PreOperative Time-Out Communication Process

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Introduction

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.

Identification of the Problem

From November 2015 to November 2016, thirty-three patients were reported to have crossed the red line with incomplete or missing required documentation. Other concerns included:

- The patient was not involved in a transfer of care process.
- Time restraints and pressures of efficiency were a source of strained employee relations and root cause of error.
- Absent handoff from the PreOperativeRN to the OR Circulator.
- Only CRNA was transporting patient to the OR frequently without any handoff.
- Due to lack of a handoff process historically, perioperative staff did not value the need of a handoff.
- Patient Satisfaction scores for Overall level of Safety were poor.

QI Questions/Purpose of the Study

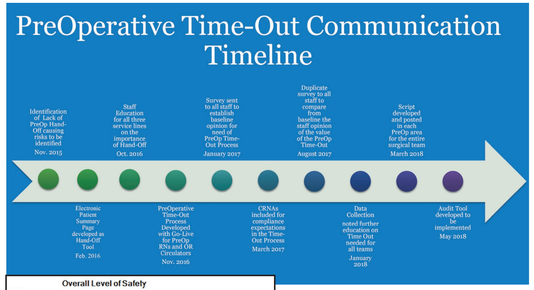
The purpose of this project was to reduce the risk for patient harm or near miss due to communication breakdown and to improve staff and patient engagement in the preoperative verification process.

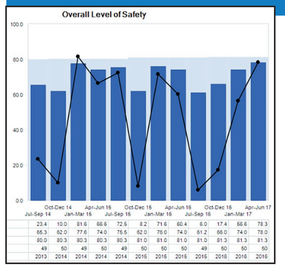
Goals

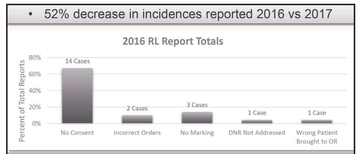
- Create a standard procedure for transfer of care where the patient is at the center.
- A standard PreOp verification process to decrease compliance errors with documentation.
- Increase the patient's participation in a handoff and perception of safety upon entering the OR
- Patient Satisfaction scores for Overall Level of Safety improve.
- Reduce delays in the OR due to incomplete documentation.
- Ensure that the Perioperative team (OR and PeriAnesthesia) has an opportunity to exchange information together and clarify/highlight important issues.
- Future system-wide compliance of the PreOperative Time-Out Tool and utilization of the Surgical Services Summary page.

Methods

- An electronic patient summary page to be utilized for investigation and as an SBAR tool was developed in February 2016 with Go-Live of tool in November 2016.
- Patient-centered standardized tool developed to ensure compliance by all three disciplines (PeriAnesthesia, OR and Anesthesia) in the PreOp area.
- Incident reporting was continually captured during the project to provide a baseline comparison for any changes in the number of incidents reported.







Results-Patient Satisfaction Graph

- Significant improvement of 71% of compliance with red line required documentation.
- At the beginning of implementation: Time-out was performed 50 -75% of the time.
- After implementation: Time-out is completed 75-100% of the time.
- 60% increase in Patient Satisfaction Scores regarding Overall Level of Safety.

Outcomes

- PreOperative Time-Out Tool included patient at the center of the handoff process.
- Improved staff relationships between PeriAnesthesia and OR
- Circulators and CRNAs transport patient together to OR after the completion of the PreOperative Time-Out.
- Increased utilization of PreOp tracking boards for patient status.
- Staff understanding of the value of the PreOperative Time-Out tool increased.
- Compliance of all three disciplines involved proved to be very high.
- Identification of the need for a script for the three teams to use in order to facilitate a thorough but time efficient process.
- With a standardized process, registration was identified as an area that contributed to errors with incorrect patient identification in the EHR.

