

Project Report on Documentation Compliance of Operation Theater Checklist

By

Sandeep Verma

*Dissertation submitted in partial fulfillment of the requirements of the degree
MBA Hospital and Health Management*

Academic year, 2018-2020



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CERTIFICATE FROM GUIDE AND DEAN
ACADEMIC AND STUDENT AFFAIRS

TO WHOMSOEVER MAY CONCERN

This is to certify that **MR SANDEEP VERMA**, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **MAHATMA GANDHI UNIVERSITY OF MEDICAL SCIENCE & TECHNOLOGY**, Sitapura Jaipur from **February 03,2020 to May 30, 2020.**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish his all success in all his future endeavours

Dr.P.R.Sodani
Dean, Institute of Health Management

Research

The IIHMR University, Jaipur

Dr.Anoop Khanna

The IIHMRUniversity, Jaipur

CERTIFICATE FROM THE ORGANISATION

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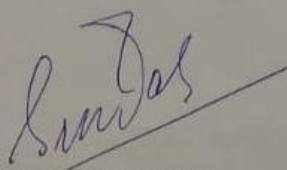
DISSERTATION COMPLETION LETTER

This is to certify that **Mr. Sandeep Verma**, Student of **MBA Hospital and Healthcare Administration** from **IIHMR University, Jaipur** has successfully completed his **Dissertation** with Mahatma Gandhi University of Medical Sciences & Technology, Jaipur from **03rd February 2020 to 03rd May 2020** in following project :

1. Audit documentation compliance on Operation Theatre Checklist.

During this period he exhibited good skills with self-motivated attitude to learn new things. His approach to project was sincere and proactive.

I wish his success in all his future endeavors.



Mr. Sukanta Kumar Das
Chief Operating Officer
Mahatma Gandhi Medical College & Hospital

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Chief Operating Officer
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ABSTRACT

DOCUMENTATION COMPLIANCE OF OPERATION THEATER CHECKLIST

Author: Sandeep Verma

Background

Audit to assess the compliance of documentation of operation theatre and improve the process of proper documentation in the simplest terms, audit of operation theatre files is a chart review which is used to identify what is being done correctly and what needs improvement.

Documentation is a communication tool exchange of information stored between nurses and caregivers as well for the patient safety. Quality documentation promotes structured, consistent and effective communication between caregivers and facilitates continuity and individuality of care and safety of patients. This study aims to audit the operation theatre file compliance & investigate the knowledge, attitude & practices regarding documentation.

Methodology

To check the compliance rate in operation theatre documentation files a standard checklist was used to find the compliance and non compliance of the study was carried out using structured closed ended questionnaire from 3th February 2019 to 3rd May 2019. Data was analyzed using excel sheet.

80 Files were taken each from the operation theatre to audit the compliance of operation theatre documentation. Among most of parameter 100% compliance rate was found in documentation and some of the parameters found non-compliance rate of 0% with the documentation of OT

Results

A total number of file is 80 in the study. The respondents were doctors and nurse. Respondents in the study had sufficient knowledge in the documentation

Conclusion

The study to audit the compliance of operation theatre documentation concluded that compliance rate is relatively very high in some parameters and particularly in some specified categories. The Doctor and nurse appeared to be familiar with the required documentation knowledge, but still there are certain areas which we need to work on like making the documentation immediately and the files to be FACT a requirement rather than formality

Key Words

Documentation, Compliance, operation theatre document

ACKNOWLEDGEMENT

I am exceptionally thankful to all the professionals at Mahatma Gandhi University of Medical Science & Technology Sitapura Jaipur for sharing generously their knowledge and precious time. I owe a great debt to Mr.Sukanta Kumar Das (Chief Operations Officer) and Ms. Seema Ahuja (Head-Quality & Medical Services) for sharing their valuable views in spite of their busy schedule. It has been my privilege to work under their dynamic supervision in the hospital.

I would like to thank Mrs. Deepati Bansali (Manager, Human Resources) for the opportunity to do my dissertation in such a reputed organization.

I would also like to grab the opportunity to thank Dr. Durga Jetwa (Chairman-Critical Care and Anaesthesiology), for continuously sharing their knowledge and expertise, as my learning would have not been possible without their support.

I am highly grateful to all the departmental heads and staff for giving me time and have helped in learning the process. Without their active cooperation and participation of MGUMST TEAM it would not have been possible to obtain in depth knowledge about quality aspects of the Hospital.

Most importantly I would like to thank my college guide Dr. Anoop Khanna (Associate Professor) for guiding and supporting me on my given project work and FACULTY OF IIHMR UNIVERSITY JAIPUR for providing facilities for my study.

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LIST OF ABBREVIATIONS

ICU	Intensive Care Unit
e-HIS	Hospital information System
IPD	In Patient Department
TPA	Third Party Administration
MT	Medical Transcriptionist
GDA	General Duty Assistant
TPTs	Transfer Patient Team
UHID	Unique Identification Number
SOP	Standard Operating Procedures
CPR	Coronary Pulmonary Resuscitation
TL	Team Leader

INTRODUCTION TO THE TOPIC

One of the most difficult areas to prepare for accreditation is Operation Theater It's a complex department where multiple critical functions happen and many categories of staff are involved. Besides, infrastructure of OT is also very important for accreditation preparation. Based upon commonly observed things during NABH assessments and standards & objective elements under different chapters, here is a checklist that can be used for preparing OT for accreditation.

