Patient safety

Timeout: It’s as easy as apple pie!

The timeout protocol is an essential step before any invasive procedure to prevent wrong site, wrong procedure, and wrong person surgery. The pause also allows for the antibiotic to be given and charted, implants to be checked for accuracy, and equipment to be assessed for functionality.

The timeout protocol is a Joint Commission mandate with required items that must be identified accurately by all 3 disciplines: nursing staff, anesthesia provider, and surgeon. The procedure is not started until any questions or concerns are resolved.

The timeout is considered a last check for accuracy prior to a procedure. The Joint Commission requires these items to be included in the timeout: patient’s identity, procedure to be done, correct side and site (laterality), equipment, position, and implants.

Several months ago, while preparing for the Joint Commission survey, I was faced with the challenge of how to help the staff remember all of the items of the timeout.

The perfect acronym

Following several failed attempts for staff to recite all the elements, I decided an acronym would help and announced to 4 staff who were present, “Whoever comes up with an acronym that includes all the critical timeout required items will receive a $50 gift certificate.” The staff who accepted this challenge are surgical technologists Ed Patton and John Briggs; Sonny Matienzo, RN; and Anthony Stanton, RN. Soon I got a call saying they had come up with the perfect acronym. As I entered the room, Ed showed me a piece of paper. On it was written the word APPLE PI. I looked confused until he began to read:

A—Antibiotics
P—Patient’s name
P—Procedure
L—Laterality
E—Equipment
P—Position
I—Implants: APPLE PI.

Although antibiotics are not one of the essential elements of the timeout, studies have shown the importance of the timing of antibiotic administration in reducing postoperative infections. So I thought the word antibiotic was a good way to usher in the timeout session.

I was pleasantly surprised and knew at once that the rest of the perioperative staff would embrace this tool. We had tried so many ways to help the nursing staff and physicians remember the items of the timeout, and here it was: clever, fun, and so easy to remember. I asked which of them had created the acronym so I could reward them with their gift certificate. Their response was, “We all came up with it together.” So I gladly rewarded each one a $50 gift certificate, and it was a pleasure to acknowledge them.
Getting the word out

As the weeks passed, everyone in the department began to hear about APPLE PI, and accepted the idea wholeheartedly. Colorful prints were on bulletin boards and sent out to colleagues via e-mail. The description of APPLE PI was published in our operating room monthly newsletter, Tidbits, published by Joyce Nacario.

Just before the acronym was finalized as a safety tool for our operating room, the patient care manager for the pediatric operating room, Cassandra Robertson, RN, made a suggestion. She said, “To complete the PI in APPLE PI, why don’t you add an E for “everyone participates”? Since the Joint Commission requirement is to include participation by disciplines involved in the procedure, it will be a constant reminder that everyone must be involved.” With the final “E” added to the acronym, a powerful safety innovation was born: APPLE PIE.

The APPLE PIE acronym is displayed on 3 x 4 foot posters protected in Lucite in every operating room at all 3 UCSF operating room sites: ambulatory care, Mount Zion, and the main campus. In addition, laminated 3 x 4 inch cards depicting the APPLE PIE reminder hang on the ID badges of all operating room staff. This nursing staff innovation has been a win for our staff and an important safety step for our patients.

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