



**Background of Each Item On the
South Carolina Surgical Safety Checklist Template**

Document Overview

This document summarizes why each item is included on the South Carolina Surgical Safety Checklist Template and where the items are derived from. It is extremely important to educate surgical team members about the purpose of each checklist item and how the items should be used in the operating room.

Before you implement the checklist in your operating rooms we recommend that you read this document and review our checklist modification guidelines. The checklist modification guidelines provide guidance on how to modify some of these items and the checklist as a whole to meet the needs of your facility as well as examples of modified checklists.

Safe Surgery 2015: South Carolina Checklist Template

Before Induction of Anesthesia

Nurse and Anesthesia Provider Verify:

- Patient identification (name and DOB)
- Surgical site
- Surgical Procedure to be performed matches the consent
- Site marked
- Known allergies
- Patient Positioning
- The anesthesia safety check has been completed

Anesthesia Provider Shares Patient Specific Information with the Team:

- Anticipated airway or aspiration risk
- Risk of significant blood loss
 - Two IVs/central access and fluids planned
 - Type and crossmatch/screen
 - Blood availability
- Risk of hypothermia - operation >1h
 - Warmer in place
- Risk of venous thromboembolism
 - Boots and/or anticoagulants in place

Before Skin Incision

Entire Surgical Team:

- Is everyone ready to perform the time out?
- Please state your name and role
- Patient's name
- Surgical procedure to be performed
- Surgical site
- Essential imaging available
- Has antibiotic prophylaxis been given within the last 60 minutes?
 - Plan for redosing discussed

Briefing

Surgeon Shares:

- Operative Plan
- Possible difficulties
- Expected duration
- Anticipated blood loss
- Implants or special equipment needed

Anesthesia Provider Shares:

- Anesthetic plan
- Airway concerns
- Other concerns

Circulating Nurse and Scrub Tech Share:

- Sterility, including indicator results
- Equipment issues
- Other concerns

Surgeon says:

"Does anybody have any concerns? If you see something that concerns you during this case, please speak up."

Before Patient Leaves Room

Nurse reviews with Team:

- Instrument, sponge and needle counts are correct
- Name of the procedure performed
- Specimen labeling
 - Read back specimen labeling including patient's name

Debriefing

Entire Surgical Team Discusses:

- Equipment problems that need to be addressed.
- Key concerns for patient recovery and management
- What could have been done to make this case safer or more efficient

 JC/Standard of Practice

 SCIP

 WHO/SC Checklist

Column One: Before Induction of Anesthesia

Where This Part of the Checklist Should Be Performed: A best practice is to have this part of the checklist performed in the operating room.

When Should These Items Be Discussed: Prior to induction of anesthesia.

Who Should Participate In This Section of the Checklist: At a minimum, the anesthesia provider, circulating nurse and patient (when possible). If other members of the team are present at this time, (surgeon and or scrub nurse/technician), then those team members should be included in the first phase of the checklist [1,2].

How To Use These Items: All of these items are designed to be read aloud from a physical copy of a checklist at a time where team members are present and have stopped all activity.

Why Are These Items Important To Include On Your Checklist: These steps are intended to be redundant to the team, and an opportunity to review key steps out loud together as a team and with the patient. In highly reliable organizations redundancy steps prevent errors. Although most of the steps have already been done in pre-op holding by individuals, most often they are done in silos and not done in unison as a team. Team members can change and in some circumstances the nurse or anesthesiologist who sees the patient preoperatively may not be the same person(s) for induction. Workflow often prohibits the nurse and anesthesiologist from conducting their pre-operative checks simultaneously in pre-op holding which prohibits the ability to run the checklist together.

Nurse and Anesthesia Provider Verify:

Patient Identification (name and DOB)

Origin: The Joint Commission (TJC) National Patient Safety Goal (NPSG) 01.01.01 [3]

The Joint Commission recommends the use of at least two ways to identify patients. Acceptable identifiers include the patient's name, date of birth, medical record number or other person specific identifiers. This should occur in all stages of diagnosis and treatment (when administering medication, blood, tests, and procedures). The intent of this goal is two fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that identifier. This is done to make sure that each patient gets the correct medicine and treatment.

