Welcome to the Time Out Surgical Checklist Webinar

The call will begin shortly.

Just a few reminders:

• Please use the chat box at *anytime* during the call to ask questions.

• If you are using the dial-in option, mute your computer speakers to avoid feedback.

• We will show three videos throughout this webinar. You will need to **unmute** your computer speakers to hear the videos.
What are you going to learn

- Provide an overview of MHA’s Surgical and Procedure Committee and the development of the Time Out Surgical Checklist
- Review the Time Out Surgical Checklist toolkit available at www.mnhospitals/timeout
- Next steps
Who’s in the room?

- Use the chat box to type your name, role and organization
  - Indicate if you are a member of MHA’s surgery and procedure committee
  - Share how your organization celebrated National Time Out Day.
Meet your speakers

Dr. Robert Quickel  
Allina Health

Tyler Lindquist  
Allina Health

Melissa Stowe  
CentraCare Health

Brenda Bearden  
Mayo Clinic Health System

Chelsie Bakken  
CentraCare Health

Deb Moengen  
CentraCare Health
Statewide quality improvement
Conduct a pre-procedure verification process

- Address missing information or discrepancies before starting the procedure.
- Verify the correct procedure for the correct patient, at the correct site.
- When possible, involve the patient in the verification process.
- Identify the items that must be available for the procedure.
- Use a standardized list to verify the suitability of items for the procedure. (It is not necessary to document that the list was used for each patient.) At a minimum, these items include:
  - Most recent documentation
  - Equipment: history and physical, signed consent form, preoperative assessment
  - Latest diagnostic and radiology test results that are properly delayed
  - Examples: radiology images and scans, pathology report, biosynthetic images
  - Any required blood products, implants, devices, special equipment
- Match the items on the list to be available in the procedure area to the patient.

Mark the procedure site

All a minimum, mark the site where there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient.

- For most procedures: Use the general anatomic region on the site. Special interoperative imaging techniques may be used to locate and mark the exact center of the lesion.
- When the site is being performed in a different location.
- If possible, involve the patient in the marking process.
- The site is marked by an unlicensed independent practitioner who is ultimately responsible for the procedure and will be present when the procedure is performed.
- In certain circumstances, site marking may be delegated to non-medical personnel or registered nurses (R.N.).
- Ultimately, the licensed independent practitioner is responsible for the procedure—ever if delegating site marking.
- The mark is permanent and is used consistently throughout the organization.
- The mark is made on the procedure site.
- The mark is sufficiently permanent to be visible when the incision is made and closed.
- Identification markers are not the sole means of marking the site.
- For patients who receive multiple procedures, it is technically or administratively impossible or impractical to mark all the sites simultaneously.
- Use your organization’s procedure for marking the site.
- The site marking is made as a separate, distinct procedure.
- The circulating nurse will then conduct the time-out by audibly reading the following information from the patient’s affirmation of informed consent:
  - Patient Name and medical record number
  - Procedure
  - Site of procedure (and level, if appropriate)
  - Position of patient

Perform a time-out

The procedure is not started until all questions or concerns are resolved.

- Conduct a time-out immediately before starting the invasive procedure or making the incision.
- A designated member of the team starts the time-out.
- The time-out is communicated.
- The time-out involves the immediate members of the procedure team: the individual performing the procedure, anesthesia providers, scrubbing nurse, operating room technician, and other active participants who will be participating in the procedure from the beginning.
- All relevant members of the procedure team actively communicate during the time-out.
- During the time-out, procedure members agree on a minimum, on the following:
  - Correct patient identity
  - Correct site
  - Procedure to be done
  - When the same patient has two or more procedures. If the person performing the procedure changes, another time-out must be performed before starting each procedure.
  - Document the completion of the time-out. The organization determines the amount and type of documentation.

