

What’s New in the Patient Safety World

November 2023

Importance of Timeouts Outside the OR

The primary purpose of the surgical timeout is to ensure the correct patient, correct procedure, correct body part, and correct laterality. While the timeout process was originally intended for surgical cases in the OR, it’s clear that this should be performed prior to any procedure done in any venue. That would include the radiology suite, cath lab, bedside, emergency department, or outpatient clinic or office. A recent AHRQ PSNet WebM&M ([Bellini 2023](#)) described a case where a failed timeout process led to a “double” never event: wrong patient and wrong side.

A first-year orthopedic surgery resident was consulted to aspirate fluid from the left ankle of a patient in the intensive care unit. The resident, accompanied by a second resident, approached the wrong patient, obtained consent from the patient’s wife via telephone, and inserted the needle into the patient’s right ankle. At this point, a third resident entered the room and stated that it was the incorrect patient. The procedure was immediately terminated and patient and family were notified of the error. There apparently were no negative sequelae for that patient. The correct patient was 2 beds away.

The original (incorrect) patient was not competent to provide informed consent. The patient’s wife affirmed the patient’s name, which was incorrect, and consented to the procedure. The report does not state how the discussion with the wife was handled but it sounds like verification of the patient’s name may have been via a passive rather than active process.

A timeout was apparently done (with the two residents and the bedside nurse). But it did not include verification of the patient and procedure location. (One wonders what was actually done during this “timeout”). The nurse questioned why an ankle aspiration procedure was being done on a patient who had wounds on both feet and osteomyelitis in his left foot. The resident responded that the aspiration was to collect fluid, not to treat osteomyelitis. One of the residents stepped away to confirm the patient’s identity in the electronic health record and returned confident that they were working with the correct patient. The nurse’s concern was not resolved and the procedure was initiated on the wrong patient and wrong site.

Unfortunately, we continue to see bedside procedures performed without timeouts. Often a resident simply goes to the supply room, grabs a procedure kit, goes to the bedside, and performs the procedure on the patient without any assistant to help. Prior to the patient safety “era”, we even used to pride ourselves in being able to do things like the “one-handed lumbar puncture” without any assistance. Boy, were we lucky we didn’t do things on the wrong patient or wrong body part!

Our June 6, 2011 Patient Safety Tip of the Week “[Timeouts Outside the OR](#)” highlighted a study from Northwestern University ([Barsuk 2011](#)) on re-engineering processes for compliance with Universal Protocol for bedside procedures. They looked at lumbar punctures, thoracenteses and paracenteses done on the medicine services at their facilities. Analyzing their processes, they found that staff were often unaware of Universal Protocol (or perhaps unaware that it was required not just for OR procedures, but for bedside procedures as well) and that nurses were frequently never notified by physicians when their patients were undergoing such procedures. In their redesigned process the physician initiates the process by entering an order via CPOE with an anticipated time. This order would automatically populate the nurse’s alert list and provide the nurse with a timeout form and notice of a procedure-specific supply kit to procure. Only the nurse has a key to those procedure kits. This is a forcing function that forces the physician-nurse communication to take place. The nurse brings the timeout checklist and the kit to the bedside at the specified time and the nurse and physician go through the timeout procedure, which gets documented in the EMR. Compliance with Universal Protocol went from 16% before to 94% after implementation of this redesigned process. Elegant! That is a process we have advocated ever since. We also recommend that a copy of the timeout checklist should be attached to the front of all procedure kits and the kit should not be opened until the items on the checklist have been agreed upon by all.

Of course, your timeout checklist would likely contain several other items, such as why the procedure is being done, that informed consent has been obtained, and what you expect to do with any specimens from the procedure.

The authors of the WebM&M case also stress the importance of communication and TeamSTEPPS concepts for improving teamwork. During a timeout everyone must agree on all the items or the procedure needs to be paused for clarification. Anyone’s concerns need to be addressed, such as the nurse questioning the reason for the procedure and the site.

It's essential that all members of the healthcare team understand the intent and importance of the timeout and adhere to the process religiously.

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

September 23, 2008 “[Checklists and Wrong Site Surgery](#)”

June 5, 2007 “[Patient Safety in Ambulatory Surgery](#)”

July 2007 “[Pennsylvania PSA: Preventing Wrong-Site Surgery](#)”

March 11, 2008	“Lessons from Ophthalmology”
July 1, 2008	“WHO’s New Surgical Safety Checklist”
January 20, 2009	“The WHO Surgical Safety Checklist Delivers the Outcomes”
September 14, 2010	“Wrong-Site Craniotomy: Lessons Learned”
November 25, 2008	“Wrong-Site Neurosurgery”
January 19, 2010	“Timeouts and Safe Surgery”
June 8, 2010	“Surgical Safety Checklist for Cataract Surgery”
December 6, 2010	“More Tips to Prevent Wrong-Site Surgery”
June 6, 2011	“Timeouts Outside the OR”
August 2011	“New Wrong-Site Surgery Resources”
December 2011	“Novel Technique to Prevent Wrong Level Spine Surgery”
October 30, 2012	“Surgical Scheduling Errors”
January 2013	“How Frequent are Surgical Never Events?”
January 1, 2013	“Don’t Throw Away Those View Boxes Yet”
August 27, 2013	“Lessons on Wrong-Site Surgery”
September 10, 2013	“Informed Consent and Wrong-Site Surgery”
July 2014	“Wrong-Sided Thoracenteses”
March 15, 2016	“Dental Patient Safety”
May 17, 2016	“Patient Safety Issues in Cataract Surgery”
July 19, 2016	“Infants and Wrong Site Surgery”
September 13, 2016	“Vanderbilt’s Electronic Procedural Timeout”
May 2017	“Another Success for the Safe Surgery Checklist”
May 2, 2017	“Anatomy of a Wrong Procedure”
June 2017	“Another Way to Verify Checklist Compliance”
March 26, 2019	“Patient Misidentification”
May 14, 2019	“Wrong-Site Surgery and Difficult-to-Mark Sites”
May 2020	“Poor Timeout Compliance: Ring a Bell?”
September 14, 2021	“Wrong Eye Injections”
October 5, 2021	“Wrong Side Again”
November 9, 2021	“Ensuring Safe Site Surgery”
February 15, 2022	“Wrong-Side Chest Tubes”
May 2022	“PPSA: Updated Wrong-Site Surgery Recommendations”
June 13, 2023	“Preventing Wrong-Site Surgery”

References:

Bellini A, Salcedo ES. A Double “Never Event”: Wrong Patient and Wrong Side. AHRQ PSNet WebM&M: Case Studies 2023; September 27, 2023
<https://psnet.ahrq.gov/web-mm/double-never-event-wrong-patient-and-wrong-side>

Barsuk JH, Brake H, Caprio T, Barnard C, Anderson DY, Williams MV. Process Changes to Increase Compliance With the Universal Protocol for Bedside Procedures. Arch Intern Med 2011; 171(10): 941-954

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