A STUDY ON ADHERENCE TO SURGICAL SAFETY CHECKLIST IN CARE HOSPITALS, BANJARA HILLS

CARE HOSPITALS

IIHMR UNIVERSITY

INTRODUCTION

This report is based on a study on the Adherence to Surgical Safety Checklist in Care Hospitals. It has secured the essential introduction of both organization and surgical safety checklist.

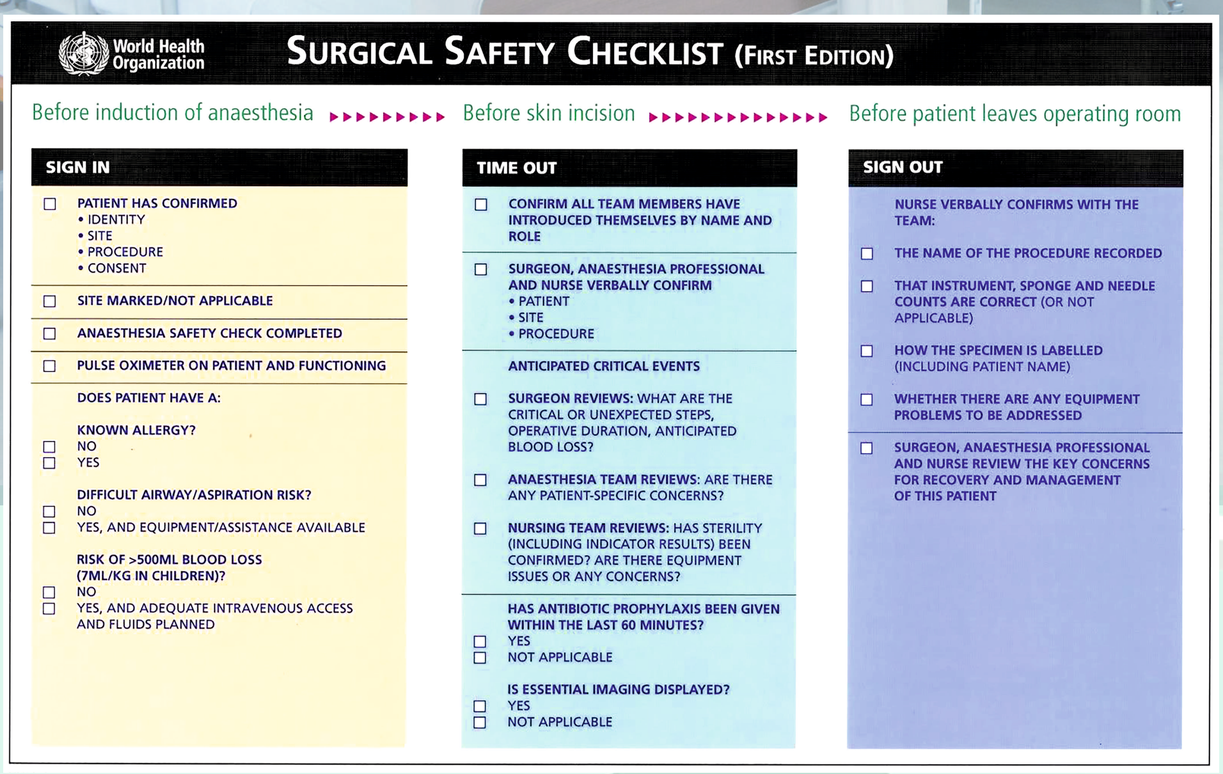
The surgical safety checklist (SSC) is intended to improve tolerant security however investigations of its effect struggle. This report investigated consistency and components that impacted SSC adherence to propose how its consistency could be streamlined.

AIM

To study adherence to surgical safety Checklist

OBJECTIVE

1. Direct observation of the Compliance with the Surgical Safety Checklist.
2. Audit extent to the compliance of Checklist Completion and documentation.



World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▸▸▸▸▸▸▸▸▸ Before skin incision ▸▸▸▸▸▸▸▸▸▸▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

METHODOLOGY

Study Area: Care Outpatient center, Banjara Hills, Hyderabad

Type of Study: Descriptive Study

Duration: 30 Days

Type of Data: Direct observations– Primary Data
Documentation Compliance– Secondary Data

Sampling Technique: Purposive Sampling

Tool for Data Collection: An instrument

Sample Size: Direct Observations– 30
Documentation Compliance– 210

DATA SOURCE

For practical implementation

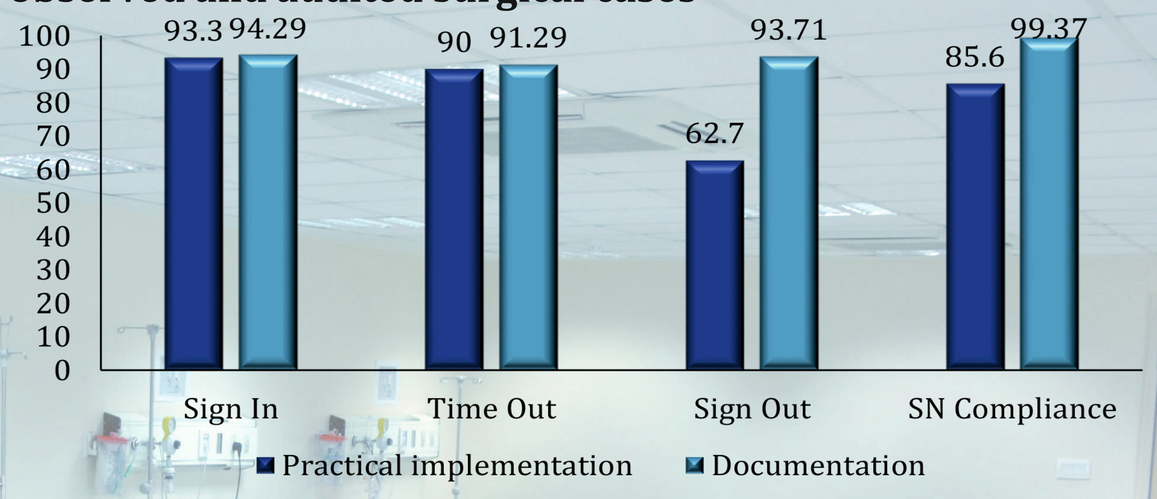
Data were collected by means of non-participant observation in the operation theater for Vascular, ENT and Gynecology surgeries.

For completion and documentation

By auditing the completion and documentation of Surgical Safety Checklist from the active case sheets.

DATA ANALYSIS

Comparison of the Compliance for both directly observed and audited surgical cases



Compliance for each separate provision for direct observation and documentation

Sl. No.	Description	Total Count	Total Compliance	Average	Total Count	Total Compliance	Average
	IP/OP NUMBER						
	CLINICIAN NAME						
	BEFORE INDUCTION OF ANAESTHESIA						
1	Patient confirmed ID, site, procedure, consent	210	208	99	30	30	100
2	Site marked	210	206	98.1	30	24	80
3	Anesthesia machine and medication check complete	210	209	99.5	30	26	86.7
4	Pulse oximetre on patient and function	210	209	99.5	30	30	100
5	Patient have known allergy	210	205	97.6	30	29	96.7
6	Patient have risk of difficult airway and aspiration	210	175	83.3	30	29	96.7
7	Patient have risk if >500 ml blood	210	174	82.9	30	28	93.3
	BEFORE SKIN INCISION	**Sign In**		**94.3**	**Sign In**		**93.3**
1	All members confirm themselves by name and role	210	203	96.7	30	13	43.3
2	Confirm patient's name, procedure and incision site	210	190	90.5	30	29	96.7
3	Antibiotic given within 1 hour	210	204	97.1	30	30	100
4	Anticipated critical events						
	a To surgeon						
	(i) critical or non-routine steps	210	183	87.1	30	29	96.7
	(ii) duration of case	210	200	95.2	30	26	86.7
	(iii) anticipated blood loss	210	200	95.2	30	27	90
	b to anesthetist						
	(i) patient specific concern	210	147	70	30	27	90
	c to nurse						
	(i) sterility is confirmed	210	198	94.3	30	30	100
	(ii) equipment issue or any concern	210	188	89.5	30	30	100
5	Essential imaging displayed	210	204	97.1	30	29	96.7
	BEFORE PATIENT LEAVES O.T	**Time Out**		**91.29**	**Time Out**		**90**
	1 Nurse verbally confirms						
	a procedure name	210	200	95.2	30	17	56.7
	b completion of instruments, sponges, needles	210	193	91.9	30	18	60
	c labeled specimen	210	193	91.9	30	13	43.3
	d any equipment problem	210	193	91.9	30	17	56.7
2	To surgeon, anesthetist and nurse key concern for patient recovery and management	210	205	97.6	30	29	96.7
	SIGNED	**Sign Out**		**93.71**	**Sign Out**		**62.7**
	a Nurse	210	210	100	30	27	90
	b Anesthetist	210	210	100	30	25	83.3
	c Surgeon	210	206	98.1	30	25	83.3
	TOTAL COMPLIANCE = 93.58	**SN Compliance**		**99.37**	**SN Compliance**		**85.6**

If both the above data is compared, it can be seen that the practical implementation compliance for each division is less than the documentation compliance.

The compliance with the surgical safety checklist practical implementation had wide variations i.e. (62.7%- 93.3%) whereas the compliance with the completion and documentation of SSC had narrow variation i.e. (91.29%-99.3%).

CONCLUSIONS

- There were 11 General Anesthesia cases requiring anesthesia team support. Out of 11 cases, there were 6 cases which lacked the cooperation from the anesthesia team
- Only 36.6% of observations reported active participation by physicians i.e. 11 cases
- Only 23.3% of observations reported that "the majority did not pay attention" i.e. 7 out of 30 cases which includes all the members of surgical team, anesthesia team and the circulating nurse.
- Only 26.6% of the total observations reported that the team was "just going through the motions" i.e. 8 out of 30 cases.
- For the documentation compliance, out of 210 audited surgical case files, 63 case files missed the section for patient specific concern with local anesthesia cases (30 %), although the provision for "Not Applicable" has to be marked.

RECOMMENDATIONS

- Recommendations included continuing education, time for pilot-testing, and engaging all staff in Surgical Safety Checklist review.
- Supplementary training and attention to actual checklist used to improve communication.
- Conducting regular audit of checklist utilization is also recommended.

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