POLICY FOR APPLICATION OF THE WHO SURGICAL SAFETY CHECKLIST

Department / Service:	Theatres, Ambulatory Care, Critical Care & Outpatients Surgery
Originators:	Senior Countywide Theatre Matron Countywide Theatre Matron
Accountable Director:	Divisional Medical Director for Specialised Clinical Services Division Divisional Medical Director for Surgery Division
Approved by:	Theatre Anaesthetic Governance Group
Date of approval:	21st August, 2024
Review Date: This is the most current document and is to be used until a revised version is available	21st August, 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Operating Theatres
Target staff categories	Consultants / Countywide Theatre staff / 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.

WAHT has produced Local Safety Standards for surgical invasive procedures (LocSSIPs), as listed below, that will ultimately govern the process for performing the **8 stages** of the WHO Surgical Safety Checklist. These **LocSSIPs** will be used in conjunction with this policy:

- **Consent and Site Marking**
- **Team Brief**
- **Sign In**
- **Time Out**
- **Implant Verification**
- **Procedure for the checking of swabs, instruments, sharps and needles**
- **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 recommendation	TLG
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
January 2021	Job roles substituted for named individuals	L Binns
April 2024	Document extended for 3 months whilst review undertaken	Stuart Coleman
21st August 2024	Document re-formatted and new LocSSIP steps added in.	Theatre Anaesthetics Governance Group

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Appendix

Supporting Documents

Policy for application of the WHO Surgical Safety Checklist

1. Introduction

Patient safety is an essential element of healthcare and staff have a duty of care to prevent harm. This policy outlines the WHO Checklist procedure that all staff must adhere to.

Worcestershire Acute Hospitals NHS Trust uses the WHO Checklist and additional checks as recommended in NatSSIPs 2.

Full details of each stage are in the separate LocSSIP policies on the Theatre Key Document page. Below is a guide to who is responsible for conducting each stage. Overall responsibility is with the Senior Operator (i.e. the consultant surgeon for that list)

2. The 8 Sequential Steps

The 8 sequential steps of the WHO Checklist and NatSSIPs 2 are:

- **Consent, procedural verification and site marking**
  - Responsible person: Operator
  - Should be completed in ward/admission area

- **Team Brief**
  - Person responsible for ensuring Brief happens: Theatre team leader
  - Emergency work is recognised as time critical and Team Brief may be with core team members only

- **Sign In**
  - Responsible person: 2 staff members (for GA: anaesthetist and anaesthetic practitioner, for non-GA cases: operator and a registered member of staff)
  - Any escorts should remain with patient during Sign in

- **Time Out**
  - Person responsible for ensuring Time Out happens: Operator
  - May be combined with Sign In for LA cases or category 1 Caesarean Section
  - Requires engagement of full team
  - Registered practitioner should Sign to confirm completion (non-registered staff can also sign, but a counter signature is then required by a registered member of staff)

- **Implant checks**
  - Responsible person: Operator inserting implant with scrub nurse
  - Requires silent focus and 2-person check

- **Reconciliation of items and prevention of foreign objects**
  - Responsible person: Shared responsibility between scrub nurse and operator
  - Full details in the Procedure for the checking of swabs, Instruments, sharps and needles SOP on Key Document page

- **Sign Out**
  - Responsible person: Theatre Team leader
  - Should be completed once instruments, swabs and sharps count confirmed

- **Debrief**
  - Responsible person: Shared responsibility between operator/anaesthetist (when present) and theatre team leader

3. General Information:

- Patients should be involved in the checking process whenever possible and appropriate.
- All staff should engage with the Sequential Steps in a professional manner.
- Behaviour should be respectful, honest and civil.
- Failure to engage with relevant Safety Steps at individual or team level should be addressed constructively but should be viewed as a risk and a performance concern.
- The checks should be performed using a paper, poster, electronic or laminated checklist around and by the side of the patient. They should never be filled out retrospectively, by memory or across distance/behind equipment of a procedural room.
- Each of the relevant Sequential Steps should be conducted and completed in an environment that is free from distractions, including music, interruptions, phone/device use, or non-essential or other conversation. Teams should ensure that external and internal factors that affect performance and communication in invasive areas are recognised, addressed and mitigated. These include noise levels (music, laminar flow systems), protective clothing (gowns, masks, hoods) and fatigue.
- Other important clinical activities – such as application of monitoring, scrubbing, positioning – should be done before or after the Sequential Steps, not during, in order to allow full attention to be given.

