AORN's "Time Out" Message Urges Team Engagement

JUNE 6, 2016 (DENVER, COLO.) -- "How can our Time Out be better?" This is the question the Association of periOperative Registered Nurses (AORN) is encouraging every OR team member to ask each other as the perioperative community prepares to recognize National Time Out Day on June 8. By taking a "time out" before operative and other invasive procedures, a requirement of The Joint Commission, surgical team members confirm the patient, the procedure and the surgery. Despite this requirement, The Joint Commission estimates wrong site surgeries occur up to 40 times each week.

Since the launch of The Joint Commission's Universal Protocol with the Time Out in 2004 and the launch of the Safe Surgery Checklist with the WHO's Safe Surgery Initiative in 2008, the perioperative nursing community has persisted in advocating for this critical safety practice and they must continue to speak up, notes AORN President Martha Stratton, MSN, MHSA, RN, CNOR, NEA-BC.

"Doing all we can to keep our patients safe is our responsibility as a nurse and is even more critical in a complex OR environment," Stratton says. "We have a trusted bond with our patients that obligates us to speak up when a safety protocol is managed ineffectively. As nurses, we must be secure in our knowledge, communicate the evidence for safety, and continue to advocate for our patients."

"While National Time Out Day brings awareness to the importance of taking a time out, it's critical to recognize that wrong site, wrong procedure and wrong person surgeries are still happening every day in the U.S., even when organizations practice the time out" says Ronald M. Wyatt, MD, MHA, patient safety officer, medical director in the Division of Healthcare Improvement, The Joint Commission. "Without a strong culture of safety in an organization, tools like the Universal Protocol can't succeed. The Joint Commission provides tools and resources to help organizations improve their safety culture and empower the entire surgical team to speak up to help assure that a process like the Universal Protocol is safe and effective."

"We believe strongly that the Time Out is also a time to check in and make sure everyone is ready," says William Berry, MD, of Ariadne Labs in Boston, where he and his team continue to refine and support adoption of the Safe Surgery Checklist. His wish for a more robust Time Out is to add more communication to cover needed information sharing, to engage everyone on the team so they feel comfortable speaking up, and to make sure everyone's questions are answered before incision because "once you cut a patient, you scar them forever—this is serious."

As Berry and his team members including Atul Gawande, MD, MPH, look back at their work over the past ten years at the center of the surgical safety checklist movement that began in Geneva, Switzerland in 2006 with the World Health Organization and professional patient safety organizations including AORN, they see tremendous progress with OR teams' ownership building more process checks and conversational prompts around the Joint Commission's Time Out.

However, they still see wide variability in team adherence to the Time Out. That's why Berry and his team have compiled a comprehensive Safe Surgery Checklist Implementation Guide that is designed to help any OR team create more engagement and more meaning for their surgical safety pause, whether it's making The Joint Commission-mandated Time Out a consistent practice or refining a multi-step surgical safety checklist that incorporates the Time Out. Here are three important pieces from the implementation guide Berry shares:

1. Make sure your checklist matches your culture and customize the checklist to fit your unique practices and processes to drive local ownership of the safety tool. (Use the culture assessment tool in the guide to better understand your unique cultural norms.)
2. Create visual guides for every team member to read through the steps of the checklist or just the Time Out—don't allow anyone to memorize the checklist. (Airline pilots don't memorize their flight safety checklist for an important reason—they will forget steps.)
3. Commit to making time for the postoperative debriefing to improve the Time Out and put a system in place that deals with issues raised during a debriefing to ensure issues are fixed and people are heard.

"Commit yourself to revisiting the tool periodically at set intervals and make sure your checklist doesn't bear the burden of safety steps that can happen at a different time," Berry cautions. "The checklist is like a horse, it can only be asked to carry so many riders or it will break and people will begin skipping steps."

About AORN

AORN represents the interests of more than 160,000 perioperative nurses by providing evidence-based research, education, standards, and practice resources—including *Guidelines for Perioperative Practice* -- to enable optimal outcomes for patients undergoing operative and other invasive procedures. AORN's 40,000 registered nurse members manage, teach, and practice perioperative nursing, are enrolled in nursing education, or are engaged in perioperative research.