World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Safe Surgery Saves Lives Newsletter

April 2010

Did You Know?

- **3,791 hospitals** representing **120 countries** have registered as Safe Surgery Saves Lives Participating Hospitals. See which hospitals have joined this program by clicking here. Is your hospital on the map? If not, click here.

- **25** countries have mobilized resources to implement the WHO Surgical Safety Checklist at a national level. To see a full list of these countries click here.

From Our Readers

In our last newsletter we asked our readers to share the ways that they measure the effect of the Checklist at their hospitals. We had an outstanding response and wanted to share some of their tips with you. Below are some of the responses we have received:

- *"We at Baptist Memorial Health Care Corporation in Memphis have struggled to come up with measurement that was not going to be labor intensive for our staff. We decided to use two of the AHRQ Patient Safety Indicators that we were already collecting data on. PSI 4, Death among surgical inpatients with serious treatable complications and PSI 12, Post-op PE or DVT. These two are then drilled down on to see if utilizing the WHO Checklist may have prevented the complication through early recognition."*
  - Suzanne Porteous-Harvey, RN, CCM

- *"My hospital has seen a dramatic impact on Surgical Site Infection Rates since we started to use the Checklist. It is without doubt that the checklist has helped improve the appropriate timing of Antibiotic Administration. Our staff is also measuring the effect of the Checklist by looking at our compliance rates, both with the overall use of the Checklist and compliance with every item on our list.*

  Additionally, our staff is really proud of the work that we have done to measure patient acceptance of our Checklist. We are looking at whether patients like the Checklist, feel annoyed, or if the use of the Checklist makes them feel safer when they are undergoing surgery. At the end of the day this is what really counts."
  - Dr. Dina Baroudi M.S. Basharahil Hospital KSA

If you have found an interesting way to measure the effect of the Checklist in your hospital we would love to hear from you.

The Checklist in Action

Every day we hear from health professionals who are trying to spread the use of the Checklist both within their hospitals and more broadly. We would like to share some of their stories with you:

- It has been more than one year since the National Health Service in the United Kingdom required the use of the Checklist in their operating theatres. Guys and St. Thomas' NHS Foundation Trust is one of more than **300** UK trusts that are now using the Checklist. Click here to read about how they implemented the Checklist over the last year.

- The Colombian Anesthesiology and Resuscitation Society (SCARE) in conjunction with the Colombian Ministry of Social Protection have developed a comprehensive program to improve surgical safety through the use of the Checklist. They have been able to educate more than 150 Colombian hospitals about the use of the Checklist by holding workshops, distributing educational materials, and conducting site visits.

- Smile Train, an organization dedicated to providing free cleft surgery for millions of poor children in developing countries as well as free cleft-related training for doctors and medical professionals, has integrated the WHO Surgical Safety Checklist into their Safety and Quality Improvement Protocol. Smile Train's commitment to the Checklist has put this tool into use in thousands of operating theatres throughout the developing world. If you are a hospital or surgeon that could benefit from Smile Train support or to learn more about the organization, click here.

- As of **April 1, 2010** all hospitals in the Canadian Providence of Ontario are required to use the Checklist in their operating theatres. One hospital in Ontario shared with us their story of implementing the Checklist:

  "We are rolling out the Surgical Safety Checklist slowly from service to service. We spent one month in Orthopaedics, one month in Gynecology, two weeks in ENT, and are now in General Surgery for a month. We have certainly had our challenges, despite having a Champion Working Group and customizing to our organization. Some members of our anaesthesia department do not feel that they should have to be present for the Briefing. We have made it mandatory for a minimum of anaesthesia and nursing to be present for the briefing, when the patient comes into the O.R. before an anaesthetic has been administered. Safe Surgery does save lives and we have been able to measure near miss events using the documentation tools that we have available to us."

Frequently Asked Questions

Q: We are interested in improving our hospital's performance in some perioperative measures not included on the checklist. How can we do this?

A: The checklist, while intended to be universally applicable, is not always a perfect fit for all institutions. Modifications can be made to include items that are deemed essential. However, we would caution against making the checklist too comprehensive. The more items added to it, the more difficult it will be to successfully implement.

Q: How do I create buy-in among my peers?

A: We recommend that when you are starting to implement the Checklist you start with your colleagues that are most enthusiastic about the project. Initially, you should work with the people that share your same values and commitment to surgical safety. Once you have identified a group of colleagues to work with, make sure that you have somebody in this core group from every discipline including, anaesthesia, nursing, and surgery.

It is also vital to have buy-in from clinical and/or hospital leadership from the beginning. These leaders can be instrumental to your success in introducing the Checklist. One convincing way to get both your colleagues and clinical leaders to back this program is through the collection of local evidence. By collecting baseline data at your hospital, you can provide the necessary information to counter skeptics' claims that the Checklist isn't necessary or wouldn't improve patient safety. Hospitals have been measuring the effect of the Checklist in a variety of ways, a number of which we highlighted earlier in this publication. Some of the other indicators you could potentially measure include:

Outcomes and Complications:

- ❑ Surgical Site Infection Rate (SSI)
- ❑ Unplanned Return to the operating theatre
- ❑ Surgical Deaths

Efficiency

- ❑ Case Length
- ❑ Length of operating day
- ❑ Number of times circulating nurse left the operating theatre for supplies

Processes:

- ❑ Number of times blood wasn't available
- ❑ Number of times antibiotic prophylaxis wasn't giving within 60 minutes
- ❑ Number of times when the case length was discussed
- ❑ Number of times that key concerns were discussed with the surgical team prior to the patient leaving the operating theatre

Adapting the Checklist to your Environment

We encourage hospitals to modify the Checklist to suit their environment. Throughout the last year we have received feedback from our Participating Hospitals that they would like to modify the Checklist for specific surgical procedures or for procedure areas outside of the operating theatre suite.

This quarter we would like highlight the procedure-specific checklists that we have received from our readers. You can view checklists that have been modified for Cardiothoracic Surgery, Endoscopy, Hysteroscopy, Labor and Delivery, Ophthalmology Surgery, and for Paediatric cases by clicking here.

To Our Readers

Numerous colleagues who have successfully introduced the Checklist in their operating theatres have written to us asking how they can sustain proper use of this tool once it becomes a routine component of care. We would like to reach out to you, our colleagues using the Checklist on the ground, to better understand how you have tackled this issue:

How have you ensured the Checklist continues to be used properly and that clinicians remain enthusiastic about using this tool in their operating theatres?

We would love to share your tips with other Checklist users. Please send your responses to safesurgery@hsph.harvard.edu. If you have any questions or comments about the WHO Surgical Safety Checklist or this newsletter, please write to us. We would love to hear about your experiences with the Checklist and include some of them in the next newsletter. We look forward to hearing from you!

www.who.int/safesurgery or www.safesurg.org