In the operating room this step is essential to ensure that the team does not operate on the wrong patient. The intent of the first column of the checklist is to perform patient identification in the operating room prior to induction. This is expected to be a redundant step for team member to re-identify the patient in the OR just prior to induction.

Surgical Site

Origin: The Joint Commission (TJC) National Patient Safety Goal (NPSG) [3]

This item assures the correct surgery is done on the correct patient and at the correct place on the patient's body. This step is essential to ensure that the team does not operate on the wrong site.

In the operating room this step is to verify with the patient and team the planned operation site/side prior to induction. This redundancy step is an opportunity to confirm the operative site with the patient and team to assure that the correct site is verified just prior to induction.

Surgical Procedure to be performed matches the consent

Origin: Past The Joint Commission (TJC) National Patient Safety Goal (NPSG) UP recommendation during Time Out to assure planned surgery matches written consent.

Surgical team members should always make sure that any procedure is what the patient needs and is performed on the right person. The surgical procedure and consent is an on-going process of information gathering and confirmation. The consent is initially confirmed in the pre-op holding by multiple team members.

Re-confirming the procedure to be performed according to the consent prior to induction is an opportunity to confirm out loud with the patient and team the procedure to be performed according to the consent. This step may include the surgeon and/or scrub nurse/technician if they are present. Team members will verify that the consent is consistent with the patient's expectations and the team's understanding of the intended procedure/site. This is a redundancy step and important opportunity to answer any questions, concerns, or discrepancies prior to induction of anesthesia.

Site Marked

Origin: The Joint Commission National Patient Safety Goals (NPSG) Universal Protocol (UP) 01.02.01 [3]

Hospitals identify those procedures that require marking of the incision or insertion site. At minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location. For spinal procedures in addition to preoperative skin marking of the general spinal region, special intra-operative imaging techniques may be used for locating and marking the exact vertebral level. Site marking should occur *before* the procedure is performed and if possible with the patient awake and involved. Mark the correct place on the patient's body where the surgery is to be done. The site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and who will be present when the procedure is performed. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. The mark is made at or near the incision site and is sufficiently permanent to be visible after the skin is prepped and draped.

Verifying correct site marking in the operating room prior to induction is a redundancy step for the patient and team to assure the correct site was marked, and rectifies any discrepancies.

Known Allergies

Origin: WHO/South Carolina Checklist

The WHO Guidelines and the South Carolina Checklist include a review of known allergies between the circulator and anesthesiologist to prevent allergic reaction during the procedure [1,2]. A review of the patient's allergies confirms that the team is aware of any allergies that pose a risk to the patient. The redundancy step of stating allergies out loud and together as a team with the patient just prior to induction is a step to ensure **all** members are aware of any allergies and precautions are taken as needed.

Patient Positioning

Origin: Past Joint Commission Recommendation

The South Carolina Checklist includes a prompt for members of the surgical team to review the patient position prior to induction. This step verifies that the team is prepared and aware of the intended patient position for the procedure and that positioning devices are available. Verifying the patient position will aid the team in planning line placement and optimal positioning for optimal access to the surgical site.

The anesthesia safety check has been completed

Origin: WHO/South Carolina Checklist

The WHO Guidelines and South Carolina Checklist recommend asking the anesthesia provider to verify completion of an anesthesia safety check. Conducting the safety check is a standard of practice. This is understood as a complete formal inspection of the anesthetic equipment, medications, and patient's anesthetic risk before each case [1,2].

Anesthesia Provider Shares Patient Specific Information with the Team:

The following safety steps are verified in the OR by the anesthesia provider with the operating room team prior to induction of anesthesia:

Anticipated Airway or Aspiration Risk

Origin: WHO/South Carolina Checklist

The WHO Guidelines and South Carolina Checklist recommend that the anesthesia provider discusses the patient airway and aspiration risk with surgical team members. Reviewing plans for a difficult airway or aspiration risk helps prepare the team in advance [1,2].

The WHO Guidelines recommend that an anesthesia provider objectively assess and determine if the patient has a difficult airway or is at risk for aspiration [1,2]. The airway can be graded by one of the scoring systems such as Mallampati score, Thyromental distance, and Bellhouse-Dore score. Preparing for a difficult airway can prevent death from airway loss during anesthesia. Patients with reflux or a full stomach are at higher risk and techniques such as rapid sequence induction or cricoid pressure during induction can reduce such risk.

