Implementing a Scripted Timeout – Preventing Wrong Site Surgery

The Problem

Root cause analysis identified lack of standardzation and effective communication as contributing factors in a wrong site surgery at BIDMC

Aim/Goal

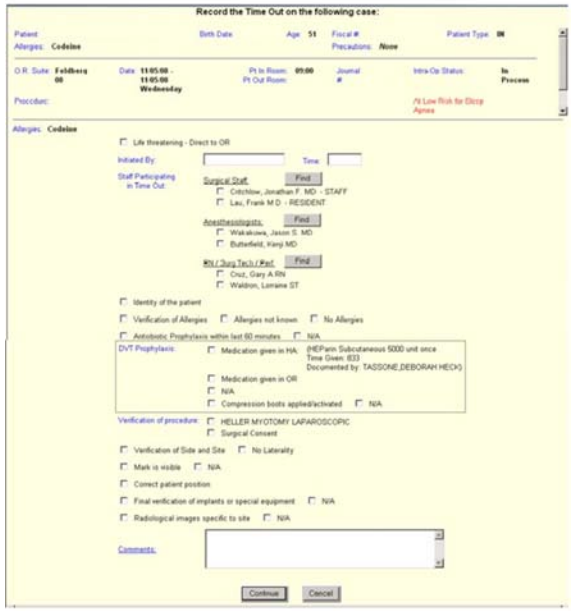
To engineer and implement a script for the final timeout prior to incision.

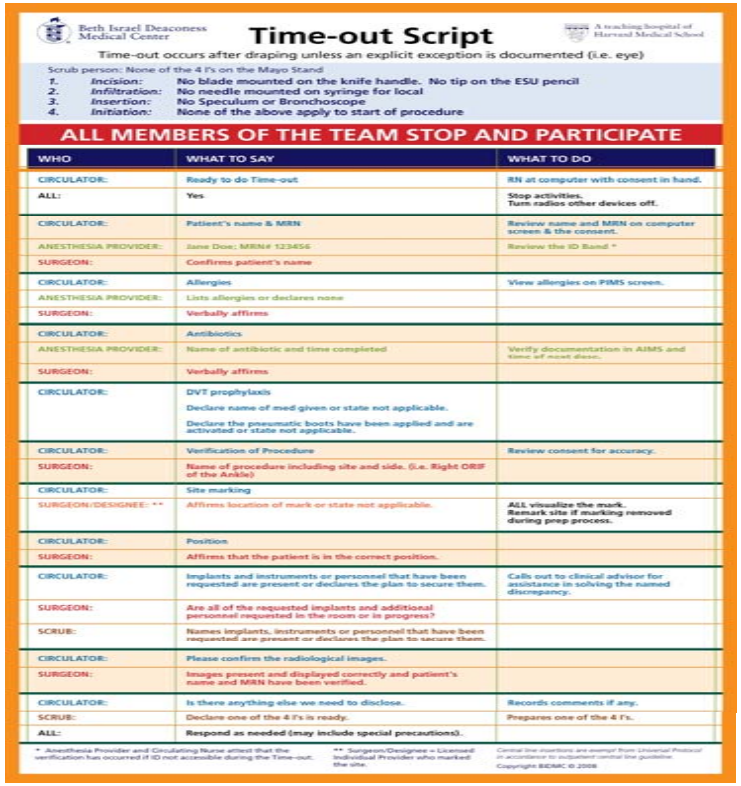
The Team

- Safety Culture Operational Task Force
- Perioperative Information Management System (PIMS) Steering Committee
- Perioperative Safety Steering Committee
- Carl J. Shapiro Skills & Simulation Center Staff

The Interventions

- Creation of a script
- Development of real time documentation in PIMS
- Role identification and clarity
- Weekly audit process by mystery shoppers





Beth Israel Deaconess Medical Center

Time-out Script

A teaching hospital of Harvard Medical School

Time-out occurs after draping unless an explicit exception is documented (i.e. eye)

Scrub person: None of the 4 I's on the Mayo Stand

1. *Incision:* No blade mounted on the knife handle. No tip on the ESU pencil
2. *Infiltration:* No needle mounted on syringe for local
3. *Insertion:* No Speculum or Bronchoscope
4. *Initiation:* None of the above apply to start of procedure

ALL MEMBERS OF THE TEAM STOP AND PARTICIPATE

WHO	WHAT TO SAY	WHAT TO DO
CIRCULATOR:	Ready to do Time-out	RN at computer with consent in hand.
ALL:	Yes	Stop activities. Turn radios other devices off.
CIRCULATOR:	Patient's name & MRN	Review name and MRN on computer screen & the consent.
ANESTHESIA PROVIDER:	Jane Doe; MRN# 123456	Review the ID Band *
SURGEON:	Confirms patient's name	
CIRCULATOR:	Allergies	View allergies on PIMS screen.
ANESTHESIA PROVIDER:	Lists allergies or declares none	
SURGEON:	Verbally affirms	
CIRCULATOR:	Antibiotics	
ANESTHESIA PROVIDER:	Name of antibiotic and time completed	Verify documentation in AIMS and time of most dose.
SURGEON:	Verbally affirms	
CIRCULATOR:	DVT prophylaxis Declare name of med given or state not applicable. Declare the pneumatic boots have been applied and are activated or state not applicable.	
CIRCULATOR:	Verification of Procedure	Review consent for accuracy.
SURGEON:	Name of procedure including site and side. (i.e. Right ORIF of the Ankle)	
CIRCULATOR:	Site marking	
SURGEON/DESIGNEE: **	Affirms location of mark or state not applicable.	ALL visualize the mark. Remark site if marking removed during prep process.
CIRCULATOR:	Position	
SURGEON:	Affirms that the patient is in the correct position.	
CIRCULATOR:	Implants and instruments or personnel that have been requested are present or declares the plan to secure them.	Calls out to clinical advisor for assistance in solving the named discrepancy.
SURGEON:	Are all of the requested implants and additional personnel requested in the room or in progress?	
SCRUB:	Names implants, instruments or personnel that have been requested are present or declares the plan to secure them.	
CIRCULATOR:	Please confirm the radiological images.	
SURGEON:	Images present and displayed correctly and patient's name and MRN have been verified.	
CIRCULATOR:	Is there anything else we need to disclose.	Records comments if any.
SCRUB:	Declare one of the 4 I's is ready.	Prepares one of the 4 I's.
ALL:	Respond as needed (may include special precautions).	

* Anesthesia Provider and Circulating Nurse attest that the verification has occurred if ID not accessible during the Time-out.

** Surgeon/Designee = Licensed Individual Provider who marked the site.

Central line insertions are exempt from Universal Protocol in accordance to outpatient central line guideline

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Lessons Learned

- Lack of standard processes, communication and reverence were found to contribute to a wrong site surgery at BIDMC.
- Empowered point of care stakeholders can create workable solutions
- Weekly timeout audits using scripts 100% compliance since implementation.

Next Steps

Expanding the process to include pre-procedure verification in Holding Area and implementation of WHO model of briefings at sign in and sign out.

Application of lessons learned to other procedure areas in the Medical Center.

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