Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy

V5.0

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1. Introduction

1.1. This version supersedes any previous versions of this document.

1.2. The primary role for all healthcare professionals is to keep patients safe. Patients undergoing surgical and other interventional procedures place their trust in all members of staff to follow the correct processes, policies and protocols required to ensure that we are properly prepared to perform the right procedure, on the right patients, every time.

1.3. In June 2008 the World Health Organisation (WHO) launched a safety challenge “Safe Surgery Saves Lives” to reduce the number of surgical deaths across the world and strengthen the commitment of clinical staff to address safety issues within the surgical setting. This included improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical infections and improving communication and teamwork within the team. A landmark paper by Haynes et al in 2009 showed that in both the developed and developing world, use of the surgical checklist significantly reduced both perioperative morbidity and mortality. In 2009, the National Patient Safety Agency (NPSA) adapted this checklist for use in England and Wales and issued an alert setting a timetable for hospitals to introduce the checklist for all patients having a surgical procedure.


1.5. This policy sets out a detailed process to be rigorously followed by all staff involved in providing surgical or interventional procedures in theatre settings, e.g. Royal Cornwall Hospital, West Cornwall Hospital and St. Michael’s Hospital, and Procedure suites, such as Endoscopy, Cardiology and Radiology.

1.6. The guidance recommends development of local standards (LocSSIPs) for invasive procedures carried out in other settings, e.g. Outpatient Departments, treatment rooms, Emergency Department, on the wards, etc. See Appendix 3 onwards for a detailed list of safety checklists associated with this Policy.

**Does this policy apply to me? / A Common Sense Approach**

1.7. This Policy mandates some key processes and behaviours applicable to all procedure within the hospital, such as the requirements for team work; to robustly confirm patients’ identity and the key details of a procedure before commencing. Clearly, however, fundamental variations exist within the processes and languages used within different operating environments, which must be taken into consideration in order for this policy to be practical and meaningful.

1.8. A key part of this Policy, for example, relates to anaesthetic check-in procedures, yet we know that many day case operations and procedures within
Cardiology and Endoscopy do not require an anaesthetist. Similarly, some variations in terminology such as “theatre, surgeon, operator, operation, surgery, procedure, treatment, interventional procedure, diagnostic test” etc., might lead some specialities to feel that this policy may not be applicable to them.

**In all cases where confusion might occur, a common sense approach should be used.**

1.9. Procedures without an anaesthetist present may not require an anaesthetic check-in, for example; however, the team would still be expected to follow those elements of this policy which are clearly applicable. Equally, pre-operative assessment may not be appropriate for all patient groups and it is not the intention of this Policy to generate unnecessary patient episodes where there is limited or no added value.

1.10. It is appropriate for some specialities to include additional checks to address specific aspects of patient management, and this is actively supported by this Policy.

1.11. All specialities are therefore required to consider this Policy carefully and implement those elements which ‘fit’ with their processes in the interests of patient safety. Working as a team, Clinical Directors, Clinical Leads, Service Managers, Clinical Matrons and other senior managers are required to review this policy and consider:

- How to implement the processes which apply to the procedures within their specialty
- How compliance will be monitored
- Any special arrangements which might be required in order to meet policy requirements
- Any areas which do not apply to their specialty, documenting controls in place to ensure patient safety is not compromised in their absence.

1.12. Failure to comply with, or act in accordance with, the terms laid down in this Policy may result in disciplinary action.

2. **Purpose of this Policy/Procedure**

2.1. This Policy describes the steps that must be taken to ensure that any surgical or invasive procedure is performed on the correct patient, the correct site and, if applicable, with the correct implant.

2.2. This Policy is applicable to all patients (adults and children) undergoing operative and other invasive procedures performed under both local and/or general anaesthetic. This includes procedures performed in settings other than the operating theatre (e.g. interventional radiology, cardiology, endoscopy, dermatology, oral surgery, gynaecology, maternity and procedures or operations performed in external services managed by the Trust (e.g. Community Theatres). Any future checklists developed within specialities should follow the principles of the original Surgical Safety Checklist, (see Appendix 17), which includes safety critical checks only.
2.3. This Policy is applicable to all medical and clinical staff involved in the pre-operative and perioperative care of patients undergoing surgery or interventional procedures in areas outlined in Section 1.1.5 and Appendix 3 onwards.