Risk of Significant Blood Loss

Origin: WHO/South Carolina Checklist

The WHO Guidelines and South Carolina Checklist recommend a discussion of blood loss and a review of appropriate IV's, type and cross, and blood availability. Discussing risk for blood loss ahead of time prepares the team in advance for appropriate line placement and preparation for blood products as needed. The South Carolina Checklist asks for the team to discuss blood loss one more time when the surgeon is present. There are times when the surgeon is the only person that holds this information.

Patients at risk for losing >500 ml (>7ml in children) of blood during surgery need preparation for this critical event by placing at least two large bore intravenous lines or a central venous catheter prior to incision [1,2].

Risk of Hypothermia

Origin: Surgical Care Improvement Project-Inf-10 - SCIP performance measure¹

This item prompts a discussion between care providers of whether warming is appropriate for the patient. Discussing the risk of hypothermia together as a team prior to induction prepares the team in advance for appropriate patient warming devices.

The Surgical Care Improvement Project (SCIP) recommends patient warming if procedure is anticipated to be greater than 1 hour for the purpose of maintaining normothermia. Core temperatures outside the normal range pose a risk in all patients undergoing surgery.

Risk of Venous Thromboembolism

Origin: Surgical Care Improvement Project - Venous Thromboembolism-1 [4]

Discussing and planning to reduce the risk of Venous Thromboembolism (VTE) prior to induction assures a plan is in place for VTE prophylaxis. SCIP performance measures recommend that VTE prophylaxis is ordered anytime from hospital arrival to 24 hours after *Anesthesia End Time*. VTE is one of the most common postoperative complications and prophylaxis is the most effective strategy to reduce morbidity and mortality. The frequency of VTE that includes deep vein thrombosis and pulmonary embolism is related to the type and duration of surgery, patient risk factors, duration and extent of postoperative immobilization, and use or nonuse of prophylaxis. Studies have shown that appropriately used thromboprophylaxis has a positive risk/benefit ratio and is cost effective. Prophylaxis recommendations for this

¹ The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations interested in improving surgical care by significantly reducing surgical complications. SCIP partners include the steering committee of 10 national organizations who have pledged their commitment and full support for SCIP. In addition, each of the SCIP target areas is advised by a technical expert panel. These groups have provided hours of technical expertise and resources to ensure the SCIP measures are fully supported by evidence-based research. Finally, TJC continues to align with Centers for Medicare and Medicaid Services (CMS) with respect to the performance measures for patients undergoing surgery (*JointcommissionSCIP*).

measure are recommended by SCIP based on selected surgical procedures from the 2008 American College of Chest Physicians guidelines.

Column Two: Before Skin Incision The Time Out

Where This Part of the Checklist Should Be Performed: In the operating room

When Should These Items Be Discussed: Immediately before skin incision when all surgical team members are present.

Who Should Participate In This Section of the Checklist: All surgical team members participating in the procedure and anybody else that is in the OR should participate. If there are manufacture/equipment representatives, observers, or students in the room it is recommend that they participate in this section of the checklist by introducing themselves by name and role. More information about this item is included on page 7 of this document.

How To Use These Items: All of these items are designed to be read aloud from a physical copy of a checklist at a time where all team members are present and have stopped **all** activity.

Why Are These Items Important To Include On Your Checklist: The Joint Commission gave us a place to stop by requiring surgical teams to perform the “Time Out”. The Time Out requires surgical teams to verify patient identity, the surgical procedure to be performed, and the surgical site immediately before skin incision. The South Carolina Checklist goes beyond the time out and includes a team briefing. The checklist promotes communication and communication between surgical team members. It also gives clinicians an opportunity to review key criteria, ask questions, and to make sure that everybody is on the same page before skin incision.

If used correctly the Checklist can also be a vehicle to promote surgical team members to feel comfortable voicing their concerns [6]. In 2005, there were more than 2500 sentinel events reported to the Joint Commission. The primary root cause for 70% of those events was communication failure and out of that group, 70% of those patients actually died. Also, when these mortality cases were debriefed, it was discovered that in a large percentage of the cases someone in the room knew something was wrong with the patient and they were not comfortable speaking up [3].