The checklist could divert attention away from the patient

Participants thought most patients regarded using the checklist as a safeguard or did not notice its use at all. However, there was concern that some patients might become anxious when the checklist was consulted, and that patients who were nervous or needed close attention might feel left alone on the operating table while the health care personnel concentrated on the checklist. One participant speculated that stressed patients might think

To reduce these problems, participants reported that they avoided turning their backs to the patient when reading the checklist. Furthermore, when patients needed special attention, the participants conducted much of the checklist before the patient arrived some participants said they informed patients of the checklist in advance. One nurse told patients that a checklist would be used in the same way that pilots use them before takeoff. Participants emphasized that they believed that most patients would have a positive experience with the checklist when the focus on the patient was not compromised.

The checklist influenced workflow and doctor-nurse cooperation

Nurses found that introduction of the checklist interrupted their streamlined pre-induction workflow and caused stress to both the patients and themselves, especially when the physician rushed into the OR and immediately started reading the checklist. The checklist was also said to cause redundant checks by the nurse and the physician. Those problems were reported to occur initially, but diminished over time, as physicians and nurses became accustomed to the checklist and managed to integrate it into their normal working routine. It was also a common experience that the workflow went more smoothly after the involved personnel were able to decide how the checklist should be read

The checklist was also perceived to ease doctor-nurse cooperation. One resident said that it felt unpleasant to ask the nurses for additional equipment, but that he no longer had to argue for it after the checklist was implemented

Senior consultants were both sceptical and supportive

According to some participant a few experienced consultants were skeptical towards the checklist and might have thought one nurse indicated that the checklist was ridiculed and made some consultants in other sections several participants emphasized that the

head physician's support and motivation were crucial for implementing the checklist. Residents said it would have been very hard to implement the checklist if their chief had had a negative attitude.

The checklist improved confidence in unfamiliar contexts

Participants valued the equipment control and communication routines achieved in the study. To improve confidence in those situations, several participants had used the checklist outside of their departments. One resident indicated that he always had the checklist in mind outside the OR. It was suggested that the checklist should be adapted to situations other than those for which it was intended.

The checklist revealed insufficient equipment standardisation

Some participants complained about the differences in both the type and location of equipment among the various As a result, redundant equipment might accumulate in an OR. Participants indicated that using the checklist had highlighted the need for improving equipment standardization and led to

Surgical safety checklist

compliance can be viewed, along with all Ontario hospitals, on the Health Quality Patient safety remains the most important priority for Quintet Health Care and this includes ensuring a safe experience for patients who undergo surgery here. One tool used to ensure a positive patient experience is a surgical safety checklist. Beginning July 30, 2010, all Ontario hospitals with operating rooms are required to publicly report on their surgical safety checklist compliance. This indicator is the most recent addition to the Ontario Government's public reporting regime Ontario website.

Compliance is calculated by the number of times all three phases of the surgical safety checklist were completed, as a percentage of the total number of surgeries performed. The surgical safety checklist is considered "performed" when the surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases: Sing In; Time Out; and Sing Out.

What is a surgical safety checklist?

A surgical safety checklist is a patient safety communication tool that is used by a team of operating room professionals (nurses, surgeons, anaesthesiologists, and others) to discuss important details about each surgical case.

In many ways, the surgical checklist is similar to an airline pilot's checklist used just before take-off. It is a final check prior to surgery used to make sure everyone knows the important medical information they need to know about the patient, all equipment is available and in working order, and everyone is ready to proceed.

What information is included in a surgical safety checklist?

Some examples of items contained in the checklist:

The Pre-Procedure Phase:

- Verify with patient name and procedure to be done
- Allergy check
- Medications check
- Operation site, side and procedure
- Lab tests, x-rays

The "Time Out" Phase:

- Patient position
- Operation site and side and procedure
- Antibiotics check

- **The Sing Out Phase:**

- Surgeon reviews important items
- Anaesthesiologist reviews important items
- Nurse reviews correct counts

REVIEW OF LITERATURE

A thorough literature review reveal focusing on prior researches related to the topic of the study which gives a strong foundation on to base knowledge thus the survey of literature is one of the vital parts of any research endeavour.'

'As proposed by , Haugen AS, Sevdalis N Søfteland E

From the Department of Anaesthesia and Intensive Care, Haukeland University Hospital, Bergen, Norway (A.S.H., E.S.) the Centre for Implementation Science, Health Service and Population Research Department, King's College London, United Kingdom (N.S.) the Institute of Clinical Medicine, Faculty of Medicine, University of Bergen, Bergen, Norway (E.S.).

The incidence of surgical complications has remained largely unchanged over the past two decades. Inherent complexity in surgery, new technology possibilities, increasing age and co morbidity in patients may contribute to this. Surgical safety checklists may be used assume of the tools to prevent such complications. Use of checklists may reduce critical workload by eliminating issues that are already controlled for. The global introduction of the World Health Organization Surgical Safety Checklist aimed to improve safety in both anaesthesia and surgery and to reduce complications and mortality by better teamwork, communication, and consistency of care. This review describes a literature synthesis on advantages and disadvantages in use of surgical safety checklists emphasizing checklist development, implementation, and possible clinical effects and using a theoretical framework for quality of provided healthcare (structure-process-outcome) to understand the checklists' possible impact on patient safety.