2.4. Failure to comply with, or act in accordance with, the terms laid down in this Policy may result in disciplinary action.

2.5. Falsification of any documentation, either paper or electronic, may be considered as gross misconduct. Staff should be aware that disciplinary action may be taken against them.

2.6. This document has been produced to support and define the purpose and role of the Team Brief, Debrief and WHO surgical checklist in improving patient safety during surgical procedures. This document describes the responsibilities for the execution of the policy and ensures they are clearly defined and clarified.

2.7. Objectives

2.7.1. No avoidable harm or death of patients undergoing surgery due to:

- Insufficient preparation before an operation
- Poor teamwork or communication
- Failure to robustly confirm key information relating to patient or the procedure being undertaken
- Ensure patient safety is maintained throughout the perioperative journey
- Assurance for Divisions and the Trust that by reliably using the Checklists listed in Appendix 3 onwards, the standards for ensuring correct site surgery/procedures are adhered to.

3. Scope

3.1. This Policy is applicable to all medical and clinical staff involved in the pre-operative and perioperative care of patients undergoing surgery or interventional procedures. This document applies to all personnel involved in the surgical intervention of any patient within the theatre setting at Royal Cornwall NHS Trust.

3.2. All patients having a surgical procedure within Royal Cornwall NHS Trust, including those under local anaesthetic within the theatre setting will have an appropriate version of the WHO surgical checklist used during their procedure. Evidence of this checklist will be retained within the patient’s notes (see appendix 3 onwards for the current WHO Surgical Checklists in use in different specialities in theatres).

3.3. Clinical areas outside of the operating theatres may choose to amend the Royal Cornwall Theatre WHO surgical checklist to suit their particular needs. All specialties are therefore required to consider this Policy carefully and implement those elements which ‘fit’ with their processes in the interests of patient safety. Working as a team, Clinical Directors, Clinical Leads, Directorate Managers, Clinical Matrons and other senior managers are required to review this policy and consider:

- How to implement the processes which apply to the procedures within their specialty
• How compliance will be monitored
• Any special arrangements which might be required in order to meet policy requirements
• Any areas which do not apply to their specialty, documenting controls in place to ensure patient safety is not compromised in their absence.

4. Definitions / Glossary


4.2. WHO – World Health Organisation.

4.3. Active Listening: a term used in Theatres to indicate the need for absolute silence and attention required by all staff during key safety checks, e.g. Time Out and Sign Out.

4.4. Briefing (Step One): meeting where operating team share vital information about patients and potential/actual safety issues prior to commencement of the list.

4.5. Sign In (Step Two): safety checks undertaken in the Anaesthetic room on arrival of the patient.

4.6. Time Out (Step Three): safety check undertaken immediately prior to undertaking surgery.

4.7. Sign Out (Step Four): safety check undertaken immediately following surgery.

4.8. Debriefing (Step Five): post-list communication between theatre team and an opportunity to review any issues that arose throughout the day.

4.9. LocSSIP: Local Safety Standards for Invasive Procedures – local guidelines developed according to the principles of the Safe Surgery Policy.

4.10. Critical Steps: Something out of the ordinary – a deviation from routine care. A critical step is a point in the process at which there are key decisions to be made (e.g. converting to open, adding another specimen); key steps that must occur for a successful outcome (e.g. throat pack removal) or any point within the process that the pathway is not certain at the outset (the 'we might do this but if we find this then we will do that instead' type operation).

5. Ownership and Responsibilities

5.1. Teamwork in Surgery

5.1.1. All aspects of healthcare rely on people working together safely and effectively and good teamwork is a vital defence available for a safer healthcare system. Recent research allows us to understand more about how errors happen in the operating theatre. It is known that the way teams work together (leadership, communication, shared situational understanding and the opportunity to ‘speak up’) contribute significantly to the risk of errors (see ‘Just a Routine Operation’, (NHS Institute for Innovation and Improvement, 2008).
5.1.2. It is known that the way teams work together (leadership, communication, shared situational understanding and the opportunity to ‘speak up’) contributes significantly to the risk of errors (see ‘Just a Routine Operation’ (NHS Institute for Innovation and Improvement, 2008).

