than it is about teamwork and a culture of safety. If the surgeon was impatient and skipped the time out intentionally, this sends a message to the rest of the OR team that safety measures are unimportant and can be ignored.

However, if this was an unintentional lapse, the team might consider whether a change in group dynamics surrounding the time out might decrease the probability of omitting it. For example, if it is not clear who is responsible for calling the time out, *no one* may feel responsible. On the other hand, if the surgeon feels that he or she alone bears all the responsibility for patient identification, he/she may feel that "it's their call" whether to ignore verification-related safety practices.

We cannot leave this case, of course, without noting that another member of the team did stop the surgeon when witnessing the wrong incision. A fundamental attribute of a culture of safety is the recognition that safety is everyone's responsibility. In another facility or in another surgical team, that same clinician may have felt too intimidated to correct the surgeon's mistake.

Notes

1. Joint Commission on Accreditation of Healthcare Organizations. Universal protocol for the prevention of wrong site, wrong procedure, and wrong patient surgery [online]. 2003 Jul 18 [Cited 16 Aug 2004]. Available from Internet: http://www.jcaho.org/ accredited+organizations/patient+safety/universal+protocol/wss_universal+protocol.htm.

2. American College of Surgeons. Statement on ensuring correct patient, correct site, and correct procedure surgery. *Bull Am Coll Surg* 2002 Dec;87(12).

3. Association of periOperative Registered Nurses. AORN position statement on correct site surgery [position statement]. 2003 Feb [Cited 2004 Aug 16]. Available from Internet: http://www.aorn.org/about/positions/correctsite.htm.

4. Mathias JM. VHA's program to curb wrong-site surgery. *OR Manager* 2002 Mar;18(3):7-9.

5. Joint Commission on Accreditation of Healthcare Organizations. Guidelines for implementing the universal protocol for the prevention of wrong site, wrong procedure, and wrong patient surgery [online]. 2003 Jul 18 [Cited 2004 Aug 16]. Available from Internet: http://www.jcaho.org/accredited+organizations/ patient+safety/universal+protocol/up+guidelines.pdf.

6. Joint Commission on Accreditation of Healthcare Organizations. Frequently asked questions about the universal protocol for preventing wrong site, wrong procedure, wrong person surgery [online]. 2003 Jul 18 [Cited 2004 Aug 16]. Available from Internet: http://www.jcaho.org/accredited+organizations/patient+safety/universal+protocol/faq_up.htm.

An Independent Agency of the Commonwealth of Pennsylvania

The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act. Consistent with Act 13, ECRI, as contractor for the PA-PSRS program, is issuing this newsletter to advise medical facilities of immediate changes that can be instituted to reduce serious events and incidents. For more information about the PA-PSRS program or the Patient Safety Authority, see the Authority's website at www.psa.state.pa.us.

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The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP's efforts are built on a non-punitive approach and systems-based solutions.