- Any team member is empowered to challenge others to respect the expected silent focus and should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.
  The minor and major procedures split recognises that some invasive procedures may require less detailed checks that are proportionate to the processes involved.

4. Roles and Responsibilities

4.1. 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 WHO Checklist 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 Checklist.

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

4.2. 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 WHO Checklist.

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

To ensure both the paper copy and electronic theatre record of the WHO Checklist are completed for every patient.

4.3. Role of Individual Staff

All staff must engage with the steps within the WHO Checklist. This will include the completion of both paper and electronic versions.

5. Standards and Practice: Legal and Professional Obligations

The operating surgeon maintains overall accountability to ensure that the WHO Checklist is 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. It may be appropriate for a non-registered member of staff to sign the steps of the WHO Checklist, but a registered member of staff must countersign this. This is because the registered practitioner retains professional accountability & must always ensure the appropriateness of the delegation of any task.

6. Dissemination and Implementation

6.1 New Staff.

The WHO Checklist policy and the LocSSIPs will be provided at induction 'pre-reading' material for all new members of theatre staff.

6.2 Existing Staff

The WHO Checklist policy and the LocSSIPs will be stored on the electronic Document Library.

6.3 Training

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

7. Monitoring compliance and effectiveness

Monitoring of the WHO Checklist will be performed daily through Bluespier reports, and also weekly and monthly 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 WHO Checklist 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

8. Updating and Review

8.1 This Policy with be reviewed every two years.

8.2 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.

9. References

Code:

WHO Guidelines for Safe Surgery 2009	
WHO Surgical Safety Checklist Implementation Manual 2009	

10. Background

10.1 Consultation

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

Key individuals involved in developing the document

Division	Designation
SCS Division	Senior Countywide Theatre Matron
SCS Division	Countywide Theatre Matron
SCS Division	Directorate Manager, Theatres, Anaesthetics, Critical Care, Pre-Operative Assessment and Day Case Surgery
SCS Division	Recruitment & Development Lead, Theatres
SCS Division	Senior Operating Department Practitioner

Heads of Department

Name	Designation
SCS Division	Divisional Medical Director
SCS Division	Divisional Director of Operations
SCS Division	Divisional Director of Nursing
Specialty Medicine	Divisional Medical Director
Surgery	Divisional Medical Director
Surgery	Divisional Director of Nursing
Women & Children (W&C) Division	Divisional Medical Director
Medicine	Divisional Director of Nursing
SCS Division	Clinical Director – Theatres/Pre-Operative Assessment
SCS Division	Clinical Director – Endoscopy
SCS Division	Clinical Director – Ophthalmology
SCS Division	Clinical Director - Radiology
Surgery	Clinical Director – Breast
Surgery	Clinical Director – Upper GI
Surgery	Clinical Director – Lower GI

Name	Designation
Surgery	Clinical Director - Vascular
Surgery	Clinical Director – Urology
Surgery	Clinical Director – ENT/Audiology
Surgery	Clinical Director – Maxillofacial/Oral Surgery
Surgery	Clinical Director – Orthopaedics/Trauma
Women & Children's Division	Clinical Director – Obstetrics/Gynaecology
Speciality Medicine	Clinical Director – Medicine including Cardiology
SCS Division	Directorate Manager – Theatres, Anaesthetics & Pre-op
SCS Division	Matron – Ambulatory Care
SCS Division	Matron – Endoscopy/Bowel Screening
Women & Children's Division	Matron – Maternity Inpatients WRH
Women & Children's Division	Matron – Maternity Inpatients Alexandra Hospital
Women & Children's Division	Consultant Obstetrician – Obstetric guidelines lead
SCS Division	Sister – Ophthalmology
SCS Division	Sister - Ophthalmology