5.1.3. The following are the responsibilities for key staff members who interact with patients during their perioperative journey. See Sections 4.4 – 4.17 for individual responsibilities in relation to completion of the Checklist.

5.2. Role of the Medical Director
- Overall Trust-wide responsibility for the development, review, implementation and monitoring of this Policy.
- Responsible for reporting compliance monitoring results to the Quality Assurance Committee

5.3. Role of the General Managers
- Responsible and accountable for ensuring that the standards of practice outlined in this Policy are maintained and assured.
- Responsible for ensuring that monitoring systems are in place to enable robust assurance of compliance with this Policy to be provided to the Medical Director and the quality assurance committee.
- Responsible for identifying and resolving gaps in service provision which might adversely impact upon compliance with this Policy within their Division.

5.4. Role of the Clinical Directors
- Responsible for ensuring medical staff receive guidance and training, understand the Policy and adopt the requirements within their practice.

5.5. Role of the Heads of Nursing
- Responsible to ensuring nursing staff and other non-medical healthcare professionals receive guidance and training, understand the Policy and adopt the requirements within their practice.

5.6. Role of the Line Managers/ Supervisors
- Ensuring all staff receive guidance and training, understand the Policy and adopt the requirements within their practice.
- Failure of any individual to adhere to this policy will result in escalation to the individual’s line manager and persistent failure may result in disciplinary action.

5.7. Role of the Scrub Practitioner
- Responsible for withholding skin preparation, instruments or equipment until Time Out has been completed.
- Responsible for ensuring all equipment used during the procedure complies with appropriate sterility standards.
- Responsible for ensuring that all swabs and instruments are accounted for.
• Responsible for ensuring all specimens undertaken during the case are documented on the specimen board and managed according to the requirements of the Specimen Handling in Theatres Policy and Procedure.
• Responsible for completing Sign Out (Step 4) of the Checklist
• Responsible for prompting the surgeon to instigate Team Debriefing
• Responsible for handover of patient to recovery staff.

5.8. Role of the Registered Ward Nurse
• On all surgical wards, Acute Medical Unit (AMU) and Endoscopy, the registered nurse is responsible for final pre-operative preparation of the patient and correct completion of the Ward Sign Out documentation.
• Registered Nurses are responsible for the final pre-operative preparation of the patient and correct completion of the ward sign out documentation prior to the patient leaving the area/ward. Areas without a competent registered nurse this should be carried out in conjunction with a trained member of theatre staff
• For all remaining medical wards, the ward registered nurse is responsible for completing the Sign Out in conjunction with a trained member of theatre staff.

5.9. Role of the Theatre Assistant (TA / ATA)
• If a theatres HCA staff member has competency training, he/she is able to retrieve the patient from Medical / Surgical wards and complete the Ward Sign Out checks with the registered ward nurse handing over the patient
• Responsible for collecting the patients from all surgical and medical wards when Ward Sign Out checks have been completed.

5.10. Role of the Surgeon/ Radiologist/ Endoscopist (Person Performing Procedure)
• Responsible for ensuring correct patient identification, correct site surgery and correct examination or treatment is performed on the patient.
• Responsible for ensuring Team Briefing, Time Out, Sign Out and Team Debriefing take place.

5.11. Role of the Anaesthetist
• Responsible for ensuring Sign In to Anaesthetic Room has occurred prior to any anaesthetic intervention and ensuring correct site regional block, i.e. Stop Before You Block, is performed on the patient.

5.12. Role of the Anaesthetist Practitioner
• Responsible for ensuring the Sign In to anaesthetic room is complete and correct.
• Responsible for collecting the patients from all surgical and medical wards when Ward Sign Out checks have been completed.

5.13. Role of the Operating Team (in Anaesthetic Room and Operating Theatre)
• Responsible for ensuring checks are completed and confirmed on the Checklist.
• Responsible for stopping and pausing while Time Out is undertaken before the treatment/surgery commences

5.14. **Role of the Team Leader/ Theatre Coordinator**
• Responsible for ensuring that the Briefing Checklist is completed.
• Responsible to ensure that all operating lists are appropriately staffed with competent personnel.

5.15. **Role of the Quality Assurance Committee**
The Quality Assurance Committee is responsible for:
• Responsibility for the ratification of this Policy and for receiving annual reports on its effectiveness.