Schwendimann R^{1,2}, Blatter C², Lüthy M³, Mohr G¹, Girard T³, Batzer S³, Davis E¹, Hoffmann H⁴.Author information

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BACKGROUND

The World Health Organization (WHO) Surgical Safety Checklist is used globally to ensure patient safety during surgery. Two years after its implementation in the University Hospital Basel's operating rooms, adherence to the protocol was evaluated.

METHODS

This mixed method observational study took place in the surgical department of the University Hospital of Basel, Switzerland from April to August 2017. Data collection was via individual structured interviews with selected OR team members regarding checklist adherence and on-site non-participant observations of Team Time Out and Team Sign Out sequences in the OR. Data were subjected to thematic analysis and descriptive statistics compiled.

RESULTS

Comprehensive local expert interviews indicated that individual, procedural and contextual variables influenced the application of the checklist. Facilitating factors included well-informed specialists who advocated the use of the Checklist, as well as teams focused on the checklist's intended process and on its content. In contrast, factors such as staff insecurity, a generally negative attitude towards the checklist, a lack of teamwork, and hesitance to complete the checklist, hindered its implementation. The checklist's application was evaluated in 104 on-site observations comprising of 72 Team Time Out (TTO) and 32 Team Sign Out (TSO) sections. Adherence to the protocol ranged between 96 and 100% in TTO and 22% in TSO respectively. Lack of implementation of the TSO was mainly due to the absence of one of the key OR team members, who were busy with other tasks or no longer present in the operating room.

CONCLUSION:

The study illustrates factors, which foster and hinder consistent application of the WHO surgical safety checklist namely individual, procedural and contextual. It also demonstrates that the TTO was consistently and correctly applied, while the unavailability of key OR team members at sign-out time were the most common reason for omission or incomplete use of the TSO.

KEYWORDS:

Adherence; Short report; Surgical checklist; Team sign out; Team time out

Susan P. Wittren, MSN, RN, Nurse Manager, Instructor of Nursing, Department of Nursing, Mayo Clinic, Rochester, Minnesota. Stephanie R. Cunningham Gregor, APRN, CNP, CNS, Instructor of Nursing, Division of Vascular and Endovascular

Surgery, Mayo Clinic, Rochester, Minnesota. Cynthia R. Niesen, DNP, MA, RN, NEA-BC, Director of Nursing, Assistant Professor of Nursing, Department of Nursing, Mayo Clinic Health System - Franciscan Healthcare, La Crosse, Wisconsin

Cunningham Gregor SR, Niesen CR.

Providing safe patient care is an important focus of healthcare organizations. In surgical settings, mortality rates have been shown to decrease from 1.5% to 0.8% and complication rates from 11% to 7% when institutions use the World Health Organization's Surgical safety checklist. In our hospital-based gastrointestinal endoscopy unit, we recognized that inconsistencies in the pre procedural readiness of patients were causing inefficiencies in scheduling. Therefore, we initiated a quality improvement project to determine whether a pre procedural checklist and positive reinforcement for the nurses in the units could improve endoscopy preparation of patients. The checklist was used to prepare patients and to facilitate nurse-to-nurse communications. We completed a 6-week pilot study (preintervention and postintervention). The results demonstrated the importance of having nurses use a checklist in hospital care units to adequately prepare patients and to accurately communicate patient readiness before gastrointestinal endoscopy procedures. Nursing leadership used positive reinforcement as a strategy to encourage the use of the preprocedural checklist. A postpilot survey of nurses involved in the study showed that the preprocedural checklist enhanced care and communication between the patient care units and resulted in direct and indirect benefits for nurses and patients.

James Todd

Audit of compliance with WHO surgical safety checklist and building a shared mental model in the operating theatre

The use of the checklist has been shown to reduce patient death and postoperative complications and is mandated for use with all National Health Service (NHS) surgery. The aim was to obtain quantitative and qualitative data on compliance with WHO surgical safety checklist during operations in an NHS hospital. Method Data collection was by prospective observational audit of 34 operations using WHO checklist and 5 qualitative criteria to establish efficacy of use: (a) Staff stopped tasks to engage; (b) Staff attentive and listening; (c) Audible to all team; (d) Understanding was checked in briefs and questions/feedback asked; (e) All required staff present. Categorisation: grade 3 (all criteria), grade 2 (three to four of criteria), grade 1 (one to two of criteria). Checklist use was recorded by stage use (eg, Sign In) and component steps. Results Checklist stages used were Brief (7/8), Sign In (32/34), Time Out (30/34), Sign Out (18/34) and Debrief (2/8). Checklist component steps were completed more fully in major versus minor operations (17.3/28 vs 8.4/28). Mean qualitative grade was greatest in major surgeries (2.2 vs 1.6) and using general anaesthesia (1.8 vs 1.3). 3/34 of operations achieved Grade 3. Conclusion Sign Out and Debrief compliance was low, as was full compliance with component steps of the WHO checklist, especially during minor operations. A focused checklist specific for minor operations could be introduced to remove unnecessary steps and mitigate against excessive omission. Improved qualitative use of the checklist is required to maximise effectiveness and facilitate a shared mental model.

