"Time Out" Documentation for Bedside and Clinic Procedures

Practicing "time out" prior to a procedure is a nationally recognized patient safety measure, which helps assure that the correct procedure is performed on the correct patient. During a recent Joint Commission survey, the physician surveyor observed that "time out" documentation was not included in physician notes for a bedside and a clinic procedure, which resulted in a formal requirement for improvement. Review of our current practice showed that a standardized, organization-wide process for proceduralists to document "time out" of bedside or clinic procedures was indicated.

In the operating room, "time out" involves all the surgical team members immediately prior to incision, verbalizing the correct procedure, side/site, position, antibiotic started, and prep dried, which is documented by the circulating nurse. Procedures at the bedside or in clinics may only involve the physician or licensed independent practitioner, and is a conscious pause and review by the proceduralist immediately before the procedure to assure the following:

1. Correct patient identity
2. Correct procedure
3. Correct side and site are marked (if applicable)
4. Correct position
5. Safety precautions based on patient history
6. Required equipment, devices, medications, images, & results available

In general, the attending physician is encouraged to be present but is not required to be present for the time out for bedside or clinic procedures.

To provide standardized documentation of "time out", Information Systems incorporated the required documentation into all WebCIS procedure notes. Documentation of "time out" is fulfilled by selecting the box associated with the following statement in procedure notes: "**Time out was performed immediately prior to the procedure."** If the box is not selected, time out will not be documented upon signature of the note, which will indicate that a "time out" was not performed.

UNCH will report compliance on time out documentation to Joint Commission for the next 4 months, and we must achieve $\geq$ 90% compliance. All physicians and licensed independent practitioners are encouraged to begin using this standardized time out documentation process immediately.

Please direct any questions or concerns to Laura Harmon, lharmon@unch.unc.edu

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On the following page is a list of procedures that fall into this category which is taken from the Universal Protocol Hospital Policy.

ATTACHMENT A
Applicability of Universal Protocol for Bedside and Outpatient Settings

Invasive Procedures: ***Follow Universal Protocol and Document Time Out in Medical Record***

- PICC line insertion
- Central line insertion
- Circumcision
- Laser treatment/therapy
- Endoscopic procedures
- Joint aspirations
- Joint injections
- Thoracentesis
- Paracentesis
- Lumbar puncture
- Oral cavity aspiration
- Vaginal/vulvar aspiration
- Endometrial biopsy
- IUD insertion
- Port removal
- G-tube exchange
- Sinogram
- Cerebral arteriogram
- Bone marrow biopsy

Also, any other procedure deemed by licensed independent practitioner to have more than minimal risk and any procedure completed using sedation.