



HOW TO RUN THE CHECKLIST: IN DETAIL – TIME OUT

“The Time Out is a momentary pause taken by the team just before skin incision in order to confirm that several essential safety checks are undertaken and involves everyone on the team.”

CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE

Operating team members may change frequently. Effective management of high risk situations requires that all team members understand who each member is and their roles and capabilities. A simple introduction will achieve this. The coordinator will ask each person in the room to introduce him or herself by name and role. Teams already familiar with each other can confirm that everyone has been introduced, but new members or staff that have rotated into the operating room since the last operation should introduce themselves, including students or other personnel.

SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM PATIENT, SITE AND PROCEDURE

This step is the standard **“Time Out”** or “surgical pause” and meets the standards of many national and international regulatory agencies. Just before the surgeon makes the skin incision, the person coordinating the Checklist or another team member will ask everyone in the operating room to stop and verbally confirm the name of the patient, the surgery to be performed, the site of surgery and, where appropriate, the positioning of the patient in order to avoid operating on the wrong patient or the wrong site. For example, the circulating nurse might announce, *“Let’s take our Time Out,”* and then continue, *“Does everyone agree that this is patient X, undergoing a right inguinal hernia repair?”* This box should not be checked until the anaesthesia professional, surgeon and circulating nurse explicitly and individually confirm agreement. If the patient is not sedated, it is helpful for him or her to confirm the same as well.

ANTICIPATED CRITICAL EVENTS

Effective team communication is a critical component of safe surgery, efficient teamwork and the prevention of major complications. To ensure communication of critical patient issues, during the “Time Out” the Checklist coordinator leads a swift discussion among the surgeon, anaesthesia staff and nursing staff of critical dangers and operative plans. This can be done by simply asking each team member the specified question out loud. The order of discussion does not matter, but each box should be checked only after each clinical discipline has provided its information. During routine procedures or those with which the entire team is familiar, the surgeon can simply state, “*This is a routine case of X duration*” and then ask the anaesthesia professional and nurse if they have any special concerns.

SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?

A discussion of “critical or unexpected steps” is intended, at a minimum, to inform all team members of any steps that put the patient at risk for rapid blood loss, injury or other major morbidity. This is also a chance to review steps that might require special equipment, implants or preparations.

ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?

In patients at risk for major blood loss, haemodynamic instability or other major morbidity due to the procedure, a member of the anaesthesia team should review out loud the specific plans and concerns for resuscitation — in particular, the intention to use blood products and any complicating



patient characteristics or comorbidities (such as cardiac or pulmonary disease, arrhythmias, blood disorders, etc). It is understood that many operations do not entail particularly critical risks or concerns that must be shared with the team. In such cases, the anaesthesia professional can simply say, *“I have no special concern regarding this case.”*

NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

The scrub nurse or technologist who sets out the equipment for the case should verbally confirm that sterilization was performed and that, for heat-sterilized instruments, a sterility indicator has verified successful sterilization. Any discrepancy between the expected and the actual sterility indicator results should be reported to all team members and addressed before incision. This is also an opportunity to discuss any problems with equipment and other preparations for surgery or any safety concerns the scrub or circulating nurse may have, particularly ones not addressed by the surgeon and anaesthesia team. If there are no particular concerns, however, the scrub nurse or technologist can simply say, *“Sterility was verified. I have no special concerns.”*

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?

Despite strong evidence and wide consensus that antibiotic prophylaxis against wound infections is most effective if serum and/or tissue levels of antibiotic are achieved, surgical teams are inconsistent about administering antibiotics within one hour prior to incision. To reduce surgical infection risk, the coordinator will ask out loud during the “Time Out” whether

prophylactic antibiotics were given during the previous 60 minutes. The team member responsible for administering antibiotics (usually the anaesthesia professional) should provide verbal confirmation. If prophylactic antibiotics have not been administered, they should be administered now, prior to incision. If prophylactic antibiotics have been administered longer than 60 minutes before, the team should consider redosing the patient; the box should be left blank if no additional dose is given. If prophylactic antibiotics are not considered appropriate (e.g. cases without a skin incision, contaminated cases in which antibiotics are given for treatment), the “not applicable” box may be checked once the team verbally confirms this.

IS ESSENTIAL IMAGING DISPLAYED?

Imaging is critical to ensure proper planning and conduct of many operations, including orthopaedic, spinal and thoracic procedures and many tumour resections. During the “Time Out”, the coordinator should ask the surgeon if imaging is needed for the case. If so, the coordinator should verbally confirm that the essential imaging is in the room and prominently displayed for use during the operation. Only then should the box be checked. If imaging is needed but not available, it should be obtained. The surgeon will decide whether to proceed without the imaging if it is necessary but unavailable. In such a circumstances, however, the box should be left unchecked. If imaging is not necessary, the “not applicable” box should be checked.

AT THIS POINT THE TIME OUT IS COMPLETED AND THE TEAM MAY PROCEED WITH THE OPERATION