What do JCAHO surveyors look for in assessing the Universal Protocol?

Compliance with the time-out before surgery has fallen off. Only 81% of hospitals and 85% of surgery centers surveyed in the first quarter of 2006 were compliant, down from 92% and 93% in 2004, according to the Joint Commission on Accreditation of Healthcare Organizations.

The reason may be that surveyors are more astute in assessing the time-out, says the Joint Commission’s executive director for patient safety, Richard Croteau, MD.

Beginning this year, all surveys are unannounced, meaning organizations have to be prepared at all times. Surveyors also spend more time observing patient care, and they judge compliance based on actual performance rather than policies and procedures, Dr Croteau notes.

Eight organizations surveyed recently shared their experiences with OR Manager about the Joint Commission’s review of their time-out process and other elements of the Universal Protocol. Most said the surveyors were satisfied, though a couple received recommendations for improvement (RFIs).

The Universal Protocol requires 3 steps for eliminating wrong site, wrong procedure, and wrong person surgery:

- preoperative verification process
- marking the operative site
- time-out immediately before the procedure to conduct a final verification.

Compliance with preoperative verification and site marking is high (chart, p 7).

Two major questions OR managers have:

- How should the time-out be documented?
- Who should mark the site?

The Joint Commission isn’t specific about documenting the time-out, saying only that it should be “briefly documented,” and the “organization should determine the type and amount of documentation.”

On site marking, the commission says the person performing the procedure should mark the site but does not say must. (See frequently asked questions on the Universal Protocol at www.jcaho.org. Look under Patient Safety, then Universal Protocol.)

Overall observations from OR managers about their surveys:

- Surveyors spent time interacting with staff in the preoperative admissions unit and holding area, particularly during tracers. (In tracers, surveyors follow a patient’s care from beginning to end, quizzing the staff, reviewing charts, and judging compliance with standards.)
- Nearly all of these facilities document the 5 elements of the time-out in their perioperative record:
  - correct patient identity
  - correct side and site
  - agreement on procedure to be done
  - correct patient position
  - availability of correct implants and any special equipment or special requirements.

Some inconsistency was noted among surveyors about who should mark the site. One facility received an RFI (later withdrawn) for not requiring the physician to mark the site, but others did not.
Documenting time-out

“The surveyors scrutinized our preop admission department very closely. As they toured our department, they watched what we were doing a lot,” says Robin Ramsey, RN, BSN, CNOR, at Poudre Valley Hospital in Fort Collins, Colo, which has 12 ORs and was surveyed in March 2006.

Surveyors pulled 4 or 5 current electronic charts in the preop area and postanesthesia care unit. Once they found those compliant, she says they didn’t probe further.

“My sense is that if they had found something, they would have dug deeper,” Ramsey says.

Poudre Valley’s electronic nursing documentation has space to document the 5 elements of the time-out.

Surveyors seemed to ask more questions about the Universal Protocol in departments like the cath lab, radiology, and the gastrointestinal endoscopy unit than in the OR, she notes.

The surveyors did not comment on Poudre Valley’s policy of not requiring the surgeon or procedural physician to mark the site.

“We thought we would get nailed on that, but they didn’t say a thing about it,” says Ramsey. About half of physicians mark the site, but some are resistant.

The hospital’s policy states: “After communication with the patient, or a patient’s representative, the physician or physician’s designee (ie, physician assistant, nurse practitioner, RN) will mark the procedure/surgical site(s) with ‘yes’ prior to the patient entering the procedure/operating room.”

Preop nurses use a specific tool when handing the patient off to the OR nurse to ensure consistency in site verification information.

Surgeon’s role in verifying site

Surveyors spent almost a full day in the OR, and then came back during tracers at the University of Wisconsin, an academic medical center with 31 ORs surveyed in October 2005. All 5 time-out elements are documented online, and a paper copy is printed for the chart.

“The surveyors did witness our verification process in the holding area. One surveyor actually went into the OR to see the time-out,” says the director of surgical services, Barbara Pankratz, RN, MSN. “They felt we met all of the requirements.”

One issue has been the staff surgeon’s role in patient verification, including cor-
The policy states that a member of the surgical team knowledgeable about the patient, either the staff surgeon or resident, must mark the site. In addition, the staff surgeon must be involved in verification either:

- in the preop holding area by verifying the correct patient and procedure and signing the site
- in the OR by participating in the time-out prior to anesthesia induction, or
- prior to incision.

“We hold the incision until the staff surgeon makes the confirmation,” Pankratz says.

“One surveyor commented that he was pleased with our policy that the scalpel is not handed to the surgeon until the time-out is complete,” she says.

**Checkbox for time-out**

Banner Desert Medical Center in Mesa, Ariz, uses a checkbox to document that the time-out was performed and indicates who was involved. The check signifies that the time-out was conducted according to hospital policy, says Elaine Anderson, RN, MSN, MEd, CNOR, director of perioperative services, endoscopy, and central processing. The hospital has 17 ORs.

During a survey in February 2006, Joint Commission surveyors asked if there was a site verification policy and if the site and side are marked, Anderson notes. They pulled charts to view the documentation but didn’t go into the ORs to observe.

Under the hospital’s policy, the surgeon and patient identify the site. Usually, the

### JCAHO surveys of Universal Protocol in 8 organizations

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<th>Facility type</th>
<th>Region</th>
<th>No. ORs</th>
<th>How is time-out documented?</th>
<th>Must person doing procedure mark site?</th>
<th>Recommendations from JCAHO?</th>
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Notes: 1. The 5 elements include: Correct patient identity; correct side/site; agreement on procedure; correct patient position; availability of implants, special equipment, or special requirements. 2. Member of surgical team. 3. Unless provider is external to system. Source: OR Manager.
The surgeon does the marking, generally with an X. The nurse observes the process.

“We believe the surgeon should mark the site. Ultimately, it’s his responsibility,” says Anderson. “The majority of our surgeons are on board with this.”

**A challenge on site marking**

A large community hospital in the West, surveyed in early 2006, decided to change its documentation after a comment from the surveyor indicated that the staff might not be remembering to call out the 5 elements during the time-out. The facility also received an RFI for not requiring the physician to mark the site in most cases. The RFI was withdrawn after the hospital challenged it.

The online documentation was changed to include the 5 elements instead of having the staff simply mark Yes or No for the time-out.

Though there were posters in each OR reminding nurses to verify the 5 elements, the staff sometimes forgot to look at the posters.

“We realized our documentation could be improved to support the process,” says the OR director, who did not wish to be named.

Because the computers in some ORs are not in a convenient place, the nurses, with chart in hand, initially document the 5 elements on a grease board and then transfer the documentation to the computer. The documentation is audited to make sure it occurs before the incision.

“We’re glad we made the change. We did it to cue the nurses not to miss any of the elements,” she says. “It also gives leaders a way to check that it is being done.”

The site-marking policy says:

- When possible, the patient marks the site and initials it.
- If the patient can identify the site but can’t mark it, the nurse marks it with the patient’s initials.
- If the patient is unwilling or incapable of marking the site because of a medical condition, age, or other factors, the surgeon or assistant initials the site.
- “The surveyor didn’t like that the physician doesn’t mark the site,” the director says. “But we pointed out that the Joint Commission’s language says the person performing the procedure should, not must, mark the site, and they withdrew the recommendation.”

**Documentation changed after wrong-site incident**

One organization changed its documentation after a wrong-site surgery made it clear that simply checking a box, “Time-out: Yes or No” was not sufficient.

“We now document exactly what procedure the time-out was called for, who was present, and that all attendees agree,” says the OR manager, who did not want to be identified.

After the wrong-site case, the staff and surgeon disputed which procedure was named during the time-out, but the staff had no documentation to back them up.

Now for the time-out process, the circulating nurse calls for the time-out, reads the name of the procedure directly from the surgical consent, and asks for all team members to state that they agree. In the electronic record, the nurse checks that the time-out was called for and types into the comment section of the electronic record: “Time out called for [name of procedure]. All attendees agreed.” As reminder, a card is posted on each computer that says:

- Time-out called for.
- Type procedure in comment section.
- All attendees agree.

**Two time-outs**

The hospital’s policy calls for 2 time-outs:

1. When the patient arrives in the OR, the circulating nurse will verify with the patient (if able) and anesthesiologist the patient’s name, procedure, and allergy status. In local or IV sedation cases, the circulating nurse, the nurse who monitors the sedation, and the scrub person verify the information.

2. In the OR prior to the incision, the circulating nurse will show the scrub person the surgical consent. While standing next to the surgical field, the nurse will verify the
correct patient, procedure, and surgical site with all case attendees. A verbal “yes” that they agree is mandatory from all case attendees.

“Ask yourself: ‘What information does your documentation contain?’” the manager says. “Does it provide enough information to protect you and your hospital? If it doesn’t, and there’s a question, it’s a he-said, she-said situation.”

The Joint Commission reviewed the documentation during a recent survey. “They thought it was great,” she says. “They were also impressed with our audit results.”

The audit is conducted in 2 ways:

• The OR assistant nurse manager observes 25 cases a month out of about 350 the facility performs.
• A random audit of the electronic documentation is conducted. Results are tallied in an Excel spreadsheet and used to produce a monthly report for the hospital’s risk manager.