Time Out: Illuminating Every Step Toward Safer Surgery

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Background

- The surgical time-out is a critical safety pause mandated to prevent wrong-site, wrong-procedure, and wrong-person surgeries.
- Despite its widespread adoption, inconsistencies in how time-outs are conducted can undermine patient safety and team communication
- Although studies support the benefits of standardized time-out, many nurses adopt their own time-out and may miss critical questions while completing the time-out.

Purpose

- The purpose of our project was to establish a standardized time-out at Holy Name Hospital. This quality improvement initiative aimed to enhance the consistency, engagement, and effectiveness of the surgical time-out process in the main operating room by implementing an audit tool and structured education.

Methods

- A standardized time-out checklist was developed based on national safety guidelines, including those from The Joint Commission and AORN.
- An audit tool was created to evaluate compliance, clarity, and participation during time-outs. Baseline data was collected over a 4-week period.
- Targeted educational sessions were provided to perioperative team members, emphasizing the purpose, elements, and shared responsibility of the time-out.
- Post-intervention audits were conducted to assess improvement at one month and three months.

Implementation

- Following randomized audits, it was determined that staff compliance was at 13%.
- To support improvement, a time-out sheet outlining the required questions was posted in each operating room.
- Subsequent audits were conducted at one month and three months following completion of staff education to monitor progress.

HolyName
NURSING

Time-Out Audit Tool

Date: ____________

Case: ____________

Time Out				
	Yes	No	N/A	Comments/Actions
Performs a time-out before an operative or invasive procedure begins.				
Halts unnecessary activities and conversations when the time-out is called.				
Uses standardized safety checklist with cognitive aids (eg, whiteboard, computerized checklist) to implement the SSC during the time out.				
Confirms correct patient				
Confirms Date of Birth				
Confirms site marked				
Confirms procedure to be performed				
Confirms Allergies				
Confirms ABX given				
Confirms SCD boots are on				
Confirms Fire Risk				
Introduces all team members involved in the surgery (including vendors)				
Diagnostic studies are visible and correctly displayed				
Documents the time out as completed in accordance with facility policy.				
Allows opportunity for questions or concerns				
All team members are wearing proper PPE				
If two or more procedures are being performed on the same patient and a different physician is performing each procedure, a time out is conducted before each procedure				

Room: ____________

Nurse: ____________

Tech: ____________

Surgeon: ____________

Anesthesiologist: ____________

Comments:

