

PREOPERATIVE TIME-OUT COMMUNICATION PROCESS

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Background Information: The focus on surgical risk has evolved from solely considering the patient's disease process and complexity of the procedure to including additional focus on the health provider's impact when evaluating surgical outcomes. From November 2015 to November 2016, thirty-three patients were reported to have entered the operating room (OR) with incomplete or missing required documentation. Other concerns included: strained employee relations, error due to time restraints and pressures of efficiency, absent handoff from the preoperative RN to the OR circulator, perioperative staff not valuing the need of a handoff, and poor patient satisfaction scores for overall level of safety.

Objectives of Project: The purpose of this project was to reduce the risk for patient harm or near miss due to communication breakdown and to improve staff and patient engagement in the preoperative verification process.

Process of Implementation: Use of a formalized preoperative time-out was implemented in the preop area. An electronic patient summary page along with a patient-centered standardized time-out tool were developed and used by all three disciplines (PeriAnesthesia, OR and Anesthesia) in the preop setting.

Statement of Successful Practice: The patient-centered time-out process has proven to be more beneficial than just an informational transfer. It provides group cohesiveness, an opportunity to identify any erroneous thinking, transfer of responsibility, education, and socialization through the use of a formalized process and tools.

From November 2016 to September 2017, ten patients entered the OR with incomplete or missing required documentation. Surveys revealed staff perceptions of compliance with time-out was 75-100% of the time and an increase in the value of a preoperative time-out. Patient satisfaction scores increased 60% for Overall Level of Safety.

Implications for Advancing the Practice of Perianesthesia Nursing: Patient safety in the perioperative setting is significantly impacted by a standardized process and formalized time-out in the preoperative area. Best practice of an OR time-out is well documented in the literature. Further research is needed on a standardized preoperative time-out process.