

The evidence	Five things you can do	The help on offer
<ul style="list-style-type: none"> □ The World Health Organisation [WHO] Surgical Safety Checklist is a tool that has been created by leaders in surgery, anaesthesia, and nursing to reduce preventable complications and deaths associated with Surgery. □ It provides a means of verifying that safety critical aspects of care have been performed, and are communicated to all members of the surgical team in a systematic manner. <p><i>“The beauty of the surgical safety checklist is its simplicity and – as a practising surgeon –</i></p> <p style="text-align: center;"><i>I would urge surgical teams across the country to use it. By using the checklist for every operation we are improving team communication, saving lives and helping ensure the highest standard of care for our patient.”</i></p> <p style="text-align: center;">Health Minister, Lord Ara Darzi</p> <ul style="list-style-type: none"> □ The checklist is a tool to deliver improved teamwork, meaningful communications and culture change in the operating room; it is not an audit tool or a ‘thing’ in itself. Simply ticking the checklist will not achieve its full potential. 	<ul style="list-style-type: none"> □ Provide personal leadership. Ensure there is Board support for implementation of the checklist. Publicly state the organisation’s commitment to the checklist at a Board meeting and within your corporate objectives. □ Set public goals. Let your whole hospital know about improvement goals you hope to achieve for the reduction of surgical complications and ‘never events’ of wrong site surgery and retained/swabs and instruments. □ Provide visible support. Visit the operating department and all staff who work there, as part of your leadership walkrounds. Provide encouragement and support. Communicate progress and celebrate success. Update your whole organisation on progress to make this a shared aim. □ Establish a Clinical and Managerial Partnership for Implementation. Clinical and managerial leadership will be needed to achieve maximum benefits you will need commitment by all members of the surgical team. Identify your enthusiasts, and plan to test implementation of the checklist in specific settings. These enthusiasts will positively role model the 	<ul style="list-style-type: none"> □ Patient Safety First seeks to provide NHS staff with the knowledge and support they need to take simple steps to improve the safety of patients in their care. You can access information on the following resources at: www.patientsafetyfirst.nhs.uk <p>“How to...” Guides:</p> <ul style="list-style-type: none"> - Leadership for safety is an intervention specifically to support you and your Boards with patient safety. We have also produced supplements relating to leadership walkrounds, human factors in safety, measurement and implementing improvement - Reducing harm in perioperative care is an intervention which specifically supports implementation of the WHO Surgical Safety Checklist as well as guidance on how to practically improve the reliability of compliance with the surgical site infections care bundle. <p>Regional Events. In collaboration with local NHS Trusts and many of the Professional Bodies with an interest in perioperative care, Patient Safety First is supporting a number of face to face events to actively support implementation based on peer to peer learning.</p> <p>On-Line Support and Advice. Through a series on on-line WebEx sessions, you and your team can get direct advice and support from our team, all for whom have practical experience of implementing improvements in peri-operative care settings.</p> <p>Share your experience with Patient Safety First. Tell your stories of success and challenges, find out how others are tackling implementation, and use the professional press opportunities we are creating to gain proper recognition for the efforts of your teams.</p>

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<ul style="list-style-type: none"> □ Supported by an extensive evidence base, the checklist is purposefully simple and widely applicable. □ A global study published in 2009 by Haynes et al, in the New England Journal of Medicine, demonstrated that using the checklist improved team work, and delivered marked improvements in surgical outcome. □ Surgical complications are devastating to patients, are costly to organisations and are often preventable. The use of the checklist and the behaviours it supports and encourages will improve the safety, quality, productivity and reliability of surgical care. <p><i>“As a former vascular surgeon, currently involved in work with the Institute to improve the reliability of surgical care, I recognise how important the Surgical Safety Checklist is. I strongly believe that the CEO needs to endorse the Checklist and engage with clinicians and clinical leaders to turn the theory into everyday practice”</i></p> <p>Dr Mark Goldman, Chief Executive, Heart of England Foundation Trust</p>	<p>behaviours that are needed to ‘deliver’ what the checklist is ultimately designed to achieve. Colleagues willing to publicly embrace the checklist use it in their day to day work and regularly enquire of others how the process of implementation is going, are your champions. You will need to support them.</p> <ul style="list-style-type: none"> □ Plan your implementation strategy. Start small, measure the impact and then spread. Starting small means introducing it in one operating room for one case...or for one list or one specialty....or for one day or one week. Learning from the WHO pilot sites and early implementer sites here in England, has highlighted that organisations that tried to implement the checklist in multiple operating rooms simultaneously, or throughout the hospital, faced the most resistance and experienced the greatest difficulty in engaging staff to use the checklist ‘in the spirit’ of that intended. □ Sosupport your teams to start small, test out the checklist, evaluate what was learned, what adaptations might be needed to suit your local context or ‘specialty’ requirements; and then move forward after problems have been addressed and as enthusiasm builds. 	<ul style="list-style-type: none"> □ NHS Institute for Innovation and Improvement <p>Leading Improvement in Patient Safety (LIPS). Designed and delivered by the NHS Institute’s Safer Care team and faculty of frontline clinicians. This programme is about building the capability and capacity to implement improvements in patient safety. It offers practical support around teamwork and communication, human factors and interventions related to perioperative safety - www.institute.nhs.uk/safercare</p> <p>The Productive Operating Theatre. This is the next programme in the NHS Institute’s successful Productive Series. Its aim is to give frontline staff the knowledge and practical improvement tools they need to improve theatre performance, giving patients a better experience, increasing the reliability and safety of care, developing more effective team working and leadership, and improving efficiency by reducing waste, and driving down waits. The product is currently in co-production with the NHS and is planned for release in September 2009. www.institute.nhs.uk/theatres</p> <p>‘Just a Routine Operation’ is an inspirational and moving film which provides a compelling reason for using the checklist – it is available on streaming at: http://www.institute.nhs.uk/safer_care/general/human_factors.html</p> <ul style="list-style-type: none"> □ National Patient Safety Agency [NPSA]. Published the alert in England and Wales, detail found at: www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert. NPSA Videos; video lecture given by Dr Atul Gawande [the WHO lead for design of the checklist], ‘how to’ and ‘how not to’ use the checklist videos. Found at www.npsa.nhs.uk/nrls. NPSA advice on how to prevent incidents of wrong site surgery and Never Events - www.npsa.nhs.uk/nrls