TIME OUT

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Harris Health System
# Time Out Taskforce

<table>
<thead>
<tr>
<th>Members</th>
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<tbody>
<tr>
<td>Sandeep Markan, MD</td>
<td>Donna McKee, RN</td>
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<td>Glorimar Medina, MD</td>
<td>Angela Sterling, RN</td>
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<td>Babajide Olutimehin, MD</td>
<td>Cynthia Laborde, RN</td>
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<tr>
<td>James Melville, MD</td>
<td>Ana Davis, RN</td>
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<tr>
<td>Lubna Chohan, MD</td>
<td>Ruby Hernandez, RN</td>
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<td>Lisa Danek, MD</td>
<td>Sharon Land, RN</td>
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<tr>
<td>Tammy Tran, IT</td>
<td>Renee Russell, RN</td>
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<tr>
<td>Christine Victorian, Quality ACS</td>
<td>Frank Baldwin, RN</td>
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<tr>
<td>Delisa Frederickson, Quality LBJ</td>
<td>Lydia Rogers, RN</td>
</tr>
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<td>Angela Russell, Quality BT</td>
<td>Bertha Beltran, COA</td>
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Problem

Inconsistent process for “Time Out” across the organization
Goal

To hardwire the time out process throughout the Harris Health system.

Effective team communication is a critical component of safe surgery, efficient teamwork and the prevention of major complications.
The desired outcome of performing a surgical time out is to improve communication among the team and protect the safety of the patient during surgery through systematic verification of essential information regarding the patient and the specific surgery that is scheduled to be performed.
Why a Time Out?

• Reduces the risk for making preventable errors during surgery including the following:
  • Performing surgery on the wrong patient
  • Performing surgery on the wrong site/side
  • Performing the wrong procedure
  • Lack of preparedness for performing the procedure
  • Lack of preparedness to respond to an emergency and or complication
Why a Checklist?

• Medical complexity is increasing
• Era of super and sub specialists
• Average hospital patient has up to 15 medical professional interactions per day compared to 2.5 FTE in 1970
• Over 6000 drugs we might prescribe from
• We are individuals and not a system – the system needs teamwork
• We are under constant time and production pressures

Atul Gawande – The Checklist Manifesto
Surgical Safety Checklist

Why we resist the checklist idea:

• We stand for autonomy and pride in our professional work
• This implies fallibility and that we are human
• Emphasizes team over individual rank and capacity
• Needs concerted discipline and feels like a chore / imposition
Surgical Safety Checklist

• The Checklist is intended to give teams a simple, efficient set of priority checks for improving effective teamwork and communication and to encourage active consideration of the safety of patients in every operation performed.

• The checklist ensures that the team shares information about potential safety problems and concerns related to the patient and the process.

• The checklist, when used routinely, helps to embed the recognition and reporting of safety issues into every day work.
Facts

• Use of the surgical safety checklist has shown to decrease surgery related deaths and complications by 33% (Ly, 2009)

• 2013 study showed mean compliance of time out at 78% (Poon, 2013)

2012 Nursing study showed (Bragg, 2012)
• 26% of nurse clinicians reported that a time out was performed correctly only in two of the last three procedures in which they participated;
• 35% of nurse clinicians reported that pressure to complete the surgery was the greatest barrier to performing a time out correctly;
• 16% of nurse clinicians reported that they worked with surgical team members that refused to participate in the time out;
• 65% of nurse clinicians reported being unaware of a non-punitive process for reporting incorrect performance of the time out.
Dysfunctional Teams

Lencioni, P: The Five Dysfunctions of a Team
Dysfunctional Teams - Absence of trust

Members don’t trust one another enough to admit their own weaknesses – they will be reluctant, for example, to say ‘I don’t know’ and individuals will not allow their vulnerability or concerns to show or come to the surface.

*Lencioni, P: The Five Dysfunctions of a Team*
Dysfunctional Teams - Fear of conflict

Individuals are afraid to disagree, challenge or raise their voice if it is in opposition to the leader or another member of the group.

They will therefore be afraid to challenge decisions for fear of conflict (ridicule, shaming, being shouted at).