Gerald Sendlhofer, Nina Mosbacher,Leitgeb Karina,Brigitte Kober,Lydia Jantscher et al. Implementation of a Surgical Safety Checklist: Interventions to Optimize the Process and Hints to Increase Compliance. PLOS ONE 10(4): e0123726

The purpose of the study was to analyze compliance, knowledge of and satisfaction with the SSC to determine further improvements. The implementation of the SSC was observed in a pilot unit. After roll-out into each operating theater, compliance with the SSC was routinely measured. To assess subjective and objective knowledge, as well as satisfaction with the SSC implementation, an online survey (N = 891) was performed. During two test runs in a piloting unit, 305 operations were observed, 175 in test run 1 and 130 in test run 2. The SSC was used in 77.1% of all operations in test run 1 and in 99.2% in test run 2. Within used SSCs, completion rates were 36.3% in test run 1 and 1.6% in test run 2. After roll-out, three unannounced audits took place and showed that the SSC was used in 95.3%, 91.9% and 89.9%. Within used SSCs, completion rates decreased from 81.7% to 60.6% and 53.2%. In 2014, 164 (18.4%) operating team members responded to the online survey, 160 of which were included in the analysis. 146 (91.3%) consultants and nursing staff reported to use the SSC regularly in daily routine. It was concluded that these data show that the implementation of new tools such as the adapted WHO SSC needs constant supervision and instruction until it

becomes self-evident and accepted. Further efforts, consisting mainly of hands-on leadership and training are necessary.

METHODOLOGY

➤ **AIM:**

The aim is to study, analyse and improve the documentation system in operation theatre and reduce the non compliance rate in ot checklist and improve the quality of work in the OT for the patient safety

➤ **RATIONALE:**

Due to increase in number of complaints regarding the documentation in operation theatre and incompleteness of document of operation procedure

➤ **OBJECTIVES:**

Towards assess the compliance rate of documentation in Operation theatre and to measure the appropriateness and completeness of the checklist in Operation theatre of the hospital and giving recommendations for further improvement for the safety in hospital environment.

➤ **STUDY DESIGN:**

The type of study performed in Mahatma Gandhi Hospital was observed. Firstly, the study was based on observation the compliance of Operation Theatre checklist through NABH standards. Secondly after the observation of Operation Theatres checklist questionnaire was formulated for 80 patients to improve the compliance

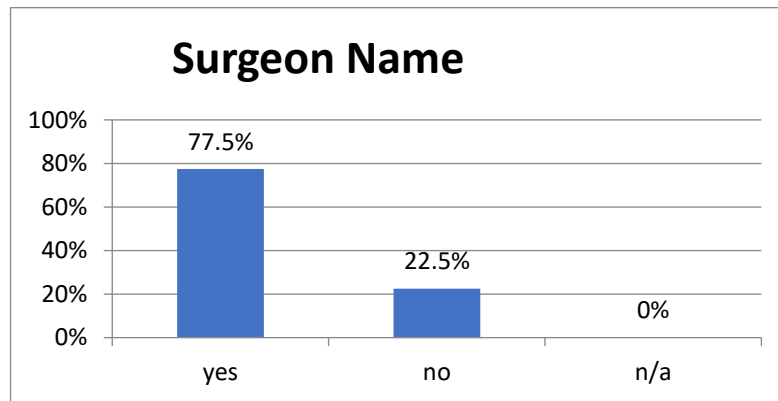
➤ **DATA COLLECTION**

- Primary data: Direct Observation, survey in the form of checklist
- Data tool- Operation Theatres checklist of the hospital
- Data Analysis- Ms excel
- Sampling – Convenient
- Sample Size- 80

Observation

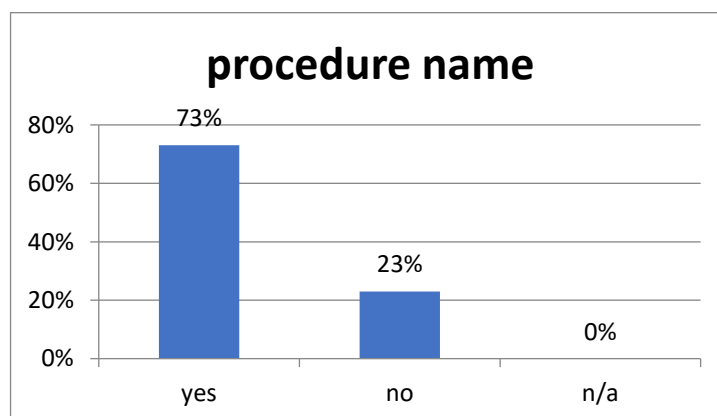
Documentation Compliance of operation theatre checklist

Surgeon name



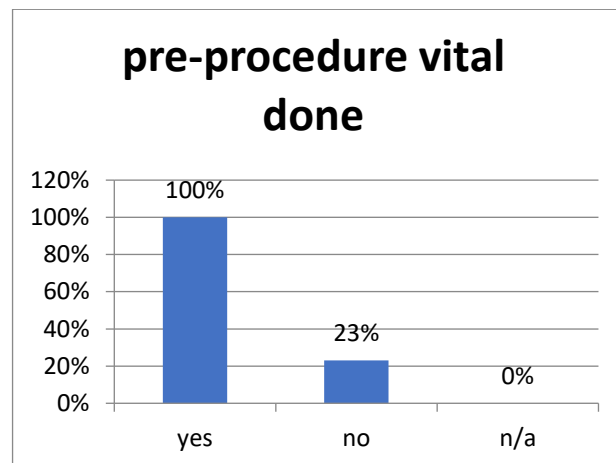
INTERPRETATION: Highest compliance rate of surgeon name is 77.5% and 22.5% files were non compliance rate in documentation out of 80 files