6. **Standards and Practice**

6.1. **Workforce**

6.1.1. Effective organisation by all members of the perioperative team is essential for the efficient management of elective and scheduled operating sessions. Managers responsible for calculating staff establishments comply with the recommendations set out in the Association for Perioperative Practice (AfPP) Standards and Recommendations for Safe Perioperative Practice, fourth edition, (Association for Perioperative Practice, 2016). The aim is to reduce or prevent the cancellation of elective surgery by ensuring that allocated theatre time is planned effectively and that perioperative personnel are deployed appropriately to identify service demand.

6.1.2. It is the responsibility of the Theatre Coordinator or designated team lead to ensure that every elective and emergency operating list is staffed by a team of appropriately trained and competent personnel who are equipped with the knowledge, skills and abilities to administer high quality patient care, and who are able to identify and minimise any risks to the patient as they journey through the perioperative environment.

6.1.3. The workforce will reflect the complexity of the operating list, and a minimum level below which a list will be cancelled (dependent on staff skill mix and list complexity) is as follows:

6.1.4. **General Theatres** (no fewer than 4 staff in theatre):
• 2 x Scrub Practitioner
• 1 x Circulator
• 1 x Anaesthetic Practitioner
• 1.5 Recovery Practitioners per theatre

6.1.5. **Endoscopy Suites**
• 1 x Decontaminator
• 1 x patient advocate (registered practitioner or Band 3 with Recovery competences) 1 x registered practitioner to admit, discharge, consent
• 1 x registered practitioner to assist the Endoscopist

**Note:** Any on call system must be adequate for the urgency and timeframe in which staff will be needed and the clinical skills required to manage emergency surgery. Emergency surgery undertaken outside of core working hours must be a consideration when providing appropriate level of skill and competence and resource to support perioperative care and provision. The number of staff required for an emergency session may be less than that required for an elective session, depending upon the specialty and normal pattern of emergency work and risk assessment.

### 6.2. Step 1: Team Brief

**6.2.1.** The surgeon is responsible for ensuring that Team Briefing occurs **prior to commencing the intervention on the first patient.**

6.2.1.1. If new members of the team arrive, they need to be updated with information discussed at Team Briefing.

6.2.1.2. The team leader is responsible for leading the Team Briefing and should use the Briefing Checklist to ensure that the items listed in appendix 17 have been appropriately discussed and document this has taken place on the electronic system.

6.2.2. **All team members** must be present with the exception of the patient escort who is to be acknowledged, but should remain in the anaesthetic room with the patient.

6.2.2.1. For patients with complex needs or specific requirements, consideration should be given to the patient escort attending Team Briefing so as to be able to communicate relevant issues.

6.2.2.2. All non-essential activity is to cease to enable staff to listen and concentrate.

6.2.2.3. The Team Brief is usually conducted in the clinical area to be used for the procedure. It will be attended by the whole theatre team including surgeon and anaesthetist. A template is used to ensure that all cases are discussed in a structured manner.

6.2.2.4. In normal circumstances the team leader will call all the members and lead the process. All staff present within the theatre at this point must stop any activity they are carrying out and participate positively in the process.

6.2.2.5. Each member of the team is required to introduce themselves. This is intended to improve communication and teamwork. Discussing each case provides a simple way for the operating team to share vital information about all patients listed for surgery within the session and discuss potential and actual safety issues. The Team Brief is an
opportunity to organise staff and equipment to ensure the maximum efficiency of the session.

6.2.3.  **Content (using the Briefing Checklist): See Appendix 17**

6.2.3.1. Any patient who refuses blood or blood products should be highlighted during briefing.

6.2.3.2. This consent form will then be checked as part of the safe surgery checks during Sign In and Time Out. – as above we need to confirm

6.2.3.3. ICU/Recovery issues – to be identified and fed back as appropriate by the team leader.

6.2.3.4. All pertinent investigation results must be available prior to sending for patients.

6.3.  **List Order**

6.3.1. Best practice is for the entire theatre team to know the operating list order at the beginning of the theatre session and that this list order is “fixed”. Local evidence tells us that changing the theatre list order has the potential for miscommunication. Therefore we should **always minimise any potential for list changes** in advance through careful planning and communications.