TIME OUT TOOL

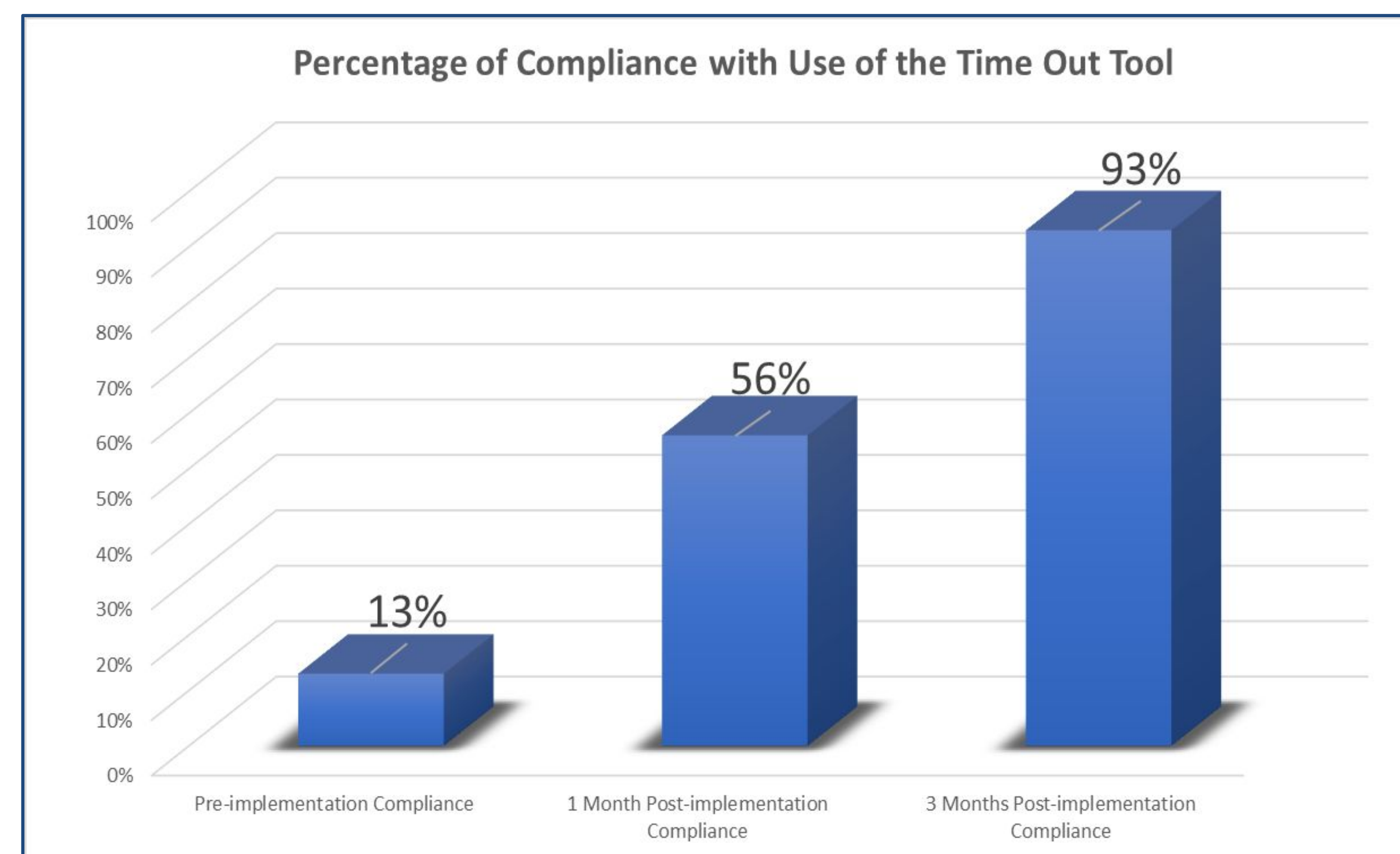
- HALT all movement/activity
- Introduction of ALL Team Members (including vendors)
- Confirm patient name and date of birth
- Confirm procedure
- Confirm site is marked and visible
- Patient allergies reviewed
- Prophylactic antibiotics administered
- Confirms SCD boots are on
- Fire risk assessment as follows: (fire triangle: heat, fuel, oxygen)
  1. Is an alcohol-based skin antiseptic or other flammable solution being used preoperatively? (fuel)
  2.Is the surgical site or procedure above the xiphoid process or in the oropharynx? (oxygen)
  3.Is open oxygen or nitrous oxide being administered?(oxygen)
  4.Is there an ignition source (cautery, laser, or fiber-optic light being used? (.heat)
  5.Are there other possible contributors, such as drills, saws, and burrs? (heat)
  High Risk- Score of 3- if all 3 components of the fire triangle are present
  Moderate Risk- Score of 2-.if 2 components of the fire triangle are present
  Low Risk Score of 1- only 1 components of the fire triangle is present
- Fire risk: confirm sterile water/saline is labeled and on the field
- Are diagnostic images visible and properly displayed?
- Is everyone wearing proper PPE?
- Any questions or concerns from the team?
- DOES EVERYONE AGREE?

*If two or more procedures are being performed on the same patient and a different physician is performing each procedure, a time out is conducted before each procedure

Results

Our outcome measures focused on:

- Staff using the Time-out standardize sheet as a reference for all Time-outs
- Audit results demonstrated a significant improvement in adherence to the surgical safety checklist, active interdisciplinary participation, and clear verbalization of critical safety elements.
- The rate of complete and standardized time-outs increased significantly, rising from a baseline of 13% to 93% following the intervention.
- Staff reported enhanced confidence and a clearer understanding of their roles during the time-out process.



Implications for Practice

- The transition to a standardized checklist, combined with targeted education, significantly enhanced the cohesiveness and reliability of the surgical time-out process.
- Standardization and team accountability were key drivers of this improvement.
- Sustaining this change requires ongoing audits, feedback, and integration into orientation for new perioperative staff.
- The compliance of staff may be better when they are aware they are being audited.
- Future goals will be enhancing data collection by using computerized standardized Time-Out sheet.

References

Association of periOperative Registered Nurses. (2024). *Guidelines for surgical time-out*. In *Guidelines for perioperative practice* (2024 ed.). AORN, Inc. https://www.aorn.org/guidelines

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