Minnesota Department of Health

Time-Out Process in Minnesota

<table>
<thead>
<tr>
<th>Minnesota Recommendation</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1. Prior to the procedure, cover the Mayo stand with a towel with “Time Out” in black lettering.</td>
<td>The time-out towel will serve as a memory trigger to remind the surgeon to initiate the time-out, and provides support to team members who may need to reinforce the need to complete the time-out for every procedure.</td>
</tr>
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<td>2. The surgeon will initiate the time-out after scrubbing and immediately prior to incision. The surgeon should initiate the time-out by saying, for example: “Let’s do the time-out.”</td>
<td>The surgeon needs to be engaged in the process, and having him/her call for the time-out reinforces its importance. Doing the time-out immediately prior to incision makes it less likely that other conversations or activities will happen between the time-out and the surgery that could distract the surgeon.</td>
</tr>
<tr>
<td>3. All team members will cease their activity. (The anesthesiologist will continue to manage ventilation.)</td>
<td>No distractions should be present during the time-out, so that all team members can listen for the information and play their part in the process.</td>
</tr>
<tr>
<td>4. The circulating nurse will then conduct the time-out by audibly reading the following information from the patient’s affirmation of informed consent:</td>
<td>The circulating nurse has access to previously verified source documents, which he/she uses for the time-out. Having the circulating nurse begin the process decreases the odds that other team members will simply agree with the most senior person in the room, which can happen if the surgeon is the first person to speak.</td>
</tr>
<tr>
<td>a. Patient Name and medical record number</td>
<td></td>
</tr>
<tr>
<td>b. Procedure</td>
<td></td>
</tr>
<tr>
<td>c. Site of procedure (and level, if appropriate)</td>
<td></td>
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<tr>
<td>d. Position of patient</td>
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</tbody>
</table>

5. The team verification will be conducted audibly in the following standard role sequence (not necessarily):

   1. The ACP will read the patient’s name, medical record number, and procedure.
   2. The scrub tech will state the procedure he/she has set up for, look for and find the site mark, and announce that he/she sees the site marking.
   3. The surgeon will state the patient’s name, complete procedure, and site.

Visualizing the site marking during the time-out is crucial, as drapes, other materials, or repositioning can obscure the mark. Having the scrub tech announce that they have seen the mark gives them an active role to play in the process, and dramatically lessens the odds of making an error due to an obscured mark. Having the surgeon go last minimizes the confirmation bias that sometimes happens in the OR, when team members defer to the surgeon and are reluctant to correct misinformation.
Quality improvement for Time Out: test, finalize and disseminate intervention

- Publish a list of critical elements that can occur in either pre procedure briefing or immediately prior to skin incision.
- Allow for flexibility for hospitals and health systems to choose where in the work flow elements fit.
Peer-to-peer learning: flexibility
Wrong site surgeries continue to happen

Figure 6: Wrong Site Surgery/Invasive Procedures 2009-2018

MN Surgical Time Out Campaign Kick-Off (June ’11)

https://www.health.state.mn.us/facilities/patientsafety/adverseevents/index.html
Wrong procedure surgeries continue to happen

Figure 7: **Wrong Surgeries/Invasive Procedures**

https://www.health.state.mn.us/facilities/patientsafety/adverseevents/index.html
A patient and surgeon story

In order to hear the video, please unmute your computer speakers.
Peer-to-peer learning: your why
It’s been a journey

Summer 2017
Subgroup drafts Time Out Surgical Checklist and MHA hosts a Time Out Day webinar

Fall/Winter 2017
Spring 2018
Table top simulations began at member hospitals. PDSA cycles for new checklist occur

Summer 2018
Final Time Out Surgical Checklist elements approved by the committee

Fall and Winter 2018
Planning and preparing Time Out Surgical Checklist toolkit

Spring and Summer 2019
TOSC Implementation Network and rollout toolkit
Checklist from 20 to 9 elements

June 2017
20 elements

November 2017
17 elements

April 2018
17 elements

May 2018-Final
9 elements
Peer-to-peer learning: table top simulations
## What’s different about this checklist?

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<td>The surgeon will initiate the time-out after scrubbing and immediately prior to incision. The surgeon should initiate the time-out by saying, for example, “Let’s do the time-out.”</td>
<td>Surgeon initiates Time Out: “Is everyone ready to perform the time out? Please state your name and role.”</td>
</tr>
<tr>
<td>All team members will cease their activity. (The anesthesia care provider will continue to manage ventilation.)</td>
<td>All activity ceases. All team members introduce themselves.</td>
</tr>
</tbody>
</table>
| The circulating nurse will then conduct the time-out by audibly reading the following information from the patient’s affirmation of informed consent:  
  a. Patient Name **and medical record number**  
  b. Procedure  
  c. Site of procedure (and level, if appropriate)  
  d. **Position of patient** | Circulating nurse reads audibly from the informed consent:  
  • Patient name and DOB  
  • Procedure to be performed  
  • Site |
| The team verification will be conducted audibly in the following standard role sequence (not concurrently):  
  1. The ACP will read the patient’s name, **medical record number, and procedure**.  
  2. The scrub tech will **state the procedure he/she has set up for**, look for and find the site mark, and announce that he/she sees the site marking.  
  3. The surgeon will state **the patient’s name**, complete procedure, and site. | 1. Anesthesia Care Professional reads patient name and DOB from arm band (if available), or alternate source such as the informed consent, ACR, or EHR).  
  2. Scrub and surgeon visually locate and verbally state the location of the site marking  
  3. Surgeon states procedure to be performed |
| Surgeon ends time out with culture statement: “Our patients expect each of us to speak up about safety concerns now and during the procedure. What concerns do you have?” |  |
Why include a culture statement

Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol.
“Our patient expects each of us to speak up about safety concerns now and during the procedure. What concerns do you have?”

“Add company logos”

“Our patient expects each of us to speak up about safety concerns now and during the procedure. What concerns do you have?”
The culture statement empowers the team to speak up.

In order to hear the video, please unmute your computer speakers.
Nine elements to be included immediately before skin incision

**Process Checks:** Remind team members to verify, perform and discuss critical safety steps.
Nine elements to be included immediately before skin incision

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Team</th>
<th>Circulator</th>
<th>ACP</th>
<th>Scrub &amp; surgeon</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiates Time Out</td>
<td>All Activity Ceases</td>
<td>Patient Identity</td>
<td>Patient Identity</td>
<td>Site Marking Confirmation</td>
<td>Procedure From Memory</td>
</tr>
<tr>
<td>Introductions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Culture Statement</td>
</tr>
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</table>

**CONVERSATION PROMPTS:** Remind team members to share and discuss critical information about the patient, risks and surgical plans so that they are prepared to work together more effectively as a unit.
Thirteen elements to be included immediately before skin incision or in pre procedure briefing

Surgeon, Scrub or Circulator
- Bio Specimen Plan
- Imaging
- Procedure Set Up

Surgeon
- Operative Plan

ACP
- Anesthetic Plan
- Airway Concerns
- Code Status
- Fire Risk Score
- Antibiotic Prophylaxis
- Other Concerns (ACP)

Circulator and Scrub
- Implants & Special Equipment
- Equipment Issues
- Other Concerns
22 time out surgical checklist elements

A training video explaining the elements in the Time Out Surgical Checklist.

In order to hear the video, please unmute your computer speakers.
What’s in the toolkit?

- 3 Training Videos
  - The Importance of the Time Out Surgical Checklist culture statement
  - Patient and Surgeon Time Out Surgical Checklist Story
  - Time Out Surgical Checklist Elements Training
- Time Out Surgical Checklist elements rationale and origin
- Frequently asked questions
- Culture statement posters
- Media and branding material (fonts, colors, logos for each element)
- TOSC implementation checklist
- Additional implementation materials taken from Ariadne Labs Safe Surgery Checklist Implementation Guide.
Frequently asked questions

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.
There is rationale behind each element

**Item 2: Introductions**

The WHO recommends that every person in the operating/procedure room introduce himself or herself by name and role before skin incision.

Introductions are also critical in creating an environment where individuals can voice concerns about the patient. People who are given the opportunity to contribute to a conversation will also find it easier to speak up later. It is recommended that every person in the operating/procedure room introduce himself or herself, including manufacturer/equipment representatives, students, and observers.

Many clinicians have raised concerns about having surgical team members introduce themselves before every case because everybody already knows each other, or the team will be working together for the entire day. A best practice is to have surgical team members introduce themselves by name and role prior to the first case and have surgical team members check off with each other in subsequent cases. An example of checking off with one another is, “Betty, are you ready to go?”

Origin: WHO Surgical Safety Checklist
Peer-to-peer learning: communication is key
Design and display your checklist with these logos

- Bio Specimen Plan
- Imaging
- Anesthetic Plan
- Airway Concerns
- Fire Risk Score
- Other Concerns (ACP)
- Implants & Special Equipment
- Equipment Issues
- Other Concerns
- Procedure Set Up
- Operative Plan
- Code Status
- Antibiotic Prophylaxis
- Initiates Time Out
- All Activity Ceases
- Introductions
- Patient Identity
- Procedure & Site
- Patient Identity
- Site Marking Confirmation
- Procedure From Memory
- Culture Statement
A checklist for the checklist

<table>
<thead>
<tr>
<th>Phase</th>
<th>Checklist Items*</th>
<th>Notes</th>
<th>Leader Responsible</th>
<th>Date Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>1. Identify the Implementation team</td>
<td>Include: surgeon, scrub tech, circulating nurses, anesthesiologist/DNA, administrator/quality improvement officer.</td>
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<td>2. Assess surgical culture and environment</td>
<td>Understand the surgical workflows in order to inform your organization's checklist.</td>
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<td>3. Decide where elements belong on the checklist</td>
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<td>Do</td>
<td>4. Test the draft checklist</td>
<td>Tabletop simulations ⇒ practice in an empty OR ⇒ one case with a patient ⇒ full day of cases for one surgical team. Stop and gather feedback at every stage and incorporate changes into the final checklist.</td>
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<td>5. Create a plan for checklist expansion</td>
<td>Create a plan before putting the finalized checklist into use across all ORs.</td>
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<td>6. Checklist design and display</td>
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<td>Check</td>
<td>7. 1-on-1 conversations</td>
<td>Meet individually with surgical team members to engage them on the new checklist and address any potential barriers to enthusiastic adoption.</td>
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<td>Act</td>
<td>8. Promote the checklist</td>
<td>Internally advertise the checklist at your organization.</td>
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<td>Observe surgical teams in action using the checklist and provide feedback and coaching.</td>
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<td>Sustain/Improve</td>
<td>11. Continuously improve</td>
<td>Celebrate and publicize the work that's been done, continue to coach surgical teams, and keep senior leadership informed of long-term success.</td>
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*All checklist items have a corresponding chapter from the Anesthesia Safe Surgery Checklist Implementation Guide.
Who is Ariadne Labs

Safe Surgery Checklist
Implementation Guide
First step in implementation is planning

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Corresponding Ariadne Lab Safe Surgery Implementation Guide chapters:
- Chapter 3: Building a checklist implementation team
- Chapter 4: Assessing your surgical culture and environment
- Chapter 7: Customizing the checklist
Second step is doing

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Corresponding Ariadne Lab Safe Surgery Implementation Guide chapters:

- Chapter 8: Testing your checklist in the operating/procedure room
- Chapter 9: Creating a plan for checklist expansion
- Chapter 6: Checklist design and display
### Third step is acting

<table>
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Corresponding Ariadne Lab Safe Surgery Implementation Guide chapters:
- Chapter 11: Promoting the checklist
- Chapter 12: Teaching the checklist
- Chapter 13: Coaching the checklist
Fourth step is sustaining

| Sustain | 11. Continually improve | Celebrate and publicize the work that’s been done, continue to coach surgical teams, and keep senior leadership informed of long-term success. |

Corresponding Ariadne Lab Safe Surgery Implementation Guide chapters:
- Chapter 15: Continually improve
Plan: identify the implementation team

CHAPTER 3: Building a checklist implementation team

Resources and materials:
• Implementation team roles and responsibilities
• Overview of checklist implementation

Key concepts:
• The implementation team is a multidisciplinary group of people responsible for planning and executing the checklist initiative.
• The team should include representatives from each role on the surgical team.
• Team members need to be enthusiastic, respected, and committed.
• Use 1-on-1 conversations to recruit people for your team.
• Finding physician champions is important but may be challenging.
Plan: assess your surgical culture and environment

CHAPTER 4: Assessing your surgical culture and environment

Resources and materials:
• Assessment Observation Tool
• Action guide: Assessment observer’s guide
• Safe Surgery Checklist Culture Survey: Pre survey (no existing checklist)
• Safe Surgery Checklist Culture Survey: Pre survey (existing checklist)/Post survey for all facilities
• Implementation Lead Project Spreadsheet

Culture surveys
The Safe Surgery Checklist culture surveys are designed specifically to collect information about the perceptions and feelings of people in the surgical environment. They are used before and after checklist implementation.
Plan: customizing the checklist

CHAPTER 7: Customizing the checklist

Resources and materials:
• Action guide: How to make improvements to your existing surgical checklist
• How to customize the Time out Surgical Checklist for your facility
• Action guide: Checklist for customizing the checklist
Peer-to-peer learning: success and challenges
Use the chat box to type your questions
Next steps

- MHA will set-up quarterly check-ins and a listserv for you to network with peers as you implement the Time Out Surgical Checklist at your organization.

- For the next three months focus on the plan sections of the implementation checklist:
  1. Identify an implementation team
  2. Assess surgical culture and environment
  3. Decide where elements belong on the checklist