Pre-Operative TEAM Face-Face Time Out

1. **Bedside Report for ALL Patients at Bedside: OR, Pre-Op, & CRNA**
   a) All activity at bedside stops - PreOp Time Out includes Patient/Family
   b) Re-introductions of team members together to Patient/Family
   c) Verify Patient Name/Allergies/Armband
2. **Team will verify correct documentation:**
   a) H&P and 24hr/Day of Surgery update
   b) Consents – Surgical and anesthesia (blood if necessary)
      • Signatures, Dates, Times and Verification of procedure(s) with laterality)
   c) DNR status
3. **Either RN may open Surgical Services Summary page:**
   a) Review Significant Medical History
      • Stop BANG/OSA Risk
      • Beta Blockers
      • Smoking
   b) Skin Assessment – Scott Triggers with dressing if needed
   c) Multi-modals/Antibiotics
   d) Clip, prep and site marking status (Site Marking Form if needed)
   e) Review status of required labs Lab Status (UPT, K+, etc.)
4. **Sign out PeriOp Doc by each team member (PreOp, OR, Anes)**

TEAM report is a HARD STOP! Patient may not proceed across the "RED Line" if everything is not complete.

Implications for Practice

- Our main aim in the development of this tool was to address the almost total lack of research evidence on the need of a formalized standard process for hand off prior to crossing the red line. We have developed this tool from direct observation and incident reporting on the daily work of the perioperative teams in the PreOperative arena.
- The tool triggered the collection of data on the actual number of incident reporting in a preoperative arena. Unfortunately as compared to a well documented best practice of an OR time-out in the literature, there is the need of further research regarding a standardized Preoperative time-out process.

Conclusion

The patient-centered standardized process and formalized time-out in the PreOperative area has proven to be more beneficial than just an informational transfer. Examples include:

- A significant emphasis on patient and family-centered care in the PreOperative area due to the whole team meeting the patient and family together.
- Improved staff cohesiveness between PreOp, OR and anesthesia teams.
- An impact upon patient safety with earlier identification of errors or missing documents.
- A transparent transfer of responsibility process.
- Further education causing increased awareness of the necessity of thorough hand offs.

Compliance of all disciplines has shown to be necessary for success. The perioperative teams cannot work in silos.

Discussion

For inpatient nursing, bedside handoff has been identified as an important component during critical transitions impacting safety outcomes. Decades of published literature and guidelines on bedside handoff attest to various results regarding the achievement of improvements with quality and safety. When nurses integrate patient expertise, nurse-to-nurse handoff becomes patient-centered (nurse and patient), and the weak link between quality and safety is mitigated.

As recognized by patient satisfaction surveys and incident reporting, the non-patient centered handoff that was practiced in the PreOperative area was noted to be ineffective in minimizing errors and creating a perception of safety for the patient. Although the sample size for this project is very small, considering the large surgical volume the institution experiences (44,000 cases/year), both before and after the implementation of the tool, the impact on each individual patient was significant enough for us to investigate and continue to change the culture including the patient as a partner in the handoff process in the Preoperative area.

For the operating room, with competing efforts in efficiency and multidisciplinary incentives to transition to the OR from the PreOp area quickly, it was observed that the hand off culture was a nurse-centered interaction rather than a patient-centered partnership. Barriers to changing the culture to a patient-centered partnership were often secondary to OR production pressures.

Although there was an improvement in the patient's perception of safety and a decrease in the amount of errors with the tool, errors did continue. A barrier that was identified even with the tool was the practice of a PreOp charge nurse helping with the handoff due to time pressures. A common occurrence was a PreOp RN had multiple patients transferring to the OR at the same time, which caused errors due to lack of continuity of care with a nurse handing off not knowing the patient and the patient not knowing the nurse.

Even after the tool was implemented in all three disciplines (OR RNs, PeriAnesthesia RNs, CRNAs), it was noted that learning how in conduct a partnership-driven handoff required a new skill set for both nurses and patients. A script was then developed in order to standardize conversations with nurses and the patients. This created an opportunity for nurses and patients to address all information and questions in an efficient manner to prevent a time barrier in transition to the OR, as compared to only using a PreOp check list.

One tool that is in the process of completion is an audit tool for the conversation itself during the Time-Out. It has continued to be noted that a skill that is not always present, again often due to production pressures in the OR is quality listening. With patient and nursing partnerships, patients feel listened to by their nurses, feel more cared for, and are able to participate to the extent they desire. Patients and their families want to be recognized as stewards of their information. Although it may appear simple, one of the hardest aspects for the perioperative RN to learn has been patience and vigilance in recognizing patient expertise.