The Entire Surgical Team:

Is everyone ready to perform the Time Out?

Origin: The Joint Commission (TJC), Universal Protocol (UP) - TJC UP.01.03.01 [3]

The Joint Commission (TJC) recommends that the entire surgical team pauses before skin to confirm patient identity, the surgical procedure to be performed, and the surgical site. The Joint Commission requires that all surgical team members actively participate in these safety checks

and that **all** activity stops in the operating room. Asking if the team is ready for the time out promotes all other activities to halt so team members can give full attention to the time out and briefing. TJC mandated Universal Protocol for all invasive procedures in 2004. TJC identified communication as the most common root cause of wrong site operations and of operative and post-operative events [7].

Please state your name and role

Origin: WHO/South Carolina Checklist

The WHO Guidelines and South Carolina Checklist recommend that every person in the OR introduce himself or herself by name and role before skin incision. In many hospitals surgical teams are not established and individual team members can change frequently. Introductions not only help team members know who each other are in the operating room, but they are key in effectively managing high-risk situations [1,2]. Team introductions are also critical in creating an environment where individuals can voice concerns about the patient. Research has shown that people who are given the opportunity to contribute to a conversation will find it easier to speak up later [6]. It is recommended that every person in the OR introduce himself or herself at this point in the checklist. This includes manufacture/equipment representatives, students, or observers.

Many clinicians have raised concerns about having surgical team members introduce themselves before every case because everybody already knows each other or the team will be working together for the entire day. A best practice is to have surgical team members introduce themselves by name and role prior to the first case and have surgical team members check off with each other in subsequent cases. An example of checking off with one another is, “Betty, are you ready to go?”

Patient’s name

Origin: The Joint Commission (TJC) - National Patient Safety Goal (NPSG) UP 1.03.01 [3]

The Joint Commission recommends that patient identity confirmed by all team members during the “Time-Out”. Confirming the patient identity prior to the incision is a redundancy step to prevent wrong patient surgery.

Surgical Procedure to be performed

Origin: The Joint Commission (TJC) – National Patient Safety Goal NPSG UP 01.01.01 [3]

This item is part of the Joint Commission’s Time Out requirements. This safety check assures that the correct procedure is performed on the correct patient and at the correct place on the patient’s body. Best practice includes verifying the stated surgery to be performed with the written consent to ensure that they match.

Surgical Site

Origin: The Joint Commission (TJC) National Patient Safety Goals (NPSG) UP 01.01.01

This item is part of the Joint Commission's Time Out requirements to prevent wrong surgical site. [3] This safety check ensures that the surgical team is going to operate on the correct body part and side.

Essential imaging available

Origin: (Previously recommended by The Joint Commission)

The WHO Guidelines and South Carolina Checklist recommend reviewing essential imaging if it is needed during the procedure and that is prominently displayed for use during the operation. If imaging is needed but not available, it should be obtained before skin incision. It is important that this item is performed at a time when the surgeon is present.

Has antibiotic prophylaxis been given within the last 60 minutes?

Origin: Surgical Care Improvement Project (SCIP Inf-1 [4])

This is a prompt to confirm that antibiotics are fully infused prior to skin incision. This item also asks the team to discuss the plan for re-dosing antibiotics, if necessary. It is recommended antibiotic prophylaxis is completely infused before skin incision. Research shows that a patient's risk of developing a surgical site infection is dramatically reduced if prophylactic antibiotics are infused within one hour prior to surgical incision [13]. Due to the longer infusion times of vancomycin and fluoroquinolone patients should have the antibiotics initiated within two hours prior to surgical incision.

Column Two: Before Skin Incision Team Briefing

Where This Part of the Checklist Should Be Performed: In the OR, prior to incision and after the time out components of the checklist have been completed.

Who Should Participate In This Section of the Checklist: All surgical team members participating in the procedure and anybody else that is in the OR should participate.

How To Use These Items: All of these items are designed to be read aloud from a physical copy of a checklist at a time where all team members are present and have stopped **all** activity.

Why Are These Items Important To Include On Your Checklist: A team briefing is intended to generate a team discussion. This is an important aspect of the checklist that goes beyond The Joint Commission time out. Fostering teamwork and communication among surgical staff members is one of the main objectives of the briefing. A briefing is a dialogue or discussion using concise and relevant information to promote clear and effective communication. The briefing provides a platform for common understanding and gives people permission to be frank and honest. Briefings provide team members with a framework for collaborative planning.

