

RO-ILS CASE STUDY 17

MAKE TIME FOR TIMEOUTS!

Shortcutting your timeout can shortchange your patient

Introduction

Confirming a patient's identification is a universal safety standard introduced by The Joint Commission more than two decades ago and is still a 2023 national patient safety goal.¹ The intent of the standard is to reliably identify the individual for whom care is intended, matching the service to the individual. Performing the two-identifier check is the initial step of a timeout. A full timeout includes verification that the site and treatment plan also matches the individual for whom care is intended. Under certain conditions, like intense time pressure, therapists may deviate from methodically conducting the timeout each time, which can result in a wrong patient error.

The following RO-ILS event is an incident in which the verification was done confirming the patient; however, the full timeout matching the service to the individual was not performed.

Event overview

- The plan was loaded for the next patient on the schedule.
- Therapist went to retrieve the patient, but the intended patient was not present.
- The decision was made to take another patient who was present back for treatment instead.
- Both the initial patient and patient retrieved were undergoing treatment for prostate cancer.
- The loaded plan was not changed when the second patient was taken into the room for treatment.
- The practice mentions that equipment used to facilitate timeout within the treatment room was temporarily inoperable, although further details were not provided.
- Two therapists were working together and confirmed the patient's identity; however, the treatment plan was not changed.
- Patient received treatment with another patient's treatment plan for one fraction.
- The error resulted in partial dose to the target; requiring a plan revision to make up the dose.

Contributing factors

- Patient identity was verified; however, confirmation of agreement with the treatment plan in mode-up was not done.
- Timeout was not conducted at the treatment console to verify the patient on the treatment table was the same as the plan that was in mode-up.
- Equipment to conduct timeout inside the treatment room was inoperable.

Lessons learned

1. This event shows that it is not sufficient to verify patient identity and treatment site as part of the timeout. We also must incorporate verification of treatment plan's concordance with patient identity as part of the timeout process.
2. Facilities need to develop a contingency workflow to use when equipment to support safety processes is not functioning.
3. Facility should consider empowering the patient in patient safety. For example, a patient might be told that when they come in for treatment, they should see their photo on the treatment monitor. This patient engagement practice might be another safeguard against such an occurrence.
4. A strong safety culture will ensure therapists know they can take the time to complete a thorough timeout, and the time they spend will be appreciated by the entire team, no matter what time pressures are present.

Conclusion

This incident demonstrates the value in following a standard process. It also hints at the threat of repetition, and how it can create false assurance. Standard processes may include structured steps and equipment used to perform a task. Ensuring both are in place is important to prevent the need for workarounds or truncating the process.

Leaders should observe staff under normal conditions to measure adherence to processes, response to interruptions and identify gaps in knowledge. This can support quality improvement in standardizing processes. Additionally, leadership can support staff in their efforts to carry out safety workflows by ensuring equipment is operable.

SAFETY CHECK

Have you ever observed the surgical timeout process? How does it compare to the process in your clinic? Is there anything to learn from it that should be adopted? Is there a contingency plan in your clinic to assure the level of safety is maintained when equipment used for conducting the timeout is inoperable?

References

1. The Joint Commission. 2023 Hospital National Patient Safety Goals. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/2023-hap-npsg-goals-102122_simple.pdf