Team Diagnostic Timeout Template

Diagnostic timeouts are pauses in patient care to reevaluate the patient's diagnosis and medical response to treatment. This template has been designed to guide organizations in determining appropriate triggers, resources and team members needed to conduct a successful timeout. This is not intended to be all-inclusive but may be useful in your efforts to improve safety within your organization. Download a poster version of the template.

Prompts for a Timeout	**Clinical Triggers** ▪ Transfers, especially to a higher level of care (e.g., from outside facility, between clinical units) ▪ Change in level of care (e.g., patient deteriorating) ▪ Lack of improvement and/or unanticipated deviation from plan of care ▪ Abnormal findings that don't make sense or could support competing diagnoses. ▪ Concern is identified (e.g., gut feeling, parent/patient/staff concern) ▪ Any diagnosis not primarily cared for on that unit or rarely seen on the unit ▪ Diagnostic uncertainty, especially around a high-risk diagnosis	
Timeout	**Question** ▪ Are there questions about the patient that need answered at this time? ▪ Have biases or other factors influenced the team's judgement/actions? ▪ What doesn't fit in our explanation of this problem? **Triage Cueing** ▪ Is the organ system or process we're focused on the only one that could cause these symptoms? ▪ Are there red flags or new symptoms to consider? o Is this an atypical presentation of a common disease? ▪ Has worst-case scenario been ruled out? o Diagnoses that are often missed o Rare diagnosis	**Evaluate** ▪ Update and reprioritize the problem list. ▪ Review all diagnostic tests (e.g., lab, radiology) for additional information. ▪ Determine if further diagnostic testing is needed and how the new information will help reprioritize the differential diagnosis. ▪ Decide if other people need to be involved in this case. ▪ Evaluate if other information needs to be collected. ▪ Assess the consequences of getting the diagnosis/treatment plan wrong. **Competing Demands** ▪ What is the sending/receiving unit's current acuity level, capacity and unknown/known threats?
Team Members	**Clinical staff will change depending on setting and patient symptoms/needs** ▪ Patient/family ▪ Nursing ▪ Attending physician ▪ Primary care physician ▪ Specialty physicians/consults/specialty non-bedside consultants (e.g., diagnostic imaging and pathology). ▪ Residents and fellows ▪ Allied health care teams (e.g., respiratory)	

Sources:

▪ Clinical Excellence Commission, "Take 2 Think, Do." (2016, January). Retrieved from http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0009/305847/Take-2-Think.-Do-Resource-for-Implementation.pdf
▪ "Diagnosis and Error Checklist." (2013, April). Retrieved October 30, 2019, from https://www.improvediagnosis.org/wp-content/uploads/2018/10/krohe_checklist.pdf.
▪ Graber, M. L., Sorensen, A. V., Biswas, J., Modi, V., Wackett, A., Johnson, S., Lenfestey, N., Meyer, A. N., & Singh, H. (2014). Developing checklists to prevent diagnostic error in Emergency Room settings. *Diagnosis (Berlin, Germany)*, *1*(3), 223–231. https://doi.org/10.1515/dx-2014-0019

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