



SECTION: Guidelines

LOCATION:

**SUBJECT: Universal Protocol Checklist
(Surgical Safety Pause/Time Out)**

Effective Date: April 2005

PURPOSE:

The Universal Protocol Check List Surgical Safety Pause/Time Out form is a one-sided, one-page permanent medical record form, which is used to document the final Safety Pause/Time Out safety check by the entire surgical team just prior to the start of the procedure.

SCOPE:

The Universal Protocol Check List, Surgical Safety Pause/Time Out form is to be completed on all surgical patients after team agreement that pertinent criteria have been met.

RESPONSIBILITY:

Unit Clerk

- Addressograph stamps upper right hand corner of the form. If the stamp is not available, writes the patient's name and medical record number in the addressograph space.
- In the absence of a unit clerk, the nurse performs this duty.

Circulating R.N.

- Completes each section by checking the appropriate box if applicable confirming team agreement
- Writes the date and time when the form is completed
- Sign the document

GENERAL INSTRUCTIONS:

1. Use black ink to complete this form.
2. Fill in the appropriate blank spaces.
3. Sign and date the form upon completion.
4. Insert the document into the patient chart.

SPECIFIC INSTRUCTIONS:

1. Each section is to be completed by the circulating R. N.
2. For the following items, place a check mark in the "box" indicating that that area has been checked and verified by the surgical team members in the room. If not applicable, place a check mark in the column titled "NA".
3. If there is a discrepancy, it must be resolved prior to start of the procedure.

Patient Identification	<ul style="list-style-type: none"> • Ensure that the patient has the correct ID bracelet with correct name & medical record number verifying that it is the same information on the consent form.
Site and side	<ul style="list-style-type: none"> • The surgical site and side, agrees with the consent and as marked by surgeon, if applicable.
OR consent form completed by surgical attending matching scheduled surgery. (Consent is dated within 60 days of date of surgery.)	<ul style="list-style-type: none"> • The consent must be completed prior to the patient leaving the inpatient unit or holding area. • It is essential that the consent match the surgical procedure as many patients have multiple surgeries during the same admission. • If the patient requires guardianship papers, ensure that the paperwork is in the medical record. • Consent is valid for 60 days as long as patient circumstances have not changed.
Relevant Studies	<ul style="list-style-type: none"> • Verify that all pre-operative diagnostic studies have been reviewed by surgeon and anesthesia.
Relevant Radiology studies	<ul style="list-style-type: none"> • There is verification of relevant Radiology studies. Actual films need to be present for final review whenever laterality of site and side are to be determined.
Special Equipment	<ul style="list-style-type: none"> • Verify that any special equipment is present prior to the start of surgery.
Implant(s)	<ul style="list-style-type: none"> • Verify that all implants are available prior to the start of surgery.
Correct position	<ul style="list-style-type: none"> • Verify that patient is in the correct position for the procedure to be performed according to the surgeon's preference.
Prophylactic antibiotics	<ul style="list-style-type: none"> • Verify that prophylactic antibiotics have been given if indicated. Document medication, dose & time in the Intraoperative Nursing Record – Tab for Universal Protocol Checklist. Discuss & document supplemental Intra-operative antibiotic redose with anesthesia provider.
Sterile indicators	<ul style="list-style-type: none"> • Verify that all indicators must be checked that items on the sterile field are sterile.
Pre-op counts	<ul style="list-style-type: none"> • Verify that pre-operative counts have been completed prior to incision according to policy – “Counts in the Operating Room.”
Blood products	<ul style="list-style-type: none"> • Verify that blood is available if indicated prior to incision.
Observers	<ul style="list-style-type: none"> • Verify that any observer or vendor in the OR has permission of patient and surgeon as written on OR consent or notation included in the progress note.
Participants	Document the name of the participants in the safety pause/time out. Place a check mark in the appropriate box. (N/A box is available only if anesthesia is not being provided or if anesthesia is doing the procedure and a surgeon is not required.)

RN Completing Information	Signature & title of the nurse completing the information. A space is provided for the nurse to print his/her name for legibility purposes.

Source: UMass Memorial Medical Center, Worcester, Mass.