6.3.2. However, it is also recognised that there are a number of very good, clinical reasons why a list order should change. Having the ability to do this ensures that patients are not cancelled, that they receive timely surgery and that they are operated on in the right order. Such examples include (but not exclusively):

- When a patient’s international normalised ratio (INR) returns from the laboratory post briefing and is raised.
- When blood or blood products are not ready.
- When a patient has not followed starvation instruction.
- When there is a clinical priority than should take precedence over another patient.

6.3.3. Having agreed exceptions to this “best practice” should not detract from our commitment to knowing everything possible about the patients and list order at Team Briefing. We must however ensure that the communications about any changes are **deliberate, clear and understood** by all. Should the order need to change, the theatre team leader **MUST** undertake a “mini briefing” so that all changes are agreed and understood.

6.4.  **Emergency Theatres**

6.4.1. Comprehensive Team Briefing using the standard Briefing Checklist should occur at the following times:

- Prior to the start of the morning theatre session
- Following commencement of the night shift
6.4.2. If a case is scheduled involving a different surgical team, a “Safety Pause” should be undertaken prior to commencing the intervention on this patient.

6.4.3. A Safety Pause should also be utilised when any emergency case is added into an elective list.

6.5. Scheduling and List Management

6.5.1. The purpose of these positive booking rules is to support the operating theatre teams to provide safer surgical care, boost productivity and take into account the Trust's financial responsibilities.

6.5.2. The management will aim to work to the rules as documented below however there will be some circumstances that will require a flexible approach as with some cancer patients.

6.5.3. The aim of the scheduling / booking process includes the following:
- To deliver an effective process that meets the needs of the surgical teams, the anaesthetic department and theatre teams.
- To simplify the configuration of Surgical and Anaesthetic staffing
- To simplify the arrangement of required equipment
- Will increase theatre utilisation
- Will reduce unused resources and promote financial savings
- Allow operational managers and clinical leads to backfill vacant theatre sessions
- Forward planning of appropriate staffing for specific lists
- Allow senior theatre staff, Care Group managers and clinicians to review lists to prevent under and over runs
- Allow surgical teams to book Critical Care beds
- To provide a clear booking process over an 6 week period
- Recognition that lists may change due to clinical urgency.

6.6. Booking Process (as per 'Theatre Scheduling Policy'):

6.6.1. Efficient use of operating theatre capacity is dependent upon effective communication and the co-ordination of resources. This will be achieved through the implementation of processes which provide stakeholders with all the relevant information required to provide the appropriate skill mix, equipment and support resources to deliver planned activity. Such processes will support early planning for special circumstances i.e. allergies, loan equipment.

The following policies will be hyperlinked once access is available on the Trust new Intranet site.

6.6.2. The Patient Access Policy states that patients should receive a minimum of 6 weeks’ notice of planned treatment, unless agreed with the patient (Patient Access Policy)
6.6.3. Patient scheduling. All patients must be booked in accordance with the agreed standard operating procedure. (Standard Operating Procedure: Patient scheduling)

6.6.4. Pre-Operative Assessment. All routine elective patients are subject to the Pre-Operative Assessment (POA) process. (Pre-Operative Assessment Process)

6.6.5. Routine elective patients are not considered booked until they have been added to the appropriate operating session within the Galaxy theatre management system (Standard Operating Procedure: Booking elective procedures).

6.6.6. Specialty review. Clinical Admin Leads and Theatre Managers will meet weekly to ensure booking remains on track and the resources are available to undertake the planned activity.

6.6.7. Session time. It is the responsibility of the operating Consultant to ensure that, as far as is reasonably practicable, allocated session times are not exceeded. Realistic scheduling of operating procedures assists in avoidance of cancellations on the day due to a lack of operating theatre time. To help guide this process Galaxy automatically adds the average procedure time of each procedure during the booking process.

6.6.8. Patient booking monitoring. Theatre teams will monitor patient booking on a weekly basis, commencing 4 weeks in advance of the day of surgery; resource issues identified will be raised at the weekly specialty review. Those which cannot be addressed during the specialty review will be escalated to the Operational Service Lead and/or Directorate Manager.

6.6.9. Booking patients on shorter pathways. There are a number of sessions with shorter patient pathways i.e. Hand Trauma, Cancers, TOP’s. The process for booking patients on shorter pathways remains the same as that of routine electives excepting patients may not be booked 3 weeks in advance however, patients should be booked (added to Galaxy) as soon as practicable.