Awad, et al. found that most surgical litigation cases involved at least one communication event that contributed to patient harm or dissatisfaction [8]. In a study by Lingard and Rubin, interprofessional checklist briefings reduced the number of communication failures and promoted proactive and collaborative team communication [9]. Previous evidence also suggests that preoperative OR briefings are associated with an improved safety culture, reductions in wrong-site/wrong procedure surgeries, early reporting of equipment issues, and reduced operational cost [7].

The Surgeon Shares: Operative Plan

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend that the surgeon share the operative plan to inform all team members of the plan for the patient [1,2]. If the plan is routine the surgeon may state routine procedure.

The Surgeon Shares: Possible Difficulties

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend a discussion of any possible difficulties or unexpected steps that put the patient at risk such as rapid blood loss, injury or other major morbidity [1,2]. If no difficulties are expected then the surgeon may state no anticipated difficulties. Possible difficulties may be included in the operative plan.

The Surgeon Shares: Expected Duration

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend informing the team of the expected duration of a case in order to facilitate team planning. Informing the team of the expected duration helps the anesthesiologist plan for an appropriate emergence and the nursing team to plan for subsequent procedures [1,2].

The Surgeon Shares: Anticipated Blood Loss

Origin: WHO/South Carolina Checklist:

This is an additional check confirming the estimated blood loss. It is important to confirm this multiple times, especially when the entire surgical team is not together at the time before the induction of anesthesia. This is the last opportunity for the team to discuss blood loss before skin incision. A discussion of blood loss may occur during the operative plan or possible difficulties; however it is specifically listed to ensure that this information is communicated.

The Surgeon Shares: Implants or Special Equipment Needed

Origin: (Previously recommended by TJC)

WHO Guidelines and the South Carolina Checklist suggest a review of implants and special equipment to adequately prepare and anticipate needs for the procedure. Discussing appropriate

implants or equipment has been shown to decrease the number of times the circulator leaves the room and ultimately decrease OR time.

Anesthesia Provider Shares: Anesthetic Plan

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend the anesthesiologist share the anesthetic plan particularly any concerns with major morbidities with the surgical team [1,2]. Sharing the anesthetic plan assures team members are adequately prepared and ready to anticipate potential risks. If none are expected then the anesthesiologist may report no risks or concerns.

Anesthesia Provider Shares: Airway Concerns

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend the anesthesiologist share with the operative team any airway concerns. The team's awareness of any airway concerns alerts all members to possible complications [1,2]. Again if no airway concerns are expected then the anesthesiologists may report no airway concerns.

Anesthesia Provider Shares: Other Concerns

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend an opportunity for the anesthesia care provider to raise any other concerns that they might have. Sometimes people won't share concerns unless they are given the specific opportunity to do so

Circulating Nurse and Scrub Technologist Share: Sterility, including indicator results

Origin: Standard of Practice

This is a standard practice in the United States. WHO Guidelines and the South Carolina Checklist recommend the scrub nurse or technologist verbally confirm that the sterilization was performed and that for heat sterilized instruments, a sterility indicator has verified successful sterilization [1,2].

Circulating Nurse and Scrub Technologist Share: Equipment Issues

Origin: Previously recommended by The Joint Commission

WHO Guidelines and the South Carolina Checklist recommend the nursing team discuss any equipment problems or concerns to adequately prepare and anticipate needs for the procedure. This is another opportunity for the nursing and technology team to discuss any equipment problems or ask question regarding the surgical teams anticipated needs [1,2]. Adequate preparations for the procedure reduce wait time in the OR and keep the circulator in the operating room.

Circulating Nurse and Scrub Technologist Share: Other Concerns

Origin: Standard of Practice

WHO Guidelines and the South Carolina Checklist recommend an opportunity for the circulating nurse or scrub nurse/technologist to ask other questions or express concerns [1,2]. Sometimes people won't share concerns unless they are given the specific opportunity to do so.

