SECOND EDITION

INTRODUCTION TO FLEXIBLE BRONCHOSCOPY

Procedural Pause (Time Out) and Universal Precautions Synopsis

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Dedicated to patient safety

THE BRONCHOSCOPY EDUCATION PROJECT SERIES

Procedural Pause (also known as 'Time Out)*

Abstracted from Institute for Clinical Systems Improvement Guidelines: safe site invasive procedures non-operating room. Downloaded ICSI.org, from http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=13702

Active oral Time Out process

The **Time Out** is to be performed immediately prior to the start of the procedure and is the final safety stop before the procedure is begun. The purpose of the Time Out is to ensure that the correct patient, site, side, positioning and procedure to be performed are all correctly verified. In addition, it is an opportunity to validate that any related images, equipment or implants are available.

The Time Out is initiated by the provider and includes active verbal acknowledgment by all members of the team. The scalpel, needle or other cutting/incising device is not to be handed to the provider until the Time Out has been completed. While it is desirable to actively include the patient in the Time Out, it is not always possible, particularly if the patient is under the influence of sedating medications or is otherwise unable to participate.

A visual memory aid can be used to trigger the initiation of the the Time Out. For example, a "Time Out" sign or towel can be used to cover the scalpel, needle or cutting/ incising device as a reminder to conduct the Time Out. When one of these aids is used, it is important to remove it from the sterile field at the conclusion of the Time Out so there is no potential for it to become retained in the patient or otherwise contaminate the field.

Every **Time Out** should include the following standard elements:

- Patient identity, using a minimum of two identifiers
- Procedure(s) to be performed (including internal and/or external laterality, multiples and/or level)
- Patient positioning if not already verified
- Procedure side, site and/or level including visualization of the provider's initials if applicable
- As appropriate, imaging, equipment, implants or special requirements (e.g., pre-procedure antibiotic administration)

The provider may delegate the Time Out elements to the nurse or other member of the team, but the initiation of the Time Out should be the responsibility of the provider. The

nurse or other team member may refer to the patient consent for the Time Out elements. However, prior to its use, the consent must have been validated against other documents, such as history and physical, radiology or pathology reports, progress notes, etc.

During the **Time Out**, each person in the procedure room must stop what he or she is doing and actively participate in the process. Involved staff may include the provider, resident, student, anesthesia, scrub, nurse and/or vendors whenever present. No individual is exempt from the process. Active participation requires each individual to state clearly and loudly that they agree with the elements of the Time Out. The scalpel, needle or other cutting/incising device is not to be handed to the provider until the Time Out has been completed. If a member of the team refuses to actively participate in the Time Out, the scalpel, needle or cutting/incising device is not handed to the provider until that individual is replaced and the Time Out completed.

Environmental distractions are to be eliminated as much as possible during the Time Out. For example, music is turned off, pagers are set on vibrate, talking other than participation in Time Out ceases and no staff are permitted to enter or exit the room. If during the Time Out an interruption or distraction occurs (pager goes off or an individual enters the room), the Time Out must be restarted.

Additional Time Outs are to be performed when there are two or more different procedures performed on the same patient during the same procedure period, whether or not the procedures involve a new procedure team. The process and elements of the Time Out as described above must occur prior to the start of the next procedure.

If the patient needs to be repositioned during the procedure and this repositioning affects the patient's presentation (i.e., the patient is turned prone), an abbreviated Time Out including the site, side, level and/or visualization of the provider's initials will be conducted. The Time Out process will be the same as described above (e.g., elimination of distractions, active participation).

Universal Precautions

Excerpt from the Fact Sheet Center for Disease Control : Provided for informational and educational use only

Downloaded from
http://www.cdc.gov/ncidod/dhqp/bp_universal_precautions.html#

"Universal precautions," as defined by CDC, are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other bloodborne pathogens.

Universal precautions took the place of and eliminated the need for the isolation category "Blood and Body Fluid Precautions" in the 1983 CDC Guidelines for Isolation Precautions in Hospitals. However, implementing universal precautions does not eliminate the need for other isolation precautions, such as droplet precautions for influenza, airborne isolation for pulmonary tuberculosis, or contact isolation for methicillin-resistant *Staphylococcus aureus*.

Universal precautions apply to blood, other body fluids containing visible blood, semen, and vaginal secretions. Universal precautions also apply to tissues and to the following fluids: cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids. Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. Universal precautions do not apply to saliva except when visibly contaminated with blood or in the dental setting where blood contamination of saliva is predictable.

Universal precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the health care worker's skin or mucous membranes to potentially infective materials. In addition, under universal precautions, it is recommended that all health care workers take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices.

Pregnant health care workers are not known to be at greater risk of contracting HIV infection than are health care workers who are not pregnant; however, if a health care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especially familiar with, and strictly adhere to, precautions to minimize the risk of HIV transmission.

GLOVING, GOWNING, MASKING, AND OTHER PROTECTIVE BARRIERS

All health care workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure during contact with any patient's blood or body fluids that require universal precautions.

Recommendations for the use of gloves are presented in detail in the Morbidity and Mortality Weekly Report dated June 24, 1988, which is available by calling the National AIDS Information Hotline at 1-800-342-2437 or the National AIDS Information Clearinghouse at 1-800-458-5231.

Gloves should be worn:

- for touching blood and body fluids requiring universal precautions, mucous membranes, or nonintact skin of all patients, and
- for handling items or surfaces soiled with blood or body fluids to which universal precautions apply.

Gloves should be changed after contact with each patient. Hands and other skin surfaces should be washed immediately or as soon as patient safety permits if contaminated with blood or body fluids requiring **universal precautions**. Hands should be washed immediately after gloves are removed. Gloves should reduce the incidence of blood contamination of hands during phlebotomy, but they cannot prevent penetrating injuries caused by needles or other sharp instruments. Institutions that judge routine gloving for all phlebotomies is not necessary should periodically reevaluate their policy. Gloves should always be available to health care workers who wish to use them for phlebotomy. In addition, the following general guidelines apply:

1. Use gloves for performing phlebotomy when the health care worker has cuts, scratches, or other breaks in his/her skin.
2. Use gloves in situations where the health care worker judges that hand contamination with blood may occur, e.g., when performing phlebotomy on an uncooperative patient.
3. Use gloves for performing finger and/or heel sticks on infants and children.
4. Use gloves when persons are receiving training in phlebotomy.

Masks and protective eyewear or face shields should be worn by health care workers to prevent exposure of mucous membranes of the mouth, nose, and eyes during procedures that are likely to generate droplets of blood or body fluids requiring universal precautions. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or body fluids requiring universal precautions.

All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped by hand, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal. The puncture-resistant containers should be located as close as practical to the use area. All reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

General infection control practices should further minimize the already minute risk for salivary transmission of HIV. These infection control practices include the use of gloves for digital examination of mucous membranes and endotracheal suctioning, handwashing after exposure to saliva, and minimizing the need for emergency mouth-to-mouth resuscitation by making mouthpieces and other ventilation devices available for use in areas where the need for resuscitation is predictable.

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