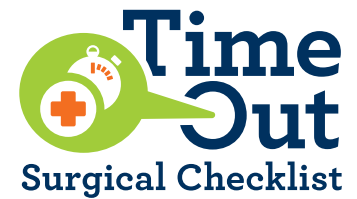


Time Out Surgical Checklist Frequently Asked Questions



This Frequently Asked Questions (FAQ) document provides more information about the implementation of a Time Out Surgical Checklist. Please review this FAQ document to learn more.

1. We already have a checklist. Why do we have to do another one?

Unfortunately, wrong site and wrong procedure events continue to happen in Minnesota. We all want patients to be as safe as possible when they are in our care and updating the Time Out checklist with evidence-based recommendations will help address some common issues, such as not visualizing the site mark or not ceasing activity during the Time Out.

2. Introducing ourselves at every case will get really redundant. Can't we just do it for the first case of the day?

It only takes a few seconds to do introductions around the room and doing it for every case is easier than trying to figure out if a new team member is in the room due to breaks or lunch. Also, research shows that OR team members are more likely to speak up if they have already said something at the beginning of the Time Out. This is another way of making sure concerns are voiced.

3. What's different about this checklist compared to the one we've been using?

The new Time Out Surgical Checklist reflects your culture and workflow and was put together by an interdisciplinary team at your hospital. There are process checks to remind team members to verify, perform and discuss critical patient safety steps. There are also conversation prompts that remind team members to discuss important information about the patient, risks, and surgical plans so everyone on the team has the same information before the case begins.

The culture statement is an additional element. This was a carefully drafted statement to be read by the surgeon or proceduralist, and is designed to encourage surgical services staff to speak up about any potential concerns they may have about the case.

4. Does the culture statement have to be said the same way every time?

The culture statement was carefully developed by the MHA Surgery and Procedure Committee and relies on principles from Ariadne Labs' framework for Safe Surgery Checklist implementation based on lessons learned in over 4,000 facilities globally. Ariadne Labs is a joint health system innovation center of Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health working to create scalable solutions that improve health care delivery. The purpose of the culture statement is to encourage OR team members to speak up if they have concerns. That is why the statement is open ended and emphasizes the patient's expectation of the OR team. It is strongly recommended that each surgeon in Minnesota say the phrase the way it is written.

5. How will I know what to do in the new checklist process?

Your hospital has an implementation team that will guide you through testing and implementing the checklist. Feedback about the new checklist process is really helpful, so make sure you let the implementation team know how you think it's going and if you have any ideas for improvement.

6. Can this checklist be used for surgeries or procedures outside of an operating room?

The MHA Surgery and Procedure Committee designed this checklist specifically for surgeries and procedures that occur in an operating room. The committee is currently in the process of exploring additional checklist options for procedures and surgeries that occur outside an operating room.