If there is fear of conflict, a team member may be unlikely to raise their voice and point out mistakes, eg. if a surgeon is about to operate on the wrong site.

Lencioni, P: The Five Dysfunctions of a Team
Dysfunctional Teams - Lack of commitment

In the context of a team, commitment is a function of two things: *clarity* and *buy-in*.

Great teams make clear and timely decisions and move forward with complete buy-in from every member of the team, even those who voted against the decision.

*Lencioni, P: The Five Dysfunctions of a Team*
Dysfunctional Teams - Avoidance of accountability

People are reluctant to discuss and admit mistakes. They may ignore errors completely or attribute blame to others or to circumstances. People do not feel accountable in these teams and find ways to deflect blame.
Dysfunctional Teams - Inattention to results

Individuals attend to what they did and they may narrow down their description of events to exactly what they did and how they did rather than see what they did or failed to do in the context of the team.

They are concerned to preserve their own sense of capability, reputation and esteem rather than take responsibility for the performance of the whole team.
High Performing Teams

• Understand their own and other members’ roles and responsibilities
• Encourage contributions of all members and ensure that all views are taken into account
• Respect the leadership of the team
• Have the shared goal of high quality care for the patient
• Show a commitment to team work in the best interest of the patient
• Recognize they are important to the outcome of the task
• Feel confident to raise their voice or intervene.
High Performing Teams

• High performing teams are characterized by communication which is timely, clear, open and respectful.

• Communication between individual team members through the use of the Surgical Safety Checklist is important.

• Team members should feel they can speak up, provide input and know that they will be heard and listened to where appropriate.
Leadership – 5 levels - John C Maxwell

5 *Pinnacle*- people follow for who you are and what you represent

4 *People Development*- people follow for what you have done for them

3 *Production*- people follow for your contribution to Company

2 *Permission*- people follow because they want to

1 *Position*- people follow since they have to
Role of Leadership

- Advocates for the change they wish to see
- Adopt the model of change themselves
- Budgetary power to support initiative
- Face and voice of change – stay clear and concise
- Provide motivation to change
- Be the enforcer – hold people accountable
Role of Leadership

Convey conviction to employees that:

- Project has right purpose
- Effort expended will be worthwhile
- Provide evidence of systems improvement
- Leaders are available and have a relationship with the team
Role of Leadership

• Provide resources and support
• Handle hot grounders – opportunity to meet and reinforce participation
• Acknowledge and celebrate champions in each unit
• Publicize safety system successes
• Be consistent in addressing non conformity - Accountability
Why Surgical Safety Checklist?

Performing the surgical safety checklist will:

- Identify and address potential sources of errors or adverse events.
- Facilitate a consistent culture of safety between all surgical team members.
- Improve compliance with basic standards of care.
# PERIOPERATIVE SURGICAL SAFETY GUIDE

**Version – 09/26/16**

<table>
<thead>
<tr>
<th>Sign-in (Pre-Op)</th>
<th>Timeout (OR)</th>
<th>Debrief (OR)</th>
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<tbody>
<tr>
<td>Verified in Pre-op Area Before</td>
<td>Prior to any invasive action done on patient by surgical team. All activity stops, music silenced.</td>
<td>After first instrument count and before Surgical Attending leaves the room</td>
</tr>
<tr>
<td><strong>• OR circulator and pre-op RN confirm the following with record and patient</strong></td>
<td><strong>• Scan patient’s arm band upon entering the OR.</strong>&lt;br&gt;<strong>• Surgeon of Record initiates, all members of the team will Pause, Listen, and Participate.</strong>&lt;br&gt;<strong>• New Surgeon or Procedure – Will require a new timeout</strong>&lt;br&gt;<strong>• All Services of the case should be present at initial timeout.</strong></td>
<td><strong>• Anesthesia, Surgery Attending, Circulating RN, scrub Tech.</strong></td>
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<tr>
<th>Verify:</th>
<th>SURGEON: Introduction then Verbalize</th>
<th>ANESTHESIA: Introduction then Verbalize</th>
<th>Procedure Confirmation (Circulator, Surgeon, and Anesthesia):</th>
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<tr>
<td><strong>• Identity – verified with armband using two identifiers</strong>&lt;br&gt;<strong>• Site/Side – verified and marked with H&amp;P or Pre-op Note</strong>&lt;br&gt;<strong>• Procedure – verified with H&amp;P and Facility Note</strong>&lt;br&gt;<strong>• Consent – verified with H&amp;P and Facility Note</strong>&lt;br&gt;<strong>• Allergies – verified with the patient and chart</strong>&lt;br&gt;<strong>• VTE Prophylaxis addressed (chemical/mechanical)</strong>&lt;br&gt;<strong>• Anesthesia consent complete</strong></td>
<td><strong>• Patient name, MRN, procedure, and site/side</strong>&lt;br&gt;(CONFIRM WITH CONSENT)&lt;br&gt;<strong>• Relevant images displayed</strong>&lt;br&gt;<strong>• Concerns or anticipated critical events</strong>&lt;br&gt;<strong>• Duration</strong>&lt;br&gt;<strong>• Blood loss</strong>&lt;br&gt;<strong>• Fire Risk</strong></td>
<td><strong>• Antibiotic name, dose, route, &amp; time</strong>&lt;br&gt;<strong>• Allergies</strong>&lt;br&gt;<strong>• Post-op plan</strong>&lt;br&gt;<strong>• Concerns or anticipated critical events</strong></td>
<td><strong>• Name of procedures</strong>&lt;br&gt;<strong>• Wound class</strong>&lt;br&gt;<strong>• Correct instrument, sponge, and needle count</strong>&lt;br&gt;<strong>• All specimens identified &amp; labeled and sent to appropriate lab - (Verification with Attending Surgeon)</strong>&lt;br&gt;<strong>• Estimated blood loss and transfusions</strong></td>
</tr>
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<tr>
<th>SCRUB TECH: Introduction then Verbalize</th>
<th>CIRULATING RN: Introduction then Verbalize</th>
<th>OTHERS: Introduction then Verbalize</th>
<th>Debrief (Scrub, Circulator, Anesthesia, and Surgeon):</th>
</tr>
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<tbody>
<tr>
<td><strong>• Instrument sterility</strong>&lt;br&gt;<strong>• Medications/solutions on field</strong></td>
<td><strong>• Equipment, devices, implants available</strong>&lt;br&gt;<strong>• Blood product status</strong></td>
<td><strong>• Reason for being there</strong></td>
<td><strong>• What went well</strong>&lt;br&gt;<strong>• What can improve, and how can this improvement happen</strong>&lt;br&gt;<strong>• Equipment problems</strong>&lt;br&gt;<strong>• Any events that need reporting</strong>&lt;br&gt;<strong>• Changes to post-op plan</strong>&lt;br&gt;<strong>• Surgery</strong>&lt;br&gt;<strong>• Anesthesia</strong>&lt;br&gt;<strong>• Armband on patient</strong></td>
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**SURGEON:** Solicit questions

“If anyone has any concerns anytime during this case, please bring it to my attention immediately.”
## Leaders of the committee

<table>
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<tr>
<th>Member</th>
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<tbody>
<tr>
<td>Sandeep Markan, MD, FCCP – Chair</td>
<td>BT - Anesthesiologist</td>
</tr>
<tr>
<td>Glorimar Medina, MD – Previous Chair</td>
<td>LBJ - Anesthesiologist</td>
</tr>
<tr>
<td>Donna McKee, MHA, BSN, RN, NE-BC – Co-Chair</td>
<td>ACS – Chief Nursing Officer</td>
</tr>
<tr>
<td>Angela Sterling, MSN, RN, Facilitator</td>
<td>Administration - RN Project Manager-Performance Improvement</td>
</tr>
<tr>
<td>Renee Russell, RN</td>
<td>LBJ - Director of Nursing, Perioperative Nursing Services</td>
</tr>
<tr>
<td>Sharon Land, RN, MBA, CNOR, NE-BC</td>
<td>BT - Administrative Director of Perioperative Nursing Services</td>
</tr>
<tr>
<td>Ruby Hernandez, BSN, RN</td>
<td>BT OR Registered Nurse</td>
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References


Thank you !