6.7. Management review:
Minimising the impact of short notice list order changes. The Consultant surgeon responsible for the session will, where practicable, confirm the list order 1 week prior to the day of surgery. Sessions will automatically be locked 1 week prior to the day of surgery.

6.8. Booking of the Emergency Theatres (CEPOD/Trauma)
It is acknowledged there is a lesser degree of control with regard to the planning of emergency operating sessions in comparison with that of elective operating sessions. However, communication and co-ordination remain key in the effective planning and delivery of emergency activity.

6.8.1. Once the decision to operate has been confirmed. It is the responsibility of the booking surgeon to inform the Consultant on-call Anaesthetist and Theatre Manager/Deputy of the procedure and provide the patient details required to complete the booking. (Standard Operating
Procedure: Booking emergency procedures)

6.8.2. Upon receipt of the completed booking form the patient will be added to the Emergency Pool within Galaxy. Emergency patients will remain in the Emergency Pool until allocated to a theatre. Trauma patients will be allocated to a theatre directly from the Emergency Pool.

6.8.3. Prioritisation of emergency cases is the responsibility of the booking surgeon. Where there are competing priorities those Consultants with patients booked in the Emergency pool will meet and agree the order of the emergency operating list.

6.9. Patient Cancellations:
Good planning, including realistic scheduling of operating procedures, is key to ensuring cancellations are kept to a minimum. Where potential cancellations prior to the day of surgery are identified the Trust escalation process must be followed (Cancellation of elective procedure on day before surgery secondary to bed unavailability).

6.9.1. Cancellations on the day of surgery for non-clinical reasons must also be escalated, prior to cancellation, to the relevant specialty directorate manager or deputy and all options for prevention must be explored.

6.9.2. Patients who defer their operation for a valid reason (i.e. patient is unwell) will be informed of the probable arrangements for their future admission by the booking team. Where possible, patients will be offered an alternative date at the time of deferral.

6.9.3. Patients who indicate they no longer wish or need their operating procedure will be removed from the waiting list, the consultant informed and referred back to their GP.

6.10. Process of cancellations:

6.10.1. Bed pressures / Capacity problems
- The Surgical manager of the day to liaise with the Directorate Manager of the specialty for the reason for cancellation
- Cancellation SOP as per Theatre Scheduling Policy

6.10.2. Availability of ICU beds
- ITU co-ordinator inform elective bed manager of bed available and patient has been accepted by the unit.

6.10.3. Cancellations for other reasons, i.e. previous operations taking longer than expected overriding emergency, safety of the department due to other lists overrunning, Recovery full
- Theatre Team Leader to liaise with the Theatre Coordinator, Surgeon, Anaesthetist and Recovery to discuss options
- Consider utilising another theatre
- Consider using the emergency theatre
- Inform Directorate Manager if in hours
• Liaise with the admission ward, Surgeon to speak to patient preferably with a new date for the procedure
• Inform the theatre team and Recovery of outcome
• If out of hours ensure the Directorate Manager and the specialty secretary are aware the next day.

6.11. Pre-Operative Assessment

6.11.1. The pre-operative patient pathway should include a preparation for surgery appointment. This may be as a one-stop following the decision to treat, a booked appointment or a telephone assessment.

6.11.2. Preparation for surgery should include:

6.11.2.1. An assessment of the patient’s fitness for surgery and anaesthesia with the aim of ensuring that the patient is as fit as possible on the day of surgery.

6.11.2.2. Social and psychological preparation, explanation of the likely course of their admission and the preparations the patient will need to make for their discharge home.

6.11.2.3. Advice about starvation times and cessation or continuation of medicines.

6.11.2.4. An opportunity for the patient to ask questions.

6.11.2.5. Infection control screening.

6.11.3. All patients should have been pre-assessed. If a patient has not been pre-assessed, the anaesthetist and surgeon should determine whether there is adequate information available to proceed with the operation.

6.11.4. Patients who have not attended a preparation for surgery appointment must be assessed on the day of surgery. This may be done by the nurses on the admission ward, but requires input from the surgical team when patients have complex health problems or are planned inpatients.

6.11.5. All patients wishing to refuse any blood product administration (including but not limited to Jehovah’s Witnesses) must be identified at the pre-operