HARVARD
School of Public Health

Tool 4: Surgical Safety Checklist Observation Instructions

This tool collects information intended to improve Surgical Safety Checklist implementation and surgical outcomes. Below are a few notes to help you use the tool.

Observer information:
This tool should be completed by the circulating nurse participating in the case being observed.

- This tool should be used in cases that last longer than one hour. It should be completed for the same cases as the Surgical Teamwork Observation Tool. Someone designated to coordinate this monitoring effort at your hospital should indicate which cases you should observe.
- The checklist observer should be present for the duration of the surgical case being observed and may complete the tool during the observation or immediately following the case.
- The Surgical Safety Checklist Observation Tool should be completed for the same cases as the Surgical Teamwork Observation Tool.
- Following the case, please give the completed observation tool to the person coordinating the monitoring effort.

General instructions:
- Please fill in the bubble (O) or box (□) that corresponds to your choice.
- If you make a mistake, ~~strike through~~ your error and fill in the correct choice.
- Please include comments or additional information on the back of the tool, if desired.

In the upper right-hand corner:
- Write the date the observation was performed.
- Write the name of your hospital.

In the Procedure and Observer Information boxes:
- Record each item requested.
- "Significant nonclinical disruptions" include interruptions that are not directly related to the procedure that disturb or distract from the progress of the operation (e.g., urgent pages requiring the surgeon's attention, scheduling, or other external concerns that demand surgical team members' attention).
- Case delays greater than 30 minutes from the scheduled start time should also be recorded.

Processes of Care:
- For each of the three processes, record whether the action was taken or not.
- By "Yes, w/o prompting", we mean that the action was taken (or discussed) <u>before</u> the Checklist was initiated.
- By "Yes, prompted by Checklist", we mean that the action was taken (or discussed) <u>after</u> the Checklist was initiated.
- If an item did not apply to the procedure (e.g., warmer NOT required for a case expected to last less than 1 hour), please mark "N/A".

Briefing:
- Check boxes (□) to indicate which individuals participated in confirming the patient's identity, procedure <u>or</u> operative site before incision.
- For Questions 6-10, which begin with the words "Before incision", fill in "Yes" or "No" to indicate whether each aspect of the procedure was discussed. For example, if the surgeon discussed details of the operation (i.e., anything more than the name of the procedure), fill in "Yes" for question 6. If the nurse is given an opportunity to discuss sterility, equipment or other concerns but has none, the appropriate response for question 9 would also be "Yes".

- For Question 11, fill in "Yes" or "No" to indicate whether the checklist was read directly from a poster, paper or electronic document without reliance on memory. All surgical teams (including those with extensive experience) are expected to read the checklist aloud prior to every surgical procedure.

Debriefing:
- As in the briefing, any discussion should prompt a "Yes" response. Discussions may be as simple as stating that there are no corresponding concerns.

Buy-In:
- For question 15, check boxes (□) to indicate which individuals actively participated in discussing Checklist items.
- For question 16-19, rate Checklist buy-in on a scale from 1 to 5. One represents "POOR" buy-in and 5 represents "EXCELLENT" buy-in. Examples of poor, neither excellent nor poor, and excellent buy-in are provided. Rate buy-in on the part of each member of the surgical team: circulating nurse, anesthesia provider (anesthesiologist or CRNA, whichever is present during the checklist), surgeon, and surgical tech. If multiple providers in the same role are present (e.g., multiple surgeons), rate the buy-in of the primary person in that role.

Additional Data:
- Fill in the bubble that corresponds to your answer for each question.
- "EBL NS" means expected blood loss was not significant.
- Question 25 asks whether the need for antibiotic re-dosing was **discussed** for operations whose expected duration is greater than 2 hours, not whether antibiotics were re-administered within 2 hours. "N/A (<2h)", means that the question is not applicable because the expected case duration was less than 2 hours.

Tool 4: Surgical Safety Checklist Coaching Tool

Date of procedure:_____/_____/_____

Hospital name:_____

Procedure Information

Patient age: _____   Time of incision: ___:___ AM / PM   Urgent/emergent case (requiring same-day completion): ○ Yes   ○ No

Patient gender: ○ M   ○ F   Surgical end time: ___:___ AM / PM   Significant nonclinical disruptions: ○ Yes   ○ No

Surgeon's specialty: _____   Case delayed >30min: ○ Yes   ○ No

Procedure performed: _____   Patient disposition: ○ Inpatient   ○ Outpatient

Observer Information

Observer age: _____   Observer gender: ○ M   ○ F   Observer role: ○ Circulating Nurse   ○ Other: _____

Years in current role at this hospital: ____

Processes of Care

1. Was an antibiotic given within 1 hour of incision?	○ Yes, w/o prompting	○ Yes, prompted by checklist	○ No	○ N/A
2. Were compression boots placed (mechanical DVT prophylaxis)?	○ Yes, w/o prompting	○ Yes, prompted by checklist	○ No	○ N/A
3. Was a warmer placed (for case >1 hour)?	○ Yes, w/o prompting	○ Yes, prompted by checklist	○ No	○ N/A

Briefing

4. Which of the following individuals participated in confirming the patient's identity, procedure **or** operative site before incision? (Mark all that apply.)

☐ Circulating nurse   ☐ Anesthesia provider   ☐ Surgeon   ☐ Surgical tech   ☐ Not confirmed

5. Did team members introduce themselves by name and role (e.g., "Lynn, the anesthesiologist.")?	○ Yes	○ No
5a. **If no**, was this team established (i.e., introductions performed earlier the same day)?	○ Yes	○ No
6. Before incision, did the surgeon discuss the operative plan?	○ Yes	○ No
7. Before incision, did the surgeon state the expected duration of the procedure?	○ Yes	○ No
8. Before incision, did the surgeon communicate the expected blood loss (EBL)?	○ Yes	○ No
9. Before incision, did the nurse discuss sterility, equipment, or any other concerns?	○ Yes	○ No
10. Before incision, did the anesthesia provider discuss the anesthesia plan (including airway or other concerns)?	○ Yes	○ No
11. Were all checklist items read aloud, without reliance on memory?	○ Yes	○ No

Debriefing

12. Before the patient left the OR, did the team discuss specimen labeling (e.g., labels / patient name read aloud)?	○ Yes	○ No
13. Before the patient left the OR, did the team discuss equipment or other problems that arose?	○ Yes	○ No
14. Before the patient left the OR, did the team discuss key concerns for patient recovery and post-op management?	○ Yes	○ No

Buy-in

15. Which of the following individuals actively participated in discussing checklist items? (Mark all that apply.)

☐ Circulating Nurse   ☐ Anesthesia provider   ☐ Surgeon   ☐ Surgical tech

For questions 16-19, rate checklist buy-in using the descriptions below. "1" represents poor buy-in; "5" represents excellent buy-in.

Poor: This team member continued other activities or conversation and exhibited poor buy-in while the checklist was performed (e.g., by not participating, speed-reading, or rolling eyes).

Neither poor nor excellent: This team member generally stopped other activities or conversation and participated, but did not appear interested, while the checklist was performed.

Excellent: This team member stopped all other activities and conversation, participated and appeared interested while the checklist was performed.

	Poor		Neither poor nor excellent		Excellent
16. Please rate the **circulating nurse's** buy-in.	①	②	③	④	⑤
17. Please rate the **anesthesia provider's** buy-in.	①	②	③	④	⑤
18. Please rate the **surgeon's** buy-in.	①	②	③	④	⑤
19. Please rate the **surgical tech's** buy-in.	①	②	③	④	⑤

Additional Data

20. Did the circulating nurse leave the OR **repeatedly** to find instruments or equipment?		○ Yes	○ No
21. Were instruments and equipment available and functioning throughout the case? **If no**, please describe difficulties on the back of this form.		○ Yes	○ No
22. Was a potential error or omission averted by the checklist? **If yes**, please describe the event on the back of this form.		○ Yes	○ No
23. If there is significant EBL, was a type and cross sent or blood products available?	○ N/A (EBL NS)	○ Yes	○ No
24. If there is significant EBL, was adequate IV access discussed and obtained?	○ N/A (EBL NS)	○ Yes	○ No
25. If expected duration of operation >2 hours, was the need for antibiotic re-dosing discussed?	○ N/A (< 2h)	○ Yes	○ No

■ Please use the back of this form to provide further comments. ■