10.2 Approval process

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

Division	Committee / group
Women & Children's Division	Obstetric Clinical Governance Committee
Surgery	Clinical Governance Committee
SCS Division	SCSD Management meeting

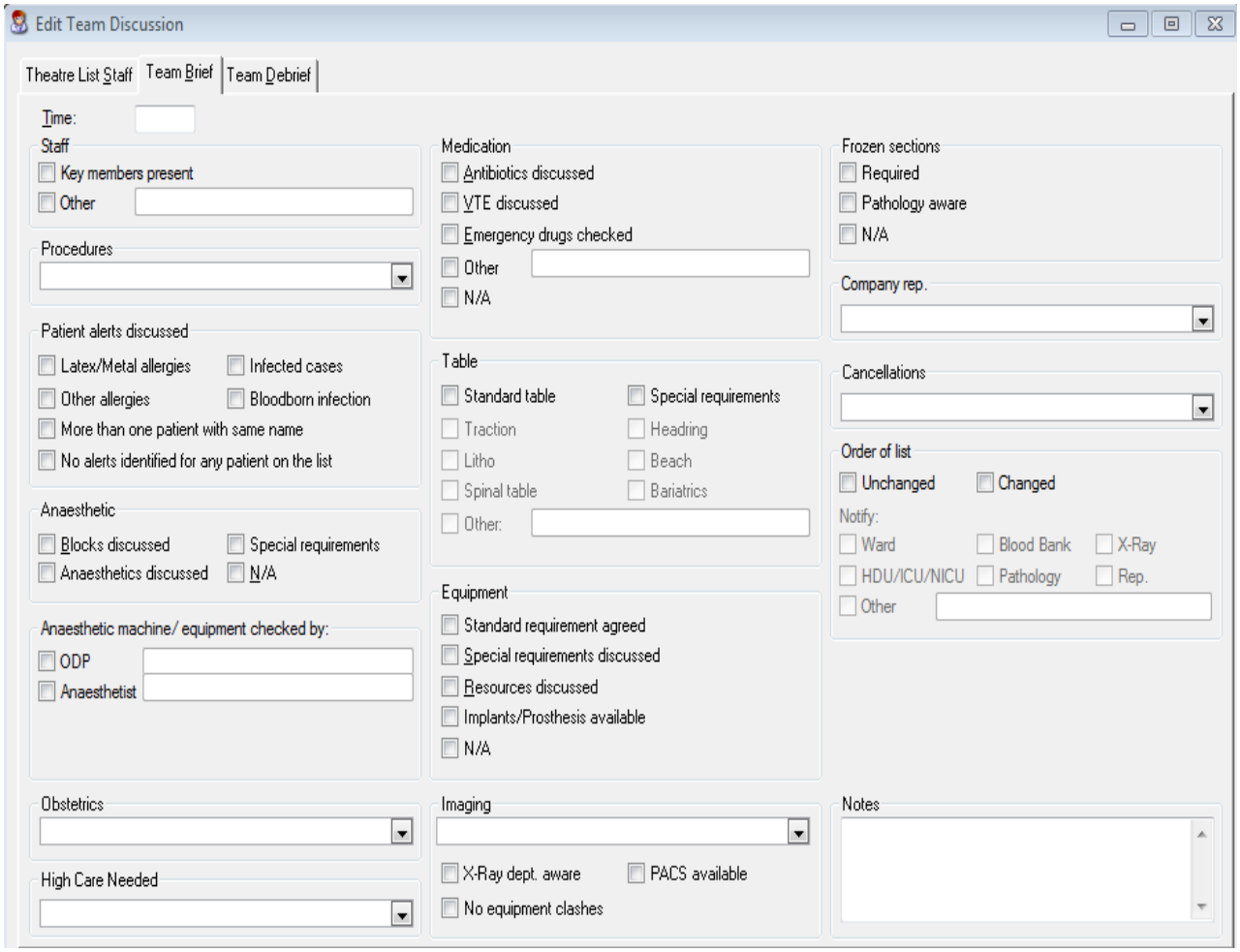
10.3 Equality requirements

See Supporting Document 1

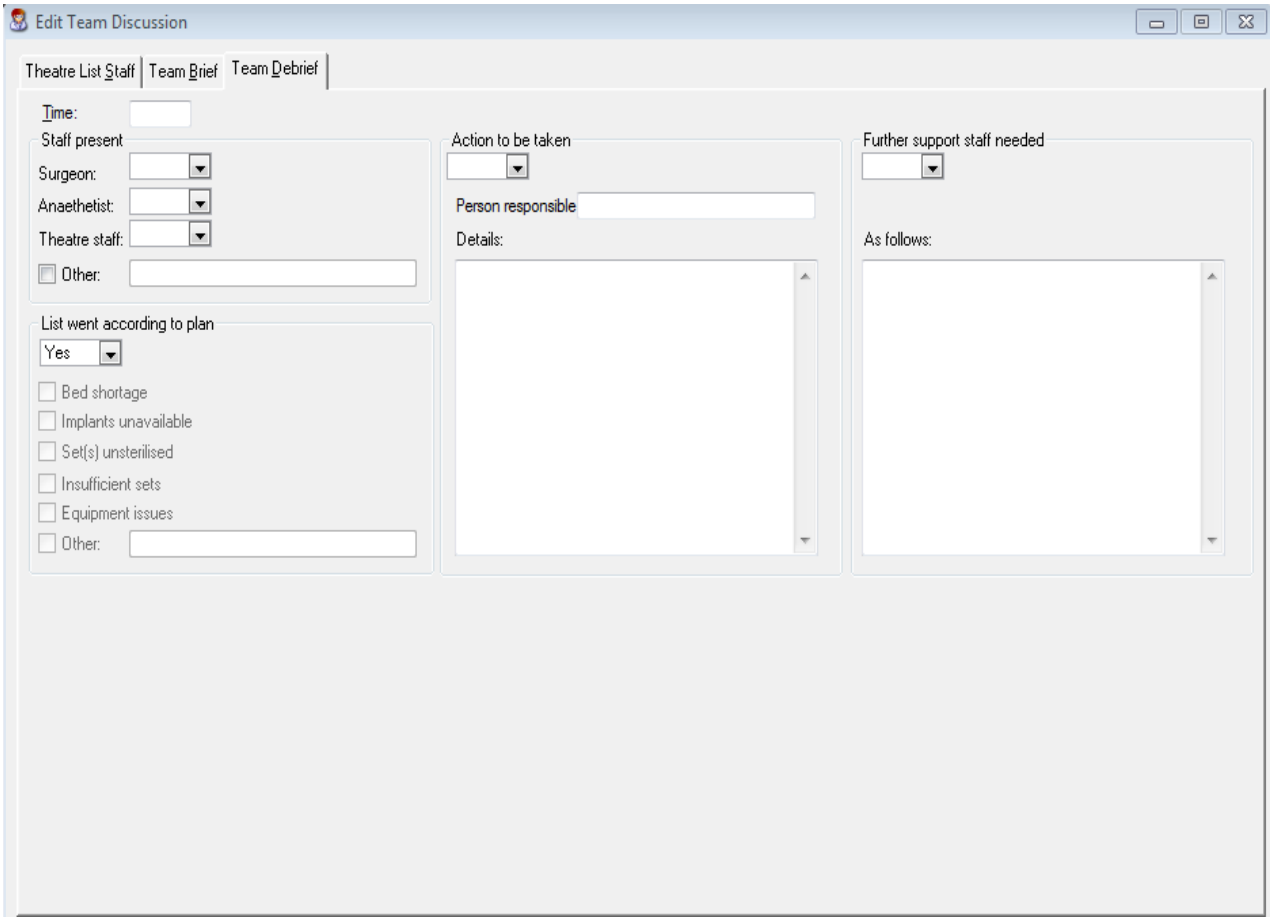
10.4 Financial risk assessment

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