Procedure name



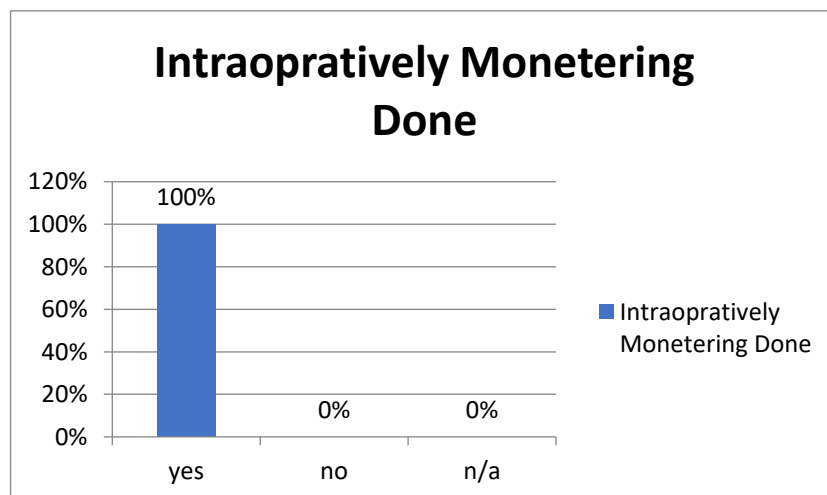
INTERPRETATION: 73% files were found to be compliance and 23% files which were non-compliance with procedure name out of 80 files

Pre procedure vital done



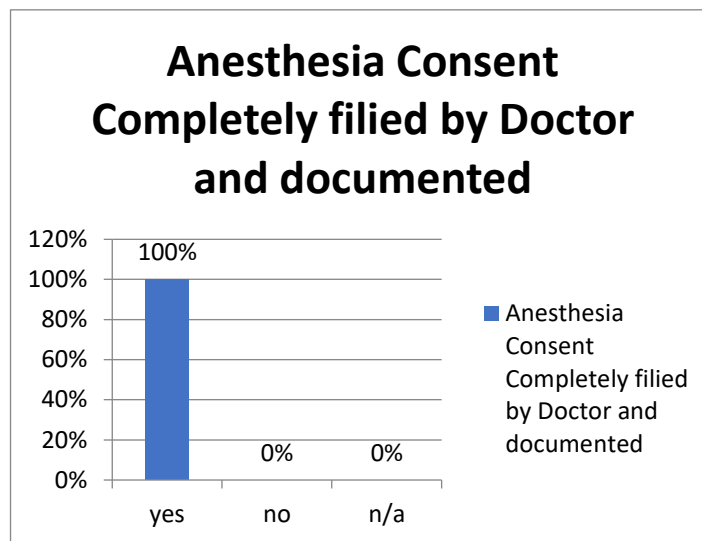
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance with pre-procedure vital out of 80 files

Intraoperatively Monitoring Done



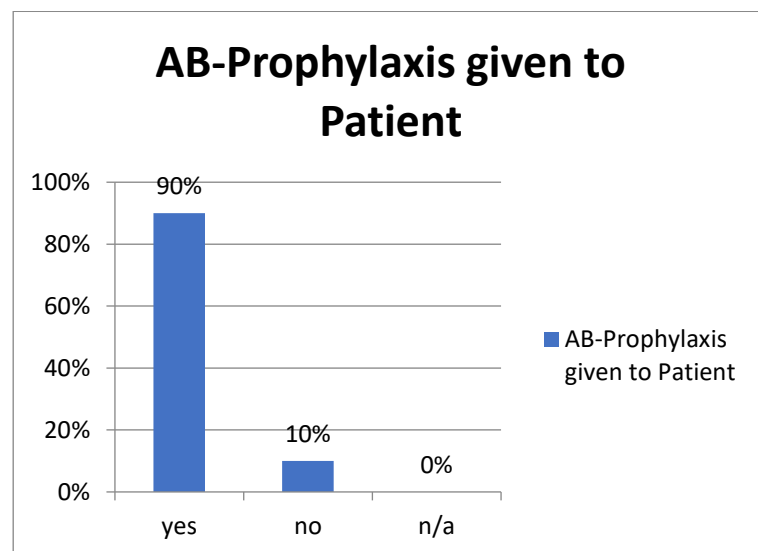
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance in checklist of intra operatively monetering out of 80 files

Anesthesia Consent Completely filed by Doctor and documented



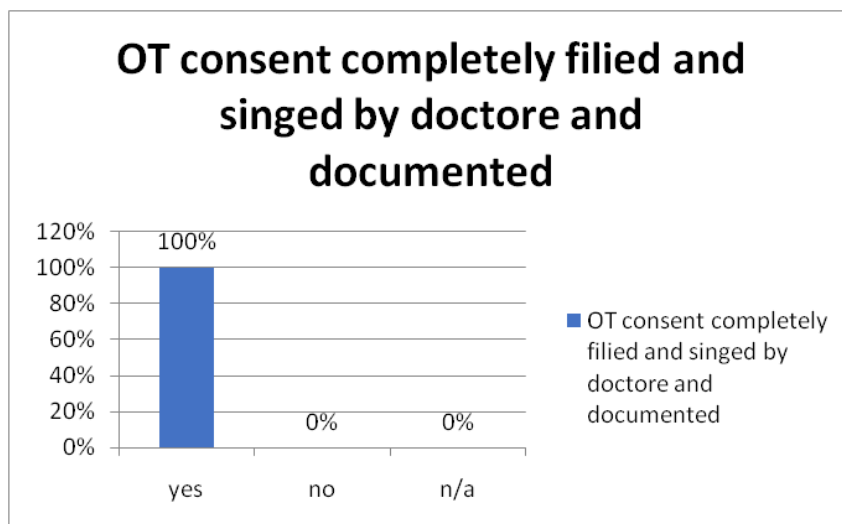
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance in checklist of anaesthesia consent completely filed by doctor and documented out of 80 files

AB-Propylaxis given to Patient



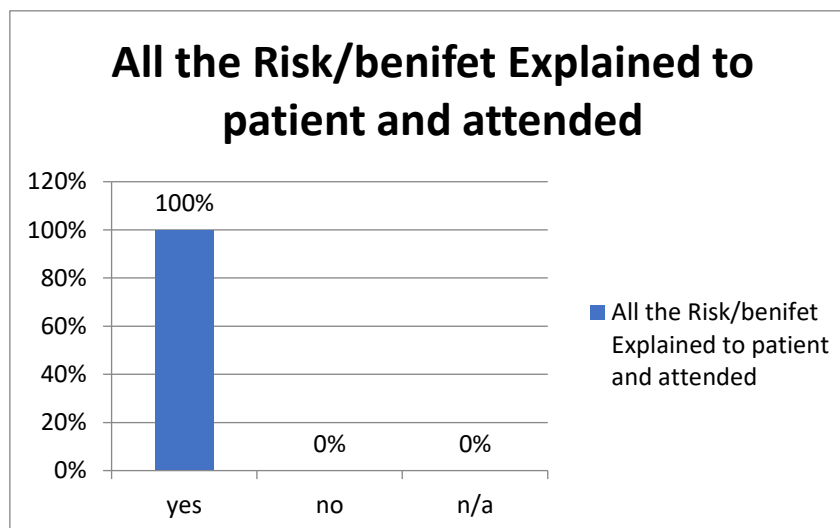
INTERPRETATION: 90% files were found to be compliance and 10% file were found with non-compliance in checklist of AB-propylaxis given to patient out of 80 files

OT consent completely filed and signed by doctor and documented



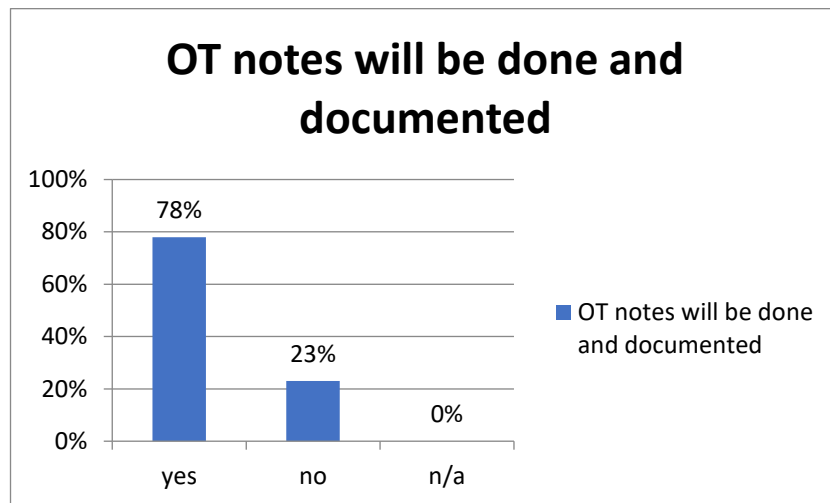
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance in checklist of OT consent completely filed and signed by doctor and documented out of 80 files

All the Risk/benefit Explained to patient and attended



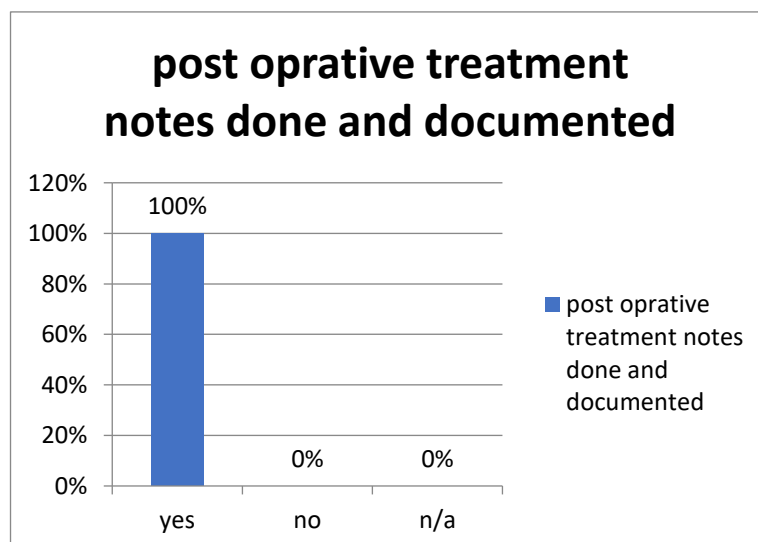
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance in checklist of all risk / benefit explained to patient and attended out of 80 files

OT notes will be done and documented



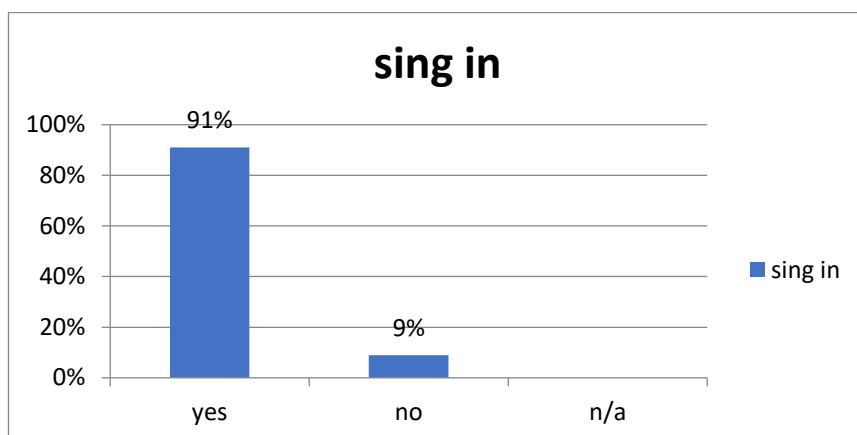
INTERPRETATION: 78% files were found to be compliance and 23% file were found with non-compliance in checklist of OT notes will be done and documented out of 80 files

Post operative treatment notes done and documented



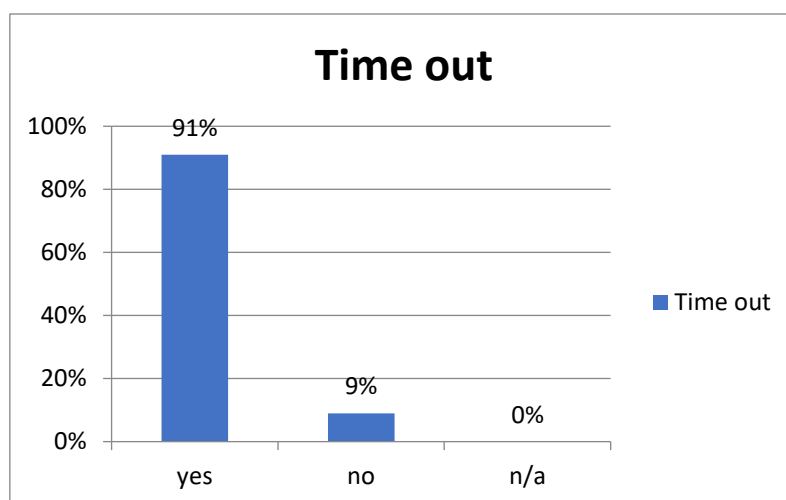
INTERPRETATION: 100% files were found to be compliance and no one file were found with non-compliance in checklist of post operative treatment notes done and documented out of 80 files

Sing In



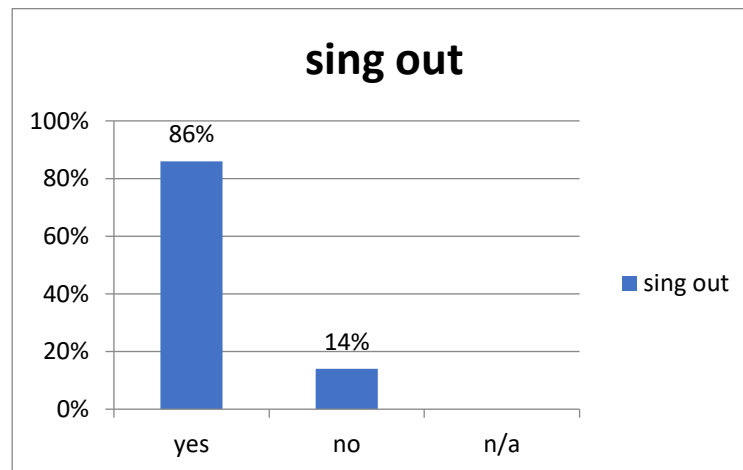
INTERPRETATION: 91% files were found to be compliance and 9% file were found with non-compliance in checklist of sing in of 80 files

Time-out



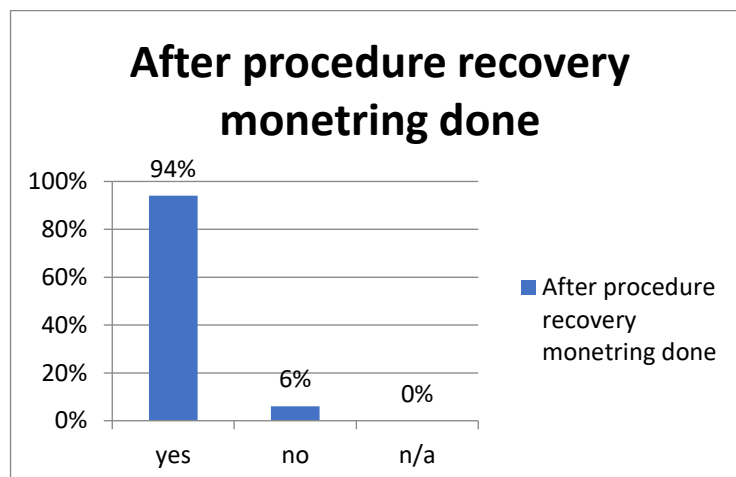
INTERPRETATION: 91% files were found to be compliance and 9% file were found with non-compliance in checklist of Tim-out of 80 files

Sing-Out



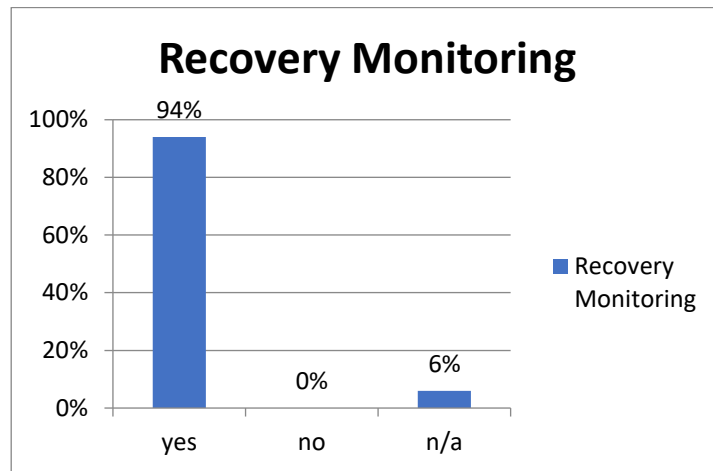
INTERPRETATION: 86% files were found to be compliance and 14% file were found with non-compliance in checklist of Sing-out of 80 files

After procedure recovery monitoring done



INTERPRETATION: 94% files were found to be compliance and 6% file were found with non-compliance checklist of After procedure recovery monitoring out of 80 files

Recovery Monitoring



INTERPRETATION: 94% files were found to be compliance and 0% file were found with non-compliance and 6%files were found with n/a because patient directly transferred to icu from ot room checklist of recovery monitoring out of 80 file.

Discussion

Data regarding compliance is essential when interpreting any impacts observed, as those with a higher compliance are more likely to be demonstrating a true impact as the checklist is properly implemented, whereas impacts observed in studies with low compliance could actually be the result of other factors. Compliance rates between studies showed extreme variation, 0-100% in one study alone (Fourcade et al 2012). This was largely due to the varying definitions of what was deemed compliance. Interestingly, Pickering et al (2013) reported that whilst their compliance data showed one level of compliance, administrative audits carried out at the same institutes while their study was ongoing reported much higher levels of compliance of more than 95% in all cases, compared to their findings of 38.5% which is similar to the findings made by Levy et al (2012). This once again demonstrates varying levels but also highlights the differing ways in which compliance is being defined and measured, even within the same institute. It also illustrates the growing concern that the checklist is becoming a 'tick box' exercise rather than fulfilling its purpose. This could actually endanger patient safety by introducing complacency and a false sense of security.

Teamwork is a complex area relating to communication, team dynamics, work culture, attitudes of staff, and staffs' perceptions of these. Examining this theme was complicated as a result of this and also because not only does the checklist have an impact upon aspects of teamwork, but it itself impacts on use of the checklist, and the extent at which other impacts are observed. However, overall, the evidence from the literature indicates that there is both an observed, and a perceived improvement in communication and teamwork (Russ et al 2013, Lyons & Popejoy 2014). This is through the checklist working as a prompt for key communication events to take place and subsequently enhances teamwork through a shared awareness of the patient and their treatment demonstrating the positive impact that the checklist aimed to achieve (Rydenfält et al 2013)

However, some interesting negative impacts also arose from these studies. Firstly the use of the checklist appears to have generated some confusion over who in the team is ultimately accountable for items on the checklist, the person who is responsible for answering the question, or the person who signs to say that the check took place. This is a particular problem when scepticism and resistance exist between staff members who then do not participate fully in the checklist, leading to mistakes (Fourcade et al 2012).

The sign out stage of the checklist seems to be an area of concern, with the impact of timing resulting in an impact on compliance. This conclusion has been noted by others (Hannam et al 2013) and is also demonstrated by a recent observational study by Russ et al (2015b). This can be explained by it occurring at a critical time of high workload for anaesthetists and circulating staff making it difficult to pause at this point to complete the checklist. This negative impact indicates an incompatibility with standard theatre practices (Russ et al 2015b) and so therefore needs reviewing in terms of when exactly it is best to complete this stage of the checklist. Current recommendations are that sign out takes place before the surgeon leaves and can coincide with wound closure

(WHO 2009) yet answers to some items are not known at this stage (Russ et al 2015b), for example, final swab and instrument counts, and concerns for recovery which from an anaesthetic viewpoint may not arise until extubation. However, if left until after closing, the surgeon is often no longer present as demonstrated by Russ et al (2015b) and circulating staff may also be absent clearing away equipment or setting up for the following case. These design and timing issues demonstrate the need to periodically review and evaluate the checklist and its use (Putnam et al 2014) as well as the need to educate and instil the value of the checklist as a safety tool amongst staff.

Suggestion

- **Proper documantion should be nessecry**
- **All the component should be filed by doctor and nurse**
- **Every month aduit should be do done**
- **Provied class for the staff any quality changes and improvements**
- **For the patient safety all the documentation is nessecery**
- **SSC is also compulsory for the patient safety it should be nessery to follow**
- **Proper monetraing is also required**

CONCLUSION

The study to audit the OT file compliance of OT documentation concluded that compliance rate is relatively very high in some parameters. And in some of the parameters 0% non-compliance. Proper patient identity card helps to reduce redundant patient records, improve accuracy for patient recognition and enhance organization's branding. Non-compliance in the files of OT checklist in some of parameters non-compliance in documentation very low but primarily since it plays a significant role in documentation.

Although efforts are being made to improve OT documentation for the medical record and patient safety. These are not sufficient, and more attempts are needed. All the surgeon and nurses appeared to be familiar with the required documentation knowledge, but still there are certain areas which we need to work on like making the documentation immediately and the files to be FACT a requirement rather than formality