Policy Applies to

All of the Mercy "surgical team" which comprises credentialed specialists, nurses, anaesthetic technicians, surgical assistants and other operating theatre personnel involved in surgery.

Related Standards

- Health & Disability Sector Standards 2001
  Standard 2.2.7 - Consumers are protected from exposure to avoidable & preventable risk during each stage of service provision.

- EQuIP standards; The organisation provides safe care and services
  Criterion 1.5.6; the organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.

Rationale

The aim is to improve the quality and safety of health care services provided to patients undergoing surgery.

The expectation is that by improving communication and teamwork within the surgical team, adverse events will be prevented.

Cultural Considerations

Patients are encouraged to communicate any specific cultural needs they may have for safety and support, including the support of their whanau / family.

Definitions:

Surgical Safety Checklist:
A tool to reduce perioperative harm and improve teamwork and communication
This consists of three phases:

1) *Sign In* - before induction of anaesthesia
2) *Time Out* –after induction and before the patient is prepped and draped/surgical incision, is the final verification of the correct patient, procedure, and site by engagement and communication among all members of the surgical team
3) *Sign Out* - before the patient leaves the operating theatre

Briefings:

A standardised communication tool aimed to create an environment in which individuals can speak up, express concerns, and alert team members to unsafe situations in a timely manner.

It is recommended that the briefing should take no longer than five minutes and is led by the surgeon.

This involves a four step process being completed before the scheduled list starts for the day:

1. Introductions
2. List outline
3. Case events for each case
4. Staffing and questions

This process enables a broader knowledge base for the planned procedure by sharing the operative plan to promote teamwork, mitigate hazards to patients, reduce preventable harm and ensure all equipment is available.

Debriefings:

Provides opportunities for improvement, learning not blaming, improvement in staff wellbeing and a forum to say thank you. This process allows teams to take time to learn from real-time situations that went well or didn't go to plan by discussing what happened after an operating list.

Objectives:

- To improve patient safety by ensuring all of the surgical team engage in the surgical safety checklist
- To reinforce accepted safety practices
- To encourage communication and teamwork
- To reduce avoidable complications

Implementation:

- A comprehensive education package is available on the Surgical Safety Checklist , Briefings and Debriefings for all members of the surgical team, which includes;
    - Access to websites with on line video instruction
    - Written resource
    - Orientation competency
    - Reference posters in each theatre

Evaluation:

- Incident reports are encouraged for any discrepancies in the Surgical Safety Checklist process
- Debrief reports will be completed with follow up actions as required. These will be given to the Theatre Coordinator, who will oversee corrective actions
- Annual observational audits will be undertaken.
- Feedback from audit data results will be shared with staff and credentialed specialists
- Non-compliance with this policy will be escalated to the Medical Advisory Board

Associated Internal Documents

- Consent Policy
- Incident Policy
- Perioperative Record
- End-of-list debrief report
- Surgical Safety Checklist & Briefing and Debriefings Audit

References:

- HQSC Improving surgical teamwork and communication – a guide to preparing and implementing (2015)
- *http: //www.hqsc.govt.nz/our-programmes/safe-surgery-nz/publications-and-resources/publications/1742/*
- *HQSC PWC Improving Teamwork and communication within surgical teams – a proof of concept project, programme review and recommendations ,Dec 2014*
- WHO Surgical Safety Checklist http://www.who.int/patientsafety/safesurgery/ss_checklist/en/
- AORN Guidelines for Perioperative Practices 2019 Edition Team Communication: Pg. 1063 - 1091
- Royal Australian College of Surgeons implementation guidelines for ensuring correct patient, correct side and correct site surgery, Ref. No. FES_PST_2031_P.
- New Zealand Orthopaedic Association, NZOA guidelines for ensuring correct patient, correct side and correct site surgery.