Surgeon Says: "Does anybody have any concerns? If you see something that concerns you during this case, please speak up"

Origin: WHO/South Carolina Checklist

This item is referred to as "The Surgeon Statement." This item is key to creating an environment where everyone in the operating room is comfortable voicing concerns anytime during the case. This type of statement sets the tone in the operating room and gives a sense of openness for all team members regarding encouragement of communication. In the article, "Preoperative Safety Briefing Project" David Lawrence said that a similar statement fostered a more collegial atmosphere and encouraged monitoring, cross-checking, and empowered all team members to be proactive to patient safety [10]. According to a study by Pisano et al., there was evidence that a cardiac surgeon encouraged a high degree of cooperation among members of the team. He reported a shift toward "the surgeon needs to be willing to allow himself to become a partner with the rest of the team so he can accept input" [6]. Pisano's article reported that a surgeon explicitly encourages input from team members and as a result members of the team stated "With this procedure the hospital was willing to empower the team. There's a real trusting relationship that allows this to occur." [6].

Column Three: Before The Patient Leaves Room

Where This Part of the Checklist Should Be Performed: In the OR after the sponge and needle counts have been confirmed.

Who Should Participate In This Section of the Checklist: All surgical team members participating in the procedure and anybody else that is in the OR should participate.

How To Use These Items: All of these items are designed to be read aloud from a physical copy of a checklist at a time where all team members are present and have stopped all activity.

Why Are These Items Important To Include On Your Checklist:

Much like briefings/debriefings are a strategy to improve patient safety, mitigate adverse events, and improve teamwork and communication. The debriefing assures adequate preparation the patients for post-operative course. The debriefings at the end of the case can note lessons learned for future patients and procedures. Makary, et al. found that "Although briefings and debriefings are not end-all solutions to the problem of errors or inefficiencies in the operating room, they help to minimize errors by allowing personnel to discuss potential problems before they lead to a "near miss" or actual harm" [11]. This gives one final opportunity for the team to

stop for conversation and questions and to assure all team members are all clear of the operative plans.

The Nurse Reviews With The Team: Instrument, Sponge and Needle Counts are Correct

Origin: WHO, South Carolina Checklist, American Association of Perioperative Registered Nurses (AORN)

The WHO Guidelines, South Carolina Checklist and AORN recommend announcing to the team final count status. Announcing the final count status allows teams to appropriately reconcile counts as needed. Any incorrect counts are alerted to the team initiating steps be taken, such as searching for the missing item, exploring the wound, or taking an intraoperative radiograph.

The Nurse Reviews With The Team: Name of Procedure Performed

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend reviewing the name of the procedure that was performed with the surgeon. In many cases the procedure changes or expands during the course of the operation. The nurse should confirm with the surgeon how to record what procedure was done and how it should be recorded in the patient records. This step avoids discrepancies of documentation by all care providers.

The Nurse Reviews With The Team: Specimen Labeling

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend reviewing correct labeling of patient specimens collected during surgery to prevent labeling or laboratory error. As researched by Makary, et al. mislabeling and/or mishandling of specimens are common errors and pose risks to all patients [12]. The circulator should confirm the correct labeling by reading out loud the patient name, specimen description and any orienting marks by verifying the label with the surgeon. Specimen reconciliation at the end of the procedure prevents errors and assures with the surgeon correct labeling and documentation of specimens.

**Column Three: Before The Patient Leaves Room
Debriefing**

The Entire Surgical Team Discusses: Equipment Problems That Need To Be Addressed

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommendation reviewing equipment problems to accurately identify instrument and/or equipment malfunctions. We have also heard that creating these types of systems and fixing problems identified help engage physicians, particularly surgeons in using the checklist.

The Entire Surgical Team Discusses: Key Concerns For Patient Recovery and Management

Origin: WHO/South Carolina Checklist

WHO Guidelines and the South Carolina Checklist recommend a discussion to review the postoperative recovery and management of the patient together as a team. This discussion should focus on intraoperative or anesthetic issues that may affect the patient and key information that should be transferred to the team that will be taking care of the patient in the recovery area.

The Entire Surgical Team Discusses: What could have been done to make this case safe and more efficient?

Origin: WHO/South Carolina Checklist

This item promotes a discussion of anything that could have been done to make the case safer and/or more efficient. This item promotes an open environment of learning and helps teams improve communication and teamwork.

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