

Perioperative Services Competency Assessment - Vanderbilt University Medical Center

Universal Protocol: Time Out	Interpretation	Rationale
A. Verbalizes importance of Time Out.	<ol style="list-style-type: none"> Time Out is part of the process for accurate identification of the correct patient, procedure, site, and side. JCAHO approved the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery and the process is effective in all accredited hospitals. 	<ol style="list-style-type: none"> Repeated verifications are employed in a coordinated effort to minimize the risk of a procedure being performed on the incorrect patient, site, or side. Wrong site, wrong procedure and wrong person surgeries are sentinel events that are tracked through the JCAHO sentinel event database. Policy - Universal Protocol - Identification of Correct Patient, Procedure, Site/Side
B. Verbalizes required participating members of the time out.	<ol style="list-style-type: none"> The procedural team participates in the Time Out, including the person who marks the incision site. The proceduralist can be the attending physician, resident or fellow who will be present during the Time Out. During Time Out, other activities are suspended. If any member of the team does not confirm an element of the Time Out, the procedure is stopped. The proceduralist reconciles the discrepancy. Upon reconciliation, the Time Out process is restarted from the beginning. 	<ol style="list-style-type: none"> All members of the procedural team (including the proceduralist who marks the site) participates in a Time Out confirming through active focus the correct patient, procedure, site, and side, and other critical elements.
C. Verbalizes the process for site marking.	<ol style="list-style-type: none"> Site marking occurs if laterality is involved. The proceduralist marks the site with his or her initials (not the letter “x” or the word “no”), prior to the patient entering the OR suite. The site is marked with patient/caregiver participation (e.g., verbal confirmation or visual pointing). The site is marked with a sufficiently permanent marker that is visible after skin is prepped and draped. 	<ol style="list-style-type: none"> Site marking is employed to minimize the risk of a procedure being performed on the incorrect patient, site, or side.
D. Verbalizes confirmation and verification process prior to patient transport to the OR.	<p>Confirm and Verify:</p> <ol style="list-style-type: none"> Patient’s name on the ID band, date of birth, and other documents that correspond with the patient’s responses. Consents. Availability of implant, if required. Availability of blood, if ordered. Radiologic exams (x-ray, CT scan, MRI, etc.). 	<ol style="list-style-type: none"> Patient / Caregiver responses must match the marked site, ID Band, Consents, Radiologic exams, scheduled procedure.
E. Verbalizes patient identification process.	<ol style="list-style-type: none"> Two Patient Identifiers must be used. Ask patient/caregiver to state the patient’s full name. Ask patient/caregiver to state the patient’s date of birth. Ask patient/caregiver to verify/state the planned procedure in the patient’s own words. When the patient rolls into the room, the patient’s identification band will be utilized to confirm the correct patient with their medical record number by two members of the surgical team. 	<ol style="list-style-type: none"> Repeated verifications are employed in a coordinated effort to minimize the risk of a procedure being performed on the incorrect patient, site, or side.
F. Verbalizes process to initiate Time Out and essential elements covered.	<ol style="list-style-type: none"> The Time Out takes place in the procedure/OR room, after the patient is prepped and draped and it involves the ENTIRE TEAM. The circulating nurse assumes the responsibility to call the Time Out. The Time Out confirms the identification of the patient, procedure, side, and site (with marking if applicable). Other elements to cover include the position, implants, diagnosis, equipment, x-rays, patient status, antibiotics, allergies, blood availability, instrument sterility, post op location, and special considerations. When the same patient has two or more procedures and the person performing the procedure changes, an additional Time Out is performed before starting each procedure. 	<ol style="list-style-type: none"> Repeated verifications are employed in a coordinated effort to minimize the risk of a procedure being performed on the incorrect patient, site, or side.
G. Verbalize implementation of Whiteboard in Time Out procedure.	<ol style="list-style-type: none"> The circulating nurse activates the electronic Time Out checklist by clicking the “Time Out” button in the VPIMS chart. The checklist questions from VPIMS will appear in red on the Whiteboard with a red bar across the top showing the Time Out is incomplete. As the checklist is addressed by the team, the color will change from red to green as the Time Out progresses. Once the Time Out is complete, the bar will turn green and say “complete” 	<ol style="list-style-type: none"> Repeated verifications are employed in a coordinated effort to minimize the risk of a procedure being performed on the incorrect patient, site, or side.

Vanderbilt University Medical Center: Perioperative Services

	and the checklist will collapse.	
--	----------------------------------	--