POLICY FOR APPLICATION OF THE WHO SURGICAL SAFETY CHECKLIST

Department / Service:	Theatres, Ambulatory Care, Critical Care & Outpatients Surgery
Originators:	Mathew Trotman - Countywide Theatre Matron Susan Smith – Senior Countywide Theatre Matron
Accountable Director:	Dr Julian Berlet / Mr Paul Rajjayabun
Approved by:	SCSD Divisional Governance
Date of approval:	7TH May 2019
First Revision Due:	7th May 2021
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Operating theatres
Target staff categories	Consultants / Theatre professionals / Medical staff

Policy Overview:

The Worcestershire Acute NHS Trust (WAHT) adopted the WHO (World Health Organisation) Surgical Safety (SS) Checklist to improve patient safety in the perioperative environment. This document sets out the Trust's Policy and Procedures for compliance with these checks.

The WHO Surgical Safety Checklist is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying essential perioperative care interventions. Effective teamwork and optimum communications are crucial to assuring safe and effective care and are an acknowledged bi-product of completing the WHO checklists. Team briefs and de-briefs will be included as part of this process.

WAHT has produced 5 Local Safety Standards for surgical invasive procedures (LocSSIPs) that will ultimately govern the process for performing the 5 stages of the Surgical Safety Checklist. These LocSSIPs will be used in conjunction with this policy:

- Team Brief
- Sign In
- Time Out
- Sign Out
- Team debrief

Key amendments to this Document:

Date	Amendment	By:
Jan 2013	Minor amendment to role of surgeon on page 5	Nick Hickey
June 2014	Document reviewed and strengthened throughout	
November 2016	Documents extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for three months as per TLG	TLG

	recommendation	
June 2018	Document extended for three months as per TLG recommendation	TLG
7th May 2019	Amendments were made to the document so that the main body of the policy comes into line with our LocSSips. We ensured each section matched what was outlined in each of the LocSSips for the Team Brief Sign In, Time Out, Sign Out and Team debrief, this was also combined with reverting as close as possible to the original WHO surgical safety checklist. We also reverted to paper copies of the checklist to aid engagement and assist in standardising the process countywide."	A Fryer M Trotman SCSD Divisional Governance

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Policy for application of the WHO Surgical Safety Checklist

1. Introduction

Patient safety is an essential element of effective, high quality patient care in the perioperative environment and all healthcare staff have a duty of care to prevent harm to the patient.

The Worcestershire Acute NHS Trust (WAHT) has adopted the WHO Surgical Safety Checklist (WHOSSC) to improve patient safety in the perioperative environment. This document in conjunction with the LocSSIPs sets out the Trust's Policy and Procedures to aid in compliance with the WHOSSC.
The WHOSSC is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying essential perioperative care interventions.

Effective teamwork and optimum communication are crucial to ensuring safe and effective patient care, pre-operative team briefs and post-operative debriefs will be included as part of this process. The WHOSSC mitigates the risks and harm associated with surgical procedures where patient safety is a key element of maintaining professional registration for registered practitioners (HCPC 2008, NMC 2008), it is an essential element of clinical governance frameworks and risk management processes.

The principles of the WHOSSC include:

- Team Brief – to discuss plans for surgical and clinical intervention which will include individualised patient care and anticipated safety concerns.
- Sign In – safety check procedure must be completed prior to the induction of anaesthesia.
- Time Out – safety check procedure must be completed prior to any surgical intervention.
- Sign Out – safety check procedure must be completed prior to any essential member of the team leaving theatre.
- Team debrief – to discuss how the session went including any possible improvements that could be introduced for future sessions

2. Purpose of this Policy/Procedure

The purpose of this policy in conjunction with the LocSSIPs is to maintain patient safety and outline the WHOSSC procedure that all staff must adhere to.

3. Scope

These guidelines apply to all staff who work in WAHT that are involved in a clinical intervention where use of the WHOSSC occurs.

4. Definitions/Glossary

- WHO - World Health Organisation.
- Surgeon – clinician performing the surgical or interventional procedure.

- Peri-operative environment – Theatre suite or intervention room where the procedure is performed.
- WHOSSC World Health Organisation Checklist
- WAHT Worcestershire Acute Hospital Trust
- HCPC Health Care Professions Council
- NMC Nursing Midwifery Council
- LocSSIPs Local Safety Standards for Invasive Procedures

5. Roles and Responsibilities

5.1. Role of the senior operating surgeon/clinician

The senior operating surgeon or clinician maintains overall accountability to ensure that the WHOSSC is fully completed.

5.2. Role of the Divisional Managers & Divisional Directors of Nursing

Divisional Managers & Divisional Directors of Nursing maintain overall responsibility for compliance with this policy within their areas. This includes ensuring that Senior Managers have agreed and instigated a structure that ensures all staff have been informed, educated and trained appropriately in the utilisation of the WHOSSC, in any environment where interventional procedures are taking place. This role should also ensure procedures are in place to maintain staff competence in the utilisation of the WHO Surgical Safety Checklist.

To receive and monitor monthly results of the WHO audits and provide compliance information to Trust committees.

5.3. Role of the Theatre/Departmental Managers

Theatre or Departmental Managers assume responsibility for the implementation of this policy on a daily basis

To ensure the health, safety and risk management standards are met and maintained, and any risks minimised during the use and safe application of the WHOSSC.

Ensuring regular audits of the WHO Surgical Safety Checklist are completed to monitor compliance and competence of staff and clinicians.

To ensure both the hard copy and bluespier theatre record of the WHO Surgical Safety Checklist are completed for every patient

5.4. Role of Individual Staff

The Trust expects all staff, including temporary members, to adhere to the principles of the WHOSSC in environments where interventional procedures are taking place. This will include the completion of both paper and electronic versions of the WHOSSC.

6. Standards and Practice

6.1 Legal and Professional Obligations

The operating surgeon maintains overall accountability to ensure that the WHOSSC is fully completed.

Registered Practitioners: Nurses, Midwives, Allied Health Professionals and Operating Department Practitioners (ODPs), have a professional obligation to provide a 'duty of care' to their patients *(NMC, 2008, HPC, 2008)*.

Registered Practitioners will maintain overall responsibility for completion of the WHO Surgical Safety Checklist but may choose to delegate any part of the tasks related to its application to non-registered staff, other than the required registered practitioner's signature. The registered practitioner retains professional accountability for the appropriateness of the delegation of any task.

6.2 Team Brief - Prior to the commencement of the operating list – participation by all available team members allocated to the operating list is required:

Team briefing should occur before the first patient arrives in the procedural area.

The team brief should be attended by as many members of the procedural team as possible. This includes the operator, anaesthetist, scrub practitioner, anaesthetic assistant, circulating practitioner and any other healthcare professionals.

Team introductions by name and role are essential.

Anticipated changes or uncertainties about the list are communicated.

Each patient is considered in turn from the perspective of the operator, anaesthetist and theatre practitioners.

Key items to be discussed from the perspective of the operating Surgeon, anaesthetist and lead theatre practitioner.

In an emergency situation team briefing may be modified.

The information gathered from the team brief will be recorded on bluespier under the team discussion section.

Any changes to the published theatre list must be agreed and a new list created.

Further aspects can be found within the full LocSSIP WAHT-KD-025 "Team Brief"

6.3 Sign In – Prior to Induction of anaesthesia, commencement of sedation or local anaesthetic injection

All patients having invasive procedures must undergo a sign in prior to induction of anaesthesia, commencement of sedation or local anaesthetic injection.

Sign in must be performed by the anaesthetist and anaesthetic assistant. For procedures without anaesthesia, the operator and assistant should perform the sign in.

A registered practitioner or delegated person will confirm all team members are present and initiate the checklist by reading out aloud all points contained in the sign in section of the WHOSSC. Discretion may be used for questions relating to blood loss or airway concerns

In cases when anaesthesia is not given and patients are admitted directly to the procedural area then sign in and time out can be combined. The same principles still apply. The whole team must pause to observe and participate in a combined sign in/time out.

It is acknowledged that an Obstetric theatre sign in requires additional critical information, for further details please refer to LocSSIP WAHT-KD-025 “sign in”

Using the paper WHOSSC, the team will verbally confirm and document all points detailed on the sign in section. Discretion may be used for questions relating to airway/aspiration risk and blood loss.

The registered practitioner or delegated person will then record the checklist is complete in the appropriate place on the WHO sign in on Bluespier.

It is acknowledged that in certain emergency circumstances it may not be possible to complete the WHO Surgical Safety Checklist at that time; however it is to be completed at the earliest opportunity. In this situation it is essential to still confirm identity, appropriate consent and correct side of surgery as a minimum requirement.

If there is a failure of I.T. systems within an area then contingency measures must be evoked and the electronic WHO completed retrospectively

Further aspects can be found within the full LocSSIP WAHT-KD-025 “Sign in”

6.4 Time Out – Before start of the procedure

To be completed by the key members of the theatre team relevant to the clinical intervention

All team members are responsible for the time out. There must be a silent focus during time out.

The person leading time out should be designated during the morning team brief. A registered practitioner or delegated person will confirm essential team members are present and initiate the checklist by reading out loud all points contained in the timeout section of the WHOSSC. Discretion may be used for questions relating to blood loss if the patient is conscious undergoing a local or regional anaesthetic.

The anaesthetist is responsible for indicating when it is safe to proceed with the time out. If it is not safe then the time out should be deferred.

If, at any point during completion of the checklist, a member of the team is required to leave the theatre the checklist must be suspended and recommenced when all are present.

If, at any point during completion of the checklist, the team is interrupted, the checklist must be suspended and recommenced when all team members can pay full attention to the process.

If at any point during the procedure, there is a change to the current team then they will be introduced by name and designation and be briefed with any necessary information

Any concerns or queries raised by any team member must be resolved before the procedure commences and documented on bluespier

The registered practitioner or delegated person will complete both the paper and the electronic checklist.

The person conducting time out reads aloud from the paper document which is stored in the patient notes.

Time out occurs once the patient is transferred onto the operating table, but before surgical intervention i.e. knife to skin, preferably before prepping and draping.

The procedure must not commence until time out is completed.

It is acknowledged that in certain emergency circumstances it may not be possible to complete the WHOSSC at that time; however it is to be completed at the earliest opportunity. In this situation it is essential to still confirm identity, appropriate consent and correct side of surgery as a minimum requirement.

If there is a failure of I.T. systems within an area then contingency measures must be evoked and the electronic WHOSSC completed retrospectively.

Further aspects can be found within the full LocSSIP WAHT-KD-025 "Time out"

6.5 Sign out - Prior to any essential staff member leaving the operating theatre

All essential team members should be present during sign out.

Sign out is completed before the patient leaves the procedural area.

A registered practitioner or delegated person will confirm essential team members are present and initiate the checklist by reading out loud all points contained in the sign out section of the WHOSSC.

To be completed by the essential members of the theatre team relevant to the clinical intervention.

Any concerns/problems/issues raised during the sign out procedure must be documented both on paper and the electronic checklist.

Any concerns or issues that have arisen during the procedure must be reported as an incident on Datix, if applicable.

If there is a failure of I.T. systems within an area then contingency measures must be evoked and the electronic WHOSSC completed retrospectively.

Further aspects can be found within the full LocSSIP WAHT-KD-025 "Sign out"

6.6 List Debriefing – At a suitable interval to review the operating session

The key team members where applicable must debrief at a suitable interval to review the procedures undertaken during the operating session.

The debrief ensures the team reflect on the progression of the session

Debriefs do not have to be lengthy. Key areas to be considered should relate to equipment, personnel and environmental factors

The information gathered from the team de-brief will be recorded on bluespier under the team discussion section.

Further aspects can be found within the full LocSSIP WAHT-KD-025 "Team debrief"

7. Dissemination and Implementation

7.1 New Staff.

The WHOSSC policy and the LocSSIPs will be provided as induction 'pre-reading' material for all new members of staff who are involved in the surgical care pathway.

7.2 Existing Staff

The WHOSSC policy will be stored on the electronic Document Library.

7.3 Training

An introduction to the WHOSSC must be included in the local induction/orientation programme for all new staff. Documentary evidence of this must be available.

8. Monitoring compliance and effectiveness

Monitoring of the WHOSSC will be performed daily through Bluespier reports and weekly and monthly reports through reports provided by the Information Department.

Results of the audits provided by the Information Department will be reviewed and any shortfall acted upon by the Divisional Management Team. The results are included in a monthly report provided by the Information Department to the Trust Board.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	All elements of the WHOSSC have been fully completed and electronically submitted	Daily, weekly and monthly reports checked by theatre leads and all non-compliance challenged. Other techniques to consider are audits, spot-checks, analysis of incident trends, monitoring of attendance at training.	Daily at departmental level, 52 times per year at directorate level and 12 times per year at divisional level.	Information Department provide data for all checks. Daily checks - Department Managers. Weekly checks to Department and Directorate Managers. Monthly checks – directorate and divisional checks.	Directorate, divisional and Trust managers and committees.	Monthly

9. Updating and Review

9.1 This Policy with be reviewed every two years.

9.2 Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author must ensure the revised document is taken through the standard consultation, approval and dissemination processes.

10. References

Code:

WHO Guidelines for Safe Surgery 2009	
WHO Surgical Safety Checklist Implementation Manual 2009	
NPSA Alert 2009 – WHO Surgical Safety Checklist	NPSA/2009/PSA002/U1

11. Background

11.1 Consultation

This document has been circulated to the following individuals for comment/approval.

Key individuals involved in developing the document

Name	Designation
Susan Smith	
Mathew Trotman	
Steve Randle	
Andy Fryer	
Stacey Ferris	

Heads of Department

Name	Designation
Julian Berlet	Divisional Medical Director – Specialised Clinical Services
Tracy Pearson	Divisional Director of Operations – SCSD
Amanda Moore	Interim Divisional Director of Nursing – SCSD
Jasper Trevelyan	Divisional Medical Director - Specialty Medicine
Paul Rajjayabun	Divisional Medical Director - Surgery
Sarah King	Divisional Director of Nursing - Surgery
Angus Thomson	Divisional Medical Director – Women & Children
Sue Smith	Divisional Director of Nursing - Medicine
TBC	Clinical Director – Theatres/Pre-op
Stephen Lake	Clinical Director – Endoscopy
Tarun Sharma	Clinical Director – Ophthalmology
Umesh Udeshi	Clinical Director - Radiology
Michelle Mullan	Clinical Director – Breast
Anthony Perry	Clinical Director – Upper GI
Steve Pandey	Clinical Director – Lower GI
Stephen Goodyear	Clinical Director - Vascular
TBC	Clinical Director – Urology
Steve Lewis	Clinical Director – ENT/Audiology

Kieron McVeigh	Clinical Director – Maxillofacial/Oral Surgery
Charles Docker	Clinical Director – Orthopaedics/Trauma
Rachel Duckett	Clinical Director – Obstetrics/Gynaecology
Nick Hudson	Clinical Director – Medicine including Cardiology
Steve Randle	Directorate Manager – Theatres, Anaesthetics & Pre-op
Tracey Baldwin	Matron – Ambulatory Care
Dawn Robins	Matron – Endoscopy/Bowel Screening
Melanie Hurdman	Matron – Maternity Inpatients WRH
Alison Talbot	Matron – Maternity Inpatients Alexandra Hospital
Swati Ghosh	Consultant Obstetrician – Obstetric guidelines lead
Lucy Waldock	Sister – Ophthalmology
Tracey Jones	Sister - Ophthalmology

11.2 Approval process

This document has been submitted to the following committees for approval.

