

# What's New in the Patient Safety World

May 2020

## Timeout Compliance: Ring a Bell?

When we review cases of wrong site surgery (wrong site, wrong patient, wrong side, wrong procedure), we often find that the surgical "timeout" was either not performed or was performed without the full attention of the entire OR team (or team in the procedure room). Every member of the team is expected to take an active role in the timeout. Responses should not be passive nods of assent. Verification should rely upon primary source documentation and not be second-hand. And any member of the team who has questions should be empowered to stop the procedure. The timeout should take place in accord with the "sterile cockpit" concept we've adopted from the aviation safety movement.

A recent review of surgical timeouts, using direct observation, found that at least 1 member of the operating room team was actively distracted in 10.2% of the time-out procedures ([Freundlich 2020](#)). That shouldn't surprise most of you. That's a rate we commonly encounter at many hospitals or ASC's or cath labs. We'll bet most of you don't actually know how often this happens because you don't actually measure this important item. Measuring it by way of OR video monitoring is one of the prime reasons we have long advocated video recording in the OR (see our columns on video monitoring listed below).

In the study by Freundlich et al. the frequent distractions occurred despite the fact that most timeouts were completed in less than one minute. They did perform a timeout before the first incision in 100% of cases and there was a formal announcement that the timeout was about to start in 163 of 166 observed surgeries. 92.8% of their timeouts were completed without interruption (the most common reason for an interruption was to verify patient information). Ten time-out procedures were stopped due to a safety concern. Fortunately, there were no wrong-site or wrong-person surgeries reported at their hospital during the study period.

We once, in a joking manner, brought a gong to a staff meeting and rang it to get everyone's attention when extraneous conversations got out of hand. Well, staff at one hospital didn't laugh at the idea – they actually brought the gong into their OR's! Brenckle and colleagues ([Brenckle 2020](#)) reported on how they used the gong to get

everyone's attention at the start of timeouts. They addressed the problem after a consultant noted, during a mock regulatory survey, that multiple members of the OR team were multitasking during the timeout and not paying sole attention to the timeout procedure.

They considered several sound-making devices to use in order to get the undivided attention of all OR staff at the onset of their timeouts. Ultimately, they chose a classic Tibetan gong. Despite some negative feedback and resistance early on, they persevered and incorporated the gong into their timeout routine.

It took almost six months before staff members began consistently using the gong properly. After piloting the gong in the cardiac cath lab, they also implemented it in their endoscopy suite and OR's. After a year, they report no further negative feedback or improper use of the gong. Even physicians who originally refused to pause and engage in the timeout are now actively engaged in the process. One even not only engages in the timeout, but also personally strikes the gong at the end of his procedure to indicate it was successful.

Interesting and innovative! Timeouts are not to be taken lightly or in a joking fashion. But it is of utmost importance to get the attention of all the OR team (or the team in any venue performing procedures) to focus on the timeout. Whatever works best in your facility to accomplish that is worthwhile.

**Some of our prior columns related to wrong-site surgery:**

September 23, 2008	<a href="#">“Checklists and Wrong Site Surgery”</a>
June 5, 2007	<a href="#">“Patient Safety in Ambulatory Surgery”</a>
July 2007	<a href="#">“Pennsylvania PSA: Preventing Wrong-Site Surgery”</a>
March 11, 2008	<a href="#">“Lessons from Ophthalmology”</a>
July 1, 2008	<a href="#">“WHO's New Surgical Safety Checklist”</a>
January 20, 2009	<a href="#">“The WHO Surgical Safety Checklist Delivers the Outcomes”</a>
September 14, 2010	<a href="#">“Wrong-Site Craniotomy: Lessons Learned”</a>
November 25, 2008	<a href="#">“Wrong-Site Neurosurgery”</a>
January 19, 2010	<a href="#">“Timeouts and Safe Surgery”</a>
June 8, 2010	<a href="#">“Surgical Safety Checklist for Cataract Surgery”</a>
December 6, 2010	<a href="#">“More Tips to Prevent Wrong-Site Surgery”</a>
June 6, 2011	<a href="#">“Timeouts Outside the OR”</a>
August 2011	<a href="#">“New Wrong-Site Surgery Resources”</a>
December 2011	<a href="#">“Novel Technique to Prevent Wrong Level Spine Surgery”</a>
October 30, 2012	<a href="#">“Surgical Scheduling Errors”</a>
January 2013	<a href="#">“How Frequent are Surgical Never Events?”</a>
January 1, 2013	<a href="#">“Don't Throw Away Those View Boxes Yet”</a>
August 27, 2013	<a href="#">“Lessons on Wrong-Site Surgery”</a>
September 10, 2013	<a href="#">“Informed Consent and Wrong-Site Surgery”</a>

July 2014	<a href="#">“Wrong-Sided Thoracenteses”</a>
March 15, 2016	<a href="#">“Dental Patient Safety”</a>
May 17, 2016	<a href="#">“Patient Safety Issues in Cataract Surgery”</a>
July 19, 2016	<a href="#">“Infants and Wrong Site Surgery”</a>
September 13, 2016	<a href="#">“Vanderbilt’s Electronic Procedural Timeout”</a>
May 2017	<a href="#">“Another Success for the Safe Surgery Checklist”</a>
May 2, 2017	<a href="#">“Anatomy of a Wrong Procedure”</a>
June 2017	<a href="#">“Another Way to Verify Checklist Compliance”</a>
March 26, 2019	<a href="#">“Patient Misidentification”</a>
May 14, 2019	<a href="#">“Wrong-Site Surgery and Difficult-to-Mark Sites”</a>

**Some of our previous columns discussing video recording:**

September 23, 2008	<a href="#">“Checklists and Wrong Site Surgery”</a>
December 6, 2010	<a href="#">“More Tips to Prevent Wrong-Site Surgery”</a>
November 2011	<a href="#">“Restricted Housestaff Work Hours and Patient Handoffs”</a>
March 2012	<a href="#">“Smile...You’re on Candid Camera!”</a>
August 27, 2013	<a href="#">“Lessons on Wrong-Site Surgery”</a>
March 17, 2015	<a href="#">“Distractions in the OR”</a>
November 24, 2015	<a href="#">“Door Opening and Foot Traffic in the OR”</a>
March 2019	<a href="#">“Another Use for Video Recording”</a>
March 17, 2020	<a href="#">“Video Recording in the OR”</a>

**References:**

Freundlich RE, Bulka CM, Wanderer JP, et al. Prospective Investigation of the Operating Room Time-Out Process. *Anesthesia & Analgesia* 2020; 130(3): 725-729  
[https://journals.lww.com/anesthesia-analgesia/Abstract/2020/03000/Prospective\\_Investigation\\_of\\_the\\_Operating\\_Room.24.aspx](https://journals.lww.com/anesthesia-analgesia/Abstract/2020/03000/Prospective_Investigation_of_the_Operating_Room.24.aspx)

Brenckle EA, Gealer D, Milligan M. Using a Tibetan Gong to Increase Staff Member Engagement During Time Outs. *AORN Journal* 2020; 111(1): 81-86  
<https://aornjournal.onlinelibrary.wiley.com/doi/10.1002/aorn.12898>  
 (Brenckle 2020)

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