Frequently Asked Questions

Q: What surgical interventions should the surgical safety checklist be used for and why?

A surgical procedure can be defined as the excision of a patient's tissue, penetration of the patient's skin or the closure of a previously sustained wound/ intervention in a 'sterile' environment e.g. operating theatre or procedure room. The use of the Checklist applies to all surgical interventions undertaken in this type of environment where the core standards for the delivery of safe effective surgical care apply. These standards have been identified by the World Health Organisation (WHO) and adapted for England and Wales by an Expert Reference Group led by the National Patient Safety Agency (NPSA).

Q: What are the core standards for Safer Surgery?

The WHO set of core standards are:

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from anaesthetic administration, while protecting the patient from pain.
3. The team will recognise and effectively prepare for life-threatening loss of airway or respiratory function.
4. The team will recognise and effectively prepare for risk of high blood loss.
5. The team will avoid inducing any allergic or adverse drug reaction known to be a significant risk for the patient.
6. The team will consistently use methods known to minimise risk of surgical site infection.
7. The team will prevent inadvertent retention of instruments or swabs in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical patient information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume, and results.

Q: Is it a legal requirement that we implement the Checklist?

The NPSA is not a regulatory organisation. Compliance is assured through the Care Quality Commission, as Trusts have to report to the CQC via their Annual Health check that they comply with NPSA requirements e.g. Alerts.

Q: Should the checklist be used for all our surgical interventions?

Organisations are encouraged to pragmatically assess the relevance of the use of the Checklist to their own areas of practice. If it is established, through

using local clinical governance procedures, that the Checklist is not relevant for a specific surgical intervention then this should be clearly documented with a formal documented Risk Assessment.

Q: What is the definition of a local anaesthetic? – does this mean if a patient requires an injection to numb a small area of skin to remove a mole for example that the checklist should be used?

The Alert recommends that the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia). This includes spinal anaesthesia and local anaesthetic blocks for more complex procedures when the patient does not have a General Anaesthetic and remains awake. All of the core elements of the Checklist are relevant in these circumstances but there are some minor local anaesthetic procedures where the use of the Checklist is not as appropriate.

Local anaesthesia in this context is a type of pain prevention used during minor procedures to numb a small site where pain is likely to occur without changing the patient's awareness. A numbing medication is either applied to or injected into the area, sometimes with several small injections, and after a few minutes the area should be completely numb. This may still be undertaken in a 'Procedure Room' type of environment but may only involve one healthcare professional and the Checklist may not be suitable on these occasions.

Q: Should the checklist be used for emergency cases?

The Checklist is a valuable tool to provide essential checks in highly complex emergency situations. At times of acute pressure and in fast moving situations the essential elements of the Sign In, Time Out and Sign Out can provide vital prompts to support clinical teams and verification of critical safety steps that assure the safety of the patient.

Q: How do we use the Checklist in rapid turn over lists?

Those organisations who have used the Checklist find it most useful in high volume lists. Briefing at the beginning of the list will help with the smooth running of the operating list and should ensure there are as few problems as possible. The three sections of the checklist become even more important when there is a risk of error in rapid throughput lists. The short time that it takes to undertake the checklist will be recouped by reducing mistakes and hold ups.

Q: Can I adapt the Surgical Safety Checklist for local use?

The Checklist is a tool to drive improvements in communication and team work in the perioperative environment. Local adaptation of this Checklist is encouraged to ensure that it is effectively integrated into clinical practice. This may mean that some of the interventions are moved to a different step in the Checklist, for example from Time Out to Sign In. Some interventions may

also be moved to the Preoperative team brief. Any adaptations should be undertaken in accordance with your organisation's governance scrutiny process'

Q: Will there be a speciality specific version of the checklist?

A speciality specific version of the surgical checklist has been developed for Ophthalmology, Radiology and Maternity in collaboration with the relevant Colleges. These address the key risks for those specialities and are based on the same principles for local adaptation as the generic checklist.

Q: To be compliant with the Alert do we have to have it in Radiology?

The Checklist should be used for all invasive procedures undertaken in Radiology i.e. a procedure which is dependant on penetration of the skin. The NPSA has been working with the Royal College of Radiologists to produce a version of the Checklist which is relevant and specific to this specialty. It addresses the specific clinical risks in the radiological environment.

Q: What is the status of the Correct Site Surgery Checklist (Alert) issued in 2004 by the NPSA?

The Correct Site Surgery Checklist (Alert) has been superseded by the Surgical Safety Checklist.

Q: Do we have to sign the Checklist?

That depends on your local clinical governance arrangements and how you choose to record and confirm that the checklist has been used. The minimum requirement of the Alert is that the use of the Checklist is entered in the clinical notes or electronic record by a registered member of the team, for example, Surgeon, Anaesthetist, Nurse, ODP. Ideally a completed copy of the Checklist should be retained in the patient's record for future reference.

Q: Should we implement slowly in one theatre/ one team or use the 'big bang' approach of all theatres/ all teams?

The methodology recommended by both the Patient Safety First and 1000 Lives Campaign (Wales) over the last two years has supported organisations to adopt an approach to implementation that begins by adapting, testing and measuring their improvement on a small scale before systematically and carefully spreading to other areas. This more considered approach to roll out means that changes become locally owned and success is more likely to be achieved.

Q: Should we do pre and post op briefings?

Feedback from clinical staff tells us that the introduction of the five steps to safer surgery (including pre operative briefing, Sign In, Time Out, Sign Out

and post operative briefing) is key to bring about sustained culture changes and improved team communication that the checklist is designed to achieve.

Q: If we do a briefing does it have to be before we send for the first patient

Briefing is usually at the start of the list, rather than at the start of every patient. This is to introduce each other and inform the whole team about what is going to happen during the list. It would often include a discussion about each patient and the potential problems or challenges.

Q: Who does the briefing?

All team members should be present at the pre list briefing in order for them to have the opportunity to discuss the requirements for the list and any anticipated safety concerns.

Q: When should we do the briefing?

The pre list briefing should be undertaken before the operating theatre list begins. Organisations should determine locally whether this should be prior to sending for the first patient on the operating theatre list or before the patient arrives in the department. This could be dependant on the proximity of the wards concerned or the speed of the portering service.

Q: Who does the Time Out?

All team members are involved in the Time Out but anyone in the team can lead it. It doesn't have to be a doctor. Culturally there is much to be gained from other members of the multi disciplinary team leading it e.g. the circulating practitioner.

Q: Does the surgeon have to be present at the 'Time Out'

It is recommended practice that the surgeon is present at the ‘Time Out’. It is for individual trusts to decide how the core elements of the Checklist are implemented. It is essential that the minimum requirements for each section of the Checklist are met by the team that is present e.g. confirmation of identity, site, procedure and consent.

Q: Who does the Sign Out?

Everyone involved with the surgical case should be part of the Sign Out.

Q: Who does the de-briefing?

Again, all team members should be present for the de briefing as it provides the team with the opportunity to evaluate the list and address issues that have arisen, for example equipment problems. It also enables the team to discuss the five step process in order to refine it locally to make implementation easier

and more reliably undertaken.

Q: When should we do the de-briefing?

The post list debriefing should be undertaken at the end of the operating list. Some teams find this difficult as this is a busy time in operating theatres so again, organisations should determine locally the best time to do this. For example, it could be done during wound closure of the last patient on the list.

Q: What have others done to encourage people to stay behind to do the de-briefing?

Promotion of the benefits of undertaking a de brief can encourage the team to adopt these principles. For example, when faulty equipment is identified as part of the de brief and arrangements made for repair, this will make it much easier the next time this equipment is required. The de brief is also an ideal opportunity to highlight aspects of the list that have gone well and how the team have contributed to this.

Q: Should the checklist be used for surgical procedures carried out in the community?

It is recommended that the checklist be used for all surgical interventions under general or local anaesthesia. It has been recognised however that it may be less relevant for some procedures carried out in the community e.g. dentistry, podiatry and ECT. In this instance, it is recommended that the organisation concerned assesses the relevance of the core set of safety checks within their areas of practice and if necessary, record this in their operational policies and procedures.

Q: Will patients be able to request for the checklist to be used for their procedure?

Yes - Due to the publicity surrounding the use of the Checklist for surgical procedures and that patients are ever increasingly more informed about what is available to them, it is likely that they will request for the Checklist to be used for their surgical procedure.

Q: Can paper versions of the UK adapted version of the Surgical Safety Checklist be ordered?

No but all documentation is freely available to download from the NPSA website http://www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert/ or via stationary order from the Welsh Health Supplies

Q: We are already very busy in theatres. Isn't this just one more task using up valuable time?

Once the Checklist has become familiar to the theatre teams, it requires minimal extra time to perform. Most of the steps are incorporated into existing

workflow and the remainder will add only one or two minutes to the theatre time. However, the Checklist can also save time by ensuring better communication between team members and minimising slowdowns for tasks like retrieval of additional equipment.

Q: How do we handle a recalcitrant staff member?

There will be a reluctance to use the checklist from some members of staff. It is often surprising who readily adopts a new process and who resists it. Those not embracing the change will be doing so for a reason. This is useful information to help with the development of your solution. If possible ask them to become involved with the work of implementation, ask them why they feel unable to do it and try to resolve their difficulty or offer them the opportunity to do it differently. If an individual is completely unhelpful then it is probably better to focus attention elsewhere and build a broad consensus. Once the majority are making it work many of these colleagues will come on board.

Q: What does the 1st February 2010 deadline for implementation mean?

Each organisation should be able to demonstrate the following:

- That they have undertaken a review of their organisation, and identified where surgical interventions are carried out
- That this was followed by an assessment of the risks and known incidents within those areas to understand the baseline data
- The process for adaptation in the organisation
- An implementation plan to demonstrate where the checklist will be used and the plans for how it will be implemented including a spread plan and timetable for how it will be spread across the organisation
- A measurement plan for how progress, compliance and outcomes will be measured
- A risk assessment document which describes the decisions made along the way including why, if relevant, the checklist is not used in certain areas based on that risk assessment

Whilst the 1st February is the deadline for implementation of the Alert, the NPSA will continue to support organisations in the broader objective of introducing team briefings for all theatre lists as well as continued implementation of the Checklist using methodology recommended by both Campaigns. Based on feedback from the frontline, both pre operative briefings and post operative debriefings have been shown to be key to improve teamwork and communication. This support has been identified as a

key programme in the NPSA's patient safety improvement strategy for the coming year.

Q: Can the checklist become part of the Surgical Care Plan/ Pathway documentation

Many NHS organisations have found this to be a way of reducing duplication of questions and ensuring a record of the checklist is filed in the notes. Local testing will mitigate the risk of duplication and ensure that the checklist complements local practice.

Q: What do we measure to ensure we are using the checklist?

A record of having used the checklist should be entered in the clinical notes or electronic record. Some NHS organisations are linking the recording of theatre timings, on the local theatre IT system, to confirming whether the appropriate part of the checklist has occurred. There are a number of different methods local organisations have used such as stickers in the notes, a record in the operation note or a copy of the checklist retained in the patient's notes will be able to be audited.

Q: What do we measure to demonstrate a benefit?

Measurement of compliance e.g. use of the checklist for each patient and measurement of outcome including improved quality of care, outcomes, improved processes and efficiency can all be used. There are teamwork and safety attitudes questionnaires that will show improvement in the culture of operating theatres. A study of the Checklist in nearly 8,000 patients, published in the New England Journal of Medicine, showed a reduction in deaths and complications. Audits of the reliability of delivery of the Surgical Site Infection bundle and VTE prophylaxis will demonstrate improvements in the reliability of these processes associated with the Checklist. Cancellations, over-runs and turn round times may also show efficiency gains resulting from quality improvements.

Further information about measurement can be found in the How to Guide for the Five Steps to Safer Surgery
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/NRLS-1291-How_to_guide_fi~urgery-2010.12.20-v1%5B1%5D.pdf