Name	Committee / group
Catherine Hillman Cooper	Obstetric Governance Committee
Sue Aston	CG Committee Surgery Division
Julian Berlet	SCSD Management meeting

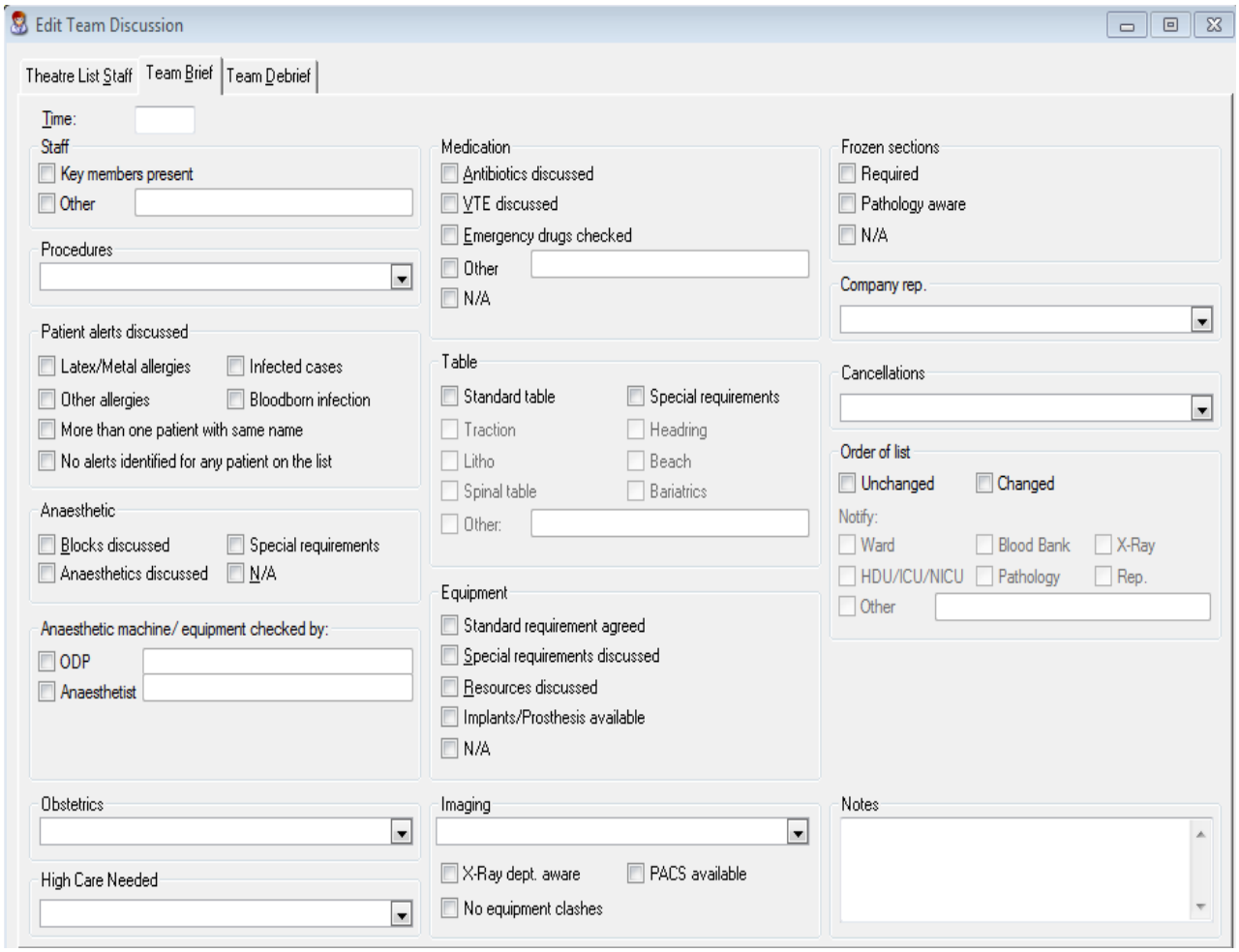
11.3 Equality requirements

See Supporting Document 1

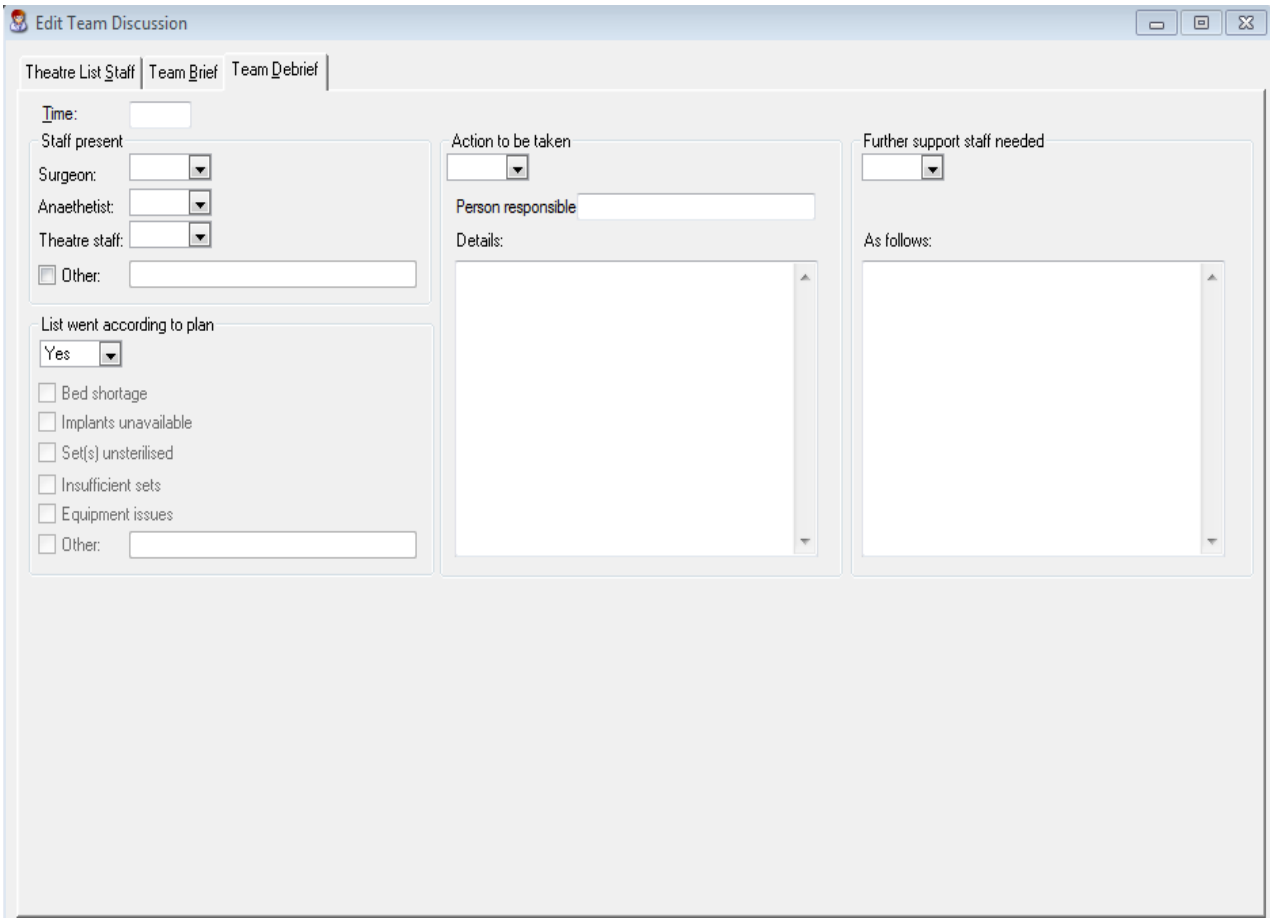
11.4 Financial risk assessment

See Supporting Document 2

Appendix 1 – Team Brief



Appendix 2 - Team Debrief



Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	No	
	• Disability	No	
	• Gender reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
	• Race	No	
	• Religion or belief	No	
	• Sex	No	
	• Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	-	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	-	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	-	
7.	**Can we reduce the impact by taking different action?**	-	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval