Surgical Safety Checklist Policy

1. Background

In November 2009 Australian Health Ministers endorsed the World Health Organisation's (WHO) Surgical Safety Checklist (Checklist) as the national strategy for surgical safety in Australia.

The checklist is supported by a range of learned Colleges and Associations, including the Royal Australasian College of Surgeons, Australian College of Operating Room Nurses, Australian and New Zealand College of Anaesthetists, and Royal Australian College of Obstetricians and Gynaecologists.

The WA Country Health Service (WACHS) supports the use of the WHO Checklist. It is designed to improve safety by focussing on anaesthetic safety practice, ensuring correct site surgery, avoiding surgical site infection and venous thromboembolism.

Most importantly, the checklist enhances communication within the surgical team, a critical factor in ensuring safety and quality of care. Its structure is based on the universally accepted sequence of surgical and other invasive procedures.

2. Policy

The elements of the WHO Checklist are to be utilised as a **minimum standard** in all WACHS operating theatres and procedure rooms where invasive procedures requiring sedation/anaesthesia are performed.

2.1 Core Principles

1. The checklist is primarily a tool to improve **verbal** communication among the surgical team.
2. The checklist is the **final** safety check before a procedure is commenced. It is not designed for planning or documenting treatment or care, and does not supplant other documentation or pre-surgical processes and procedures.
3. The checklist should be **simple**, easy to follow and it should not take longer than one minute to complete each section.

2.2 Using the surgical safety checklist

Specific interpretation of this policy in relation to the Surgical Safety Checklist is outlined below. Additionally, the flowchart at Appendix 1 serves as a quick reference guide to assist in carrying out the checklist. It is recommended that this flowchart be laminated and placed in operating theatres and procedure rooms, if not already contained within perioperative/procedural documentation.

2.2.1 Ensuring that the patient's consent has been gained for the treatment or procedure

As per the WA Health Consent to Treatment Policy,
"Consent to treatment is a person's agreement for a health professional to proceed with a specific proposed treatment. That agreement is obtained (or withheld) following communications between one or more health professionals and the patient about the proposed treatment(s) and their inherent risks and benefits. Consent communications are likely to comprise of one or more verbal exchanges between the patient and the health professional(s), and also in the case of more invasive or risky procedures, documentation of that exchange including written consent provided by the patient".

Refer to the WA Health Consent to Treatment Policy for the process for seeking consent.

2.2.2 Marking of site of surgery or invasive procedures

The site of the surgery or invasive procedure should ideally be marked by the person performing the procedure (proceduralist). A hospital/health service may permit the task of marking the site of the surgery or invasive procedure to be delegated to another health practitioner. Any health practitioner delegated to mark the site of the surgery or invasive procedure must be sufficiently competent and knowledgeable about the patient's case to be able to undertake this task.

If any health care practitioner is at any time concerned that the incorrect side/site is being prepared for surgery or invasive procedure, or feels uncomfortable or too inexperienced to undertake the verification task, they should immediately voice their concerns. Raising concerns by health care practitioners should always be encouraged, even if these concerns prove to be unfounded.

Where a patient refuses marking, this must be documented in the medical record and alternative strategies must be employed to prevent the procedure being performed on the wrong site.

The proceduralist retains overall responsibility for ensuring that the site of the surgery/invasive procedure has been correctly identified and marked, and that the surgery/invasive procedure is performed on the correct side and at the correct site.

The proceduralist may be held responsible if the side/site of the procedure was not marked or the task was not properly carried out, resulting in the procedure being performed on the wrong side/site.

Process

- When marking the site of the surgery / invasive procedure, care should be taken to ensure that the patient is not injured or compromised.
- The intended site of incision or site of insertion must be unambiguously marked. Multiple sites must be individually marked.
- All cases involving laterality, multiple structures (e.g. fingers, toes or lesions) or levels (e.g. spine) must be clearly marked.

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Date of Last Review: September 2019   Page 2 of 7   Date Next Review: September 2024

- The mark must be visible and sufficiently permanent so as to remain visible following skin preparation and draping. Site marking should be performed with an indelible marker, wherever practical.
- Do **not** mark non-procedure sides/sites.
- Marking of the operative site should be done in such a way as to ensure that when a patient is turned or placed in a different position, the mark is still clearly visible to the surgical team.
- Marking must take place when the patient is awake and before the patient enters the procedure room. Except in an emergency, the patient should not enter the procedure room until this has been completed.
- Where imaging is used during the marking process, members of the clinical team must confirm that the images are properly labelled and are for the correct patient.
- The method of marking should be consistent throughout the hospital/health service.

Hospitals/health services are to use single-use marker pens to mark the site of the surgery or invasive procedure in order to minimise risk of infection.

Once appropriate marking has been completed, the patient's medical record is to be properly documented. 'Left' or 'Right' is to be written in full on all documentation.

Possible exceptions

Exceptions to the requirement for operative sites to be clearly marked may include:

- interventional cases for which the catheter or instrument site is not pre-determined (e.g. cardiac catheterisation, epidural or spinal analgesia or anaesthesia)
- procedures performed on midline organs/structures such as the umbilical, perineal, or anal areas. Note that the vertebral level of the spinal column where surgery/procedure is required or entry into the spinal cord is indicated should always be marked.
- endoscopic or other procedures performed through the mouth or anus
- single organ cases such as caesarean section, midline sternotomy, laparoscopy, laparotomy or urethtrotomy
- where the procedure site cannot be marked (e.g. teeth). Relevant radiographs or other scans must, if possible, be marked to indicate the operative site. Where this is not possible, a diagram clearly indicating the site and side must be prepared and entered into the patient's medical record.
- where marking of premature infants may cause permanent tattoos
- where the operative site is a traumatic site (obvious surgical site)
- where intra-procedure imaging for localisation (e.g. radiological, MRI, stereotaxis) will be used
- where the urgency of surgery precludes marking. This is to be documented in the medical record as soon as practicable.

Where the site of the surgery is not marked for urological procedures involving the ureter, clinicians are to develop and implement agreed processes and procedures to prevent errors such as the wrong ureter being instrumented.

It is strongly recommended that extra precautionary measures are also taken when preparing a patient for eye surgery. Where possible, the eye should be marked in the ward by the ophthalmologist. Other recommended in-house risk management strategies include:

- labelling eye drops 'left eye' or 'right eye' as appropriate, on the bottle
- including tick box section on the pre-op nursing record verifying that the type of procedure and correct side has been fully stated on the consent form and also marked on the patient
- including elements of the policy on an operating theatre policy document
- including a 'time-out' prompt in the 'prep' dish of all bowl sets, which is then handed to the surgeon with every prepping solution

It is recognised that the above list of possible exemptions may not cover the full range of surgical and medical procedures undertaken in all WACHS hospitals. Therefore, the hospital/health service executive, in consultation with relevant clinicians, learned Colleges and associations may modify this policy and expand the list of exempted procedures to suit clinical and administrative conditions at the local level.

As a minimum, where this site-marking policy has been modified to suit local clinical conditions, it is expected that hospitals/health services will implement appropriate audit procedures to verify that clinical teams are following the mandated procedures.

2.2.2 Patient identification procedure

Prior to the patient receiving any medication that could affect their cognitive function, members of the clinical team should ask the patient to state (not confirm) their full name, date of birth, the reason for the procedure and the site of the procedure to be performed. Staff must check the patient's responses against each patient ID band, consent form and other information provided in the patient's clinical record.

Refer to the WACHS Patient Identification Policy (*in development*)

2.2.3 Time out section

One of the principal aims of the checklist is to improve verbal communication among the surgical team. Correct execution of the Time Out is therefore crucial. The precise timing of the Time Out is contingent on several factors such as the type of procedure and the constitution of the surgical team.

The Time Out must be initiated at an appropriate time before incision. This time should be agreed according to requirements unique to individual teams, procedures and local context. All members of the team are required to participate verbally in the Time Out.

In the past there have been cases of error in emergency situations that could have been avoided with a Time Out. It is strongly encouraged that Time Out be carried out in all cases, including emergencies. In these cases an abridged format may be adopted to expedite commencement of the procedure. This condensed Time Out should aim to confirm / ensure:

1. patient identification
2. correct procedure
3. correct site

2.2.4 Signature

The checklist is a tool to improve verbal communication in the operating theatre. The requirement for a signature has been requested to provide accountability that the checklist has been utilised, with the aim of enhancing its use and uptake.

The checklist signatory (generally the Checklist Coordinator) is confirming that all the elements have been checked off verbally. This is **not** a confirmation that each item has been actioned, a task which always remains the responsibility of the respective team member.

2.2.5 Diagnostic images

Where imaging data is used during the marking process, 2 or more members of the clinical team must confirm that the images are properly labelled and are for the correct patient.

3. Roles and Responsibilities

Clinical incidents involving wrong patient, wrong procedure and wrong site are to be reported via Datix CIMS. Refer to the WA Health Clinical Incident Management Policy

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health system MP0031/16 Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

5. Records Management

Records Management Policy
Health Record Management Policy

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Date of Last Review: September 2019   **Page 5 of 7**   **Date Next Review:** September 2024

6. Evaluation

Evaluation of this policy is to be carried out by the local staff utilising the checklist.

Monitoring through Datix Clinical Incident Management System of wrong patient, wrong site or wrong procedure clinical incidents will be undertaken.

7. Standards

[National Safety and Quality Health Care Standards](#)
Communicating for Safety Standard: 6.1, 6.4, 6.5, 6.6, 6.7 and 6.9

8. Related WACHS Policy Documents

WACHS [Patient Identification Policy](#)

9. Related WA Health System Policies

[OD061/15 Clinical Incident Management Policy](#)
[OD0657/16 WA Health Consent to Treatment Policy](#)

10. Policy Framework

[Clinical Governance, Safety and Quality](#)

11. Appendix

Appendix 1: [Surgical Safety Checklist Procedural Flowchart](#)

**This document can be made available in alternative formats
on request for a person with a disability**

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Appendix 1: Surgical Safety Checklist Procedural Flowchart

FIRST STEP:
Designate Checklist Coordinator (CC) for the duration of the procedure.
- Can be any member of the surgical team
- The CC can be appointed for an entire operative session

1. Sign In:
- Directly before induction of anaesthesia.
- Surgeon's preference advised but not essential.

1. Confirm Pt ID/procedure **with patient**:*
   a. 'What is your FULL name? (ask to spell if unclear)
   b. 'What is your date of birth?'
   c. 'What is your address?'
   d. 'What procedure are you here for; what site/side?'

2. Check that consent has been provided and that the ID, procedure and site specified on the form matches verbal confirmation.**

3. Visual confirmation of site marking (if appropriate).***

4. Full anaesthesia check completed by anaesthetic team.

5. Confirm with anaesthetist re. risk of blood loss (ensure group/screen and/or cross match available), airway problems or allergic reactions.

6. Confirm that special equipment/prosthesis has been checked

* Can be legal guardian/family member. If skipped (e.g. in an emergency) – leave box unchecked. Refer to WACHS Patient Identification Policy
** Refer to WA Health Consent to Treatment (OD0657/16)
*** 'left' and 'right' must always be written in full in documentation; refer to WACHS Surgical Safety Checklist Policy

2. Time Out:
Directly after induction of anaesthesia, before any incision/insertion

1. CC Initiates time-out.

2. Each member of team introduces themselves (confirm that everyone known to each other if team is part way through operative session).

3. Pause before incision to confirm out loud that the correct operation is being performed on the correct patient and site.

4. Verbal team-briefing on intended procedure, critical steps, concerns, anticipated events and equipment.

5. CC confirms that:
   a. Prophylactic ABs have been given
   b. Thromboprophylaxis has been ordered/given (specify if pharmacological or mechanical)
   c. Essential imaging is displayed and matches the patient's ID

3. Sign Out:
Immediately after wound closure/completion of procedure.

1. Coordinator verbally confirms with team:
   a. Name of procedure recorded (this may be different to the operation initially planned)
   b. Instrument count
   c. Specimen labelling (Name, DOB, UMRN)

2. Team reviews key plans and concerns regarding post-op management/ recovery before patient leaves operating room.

3. One signature at end.

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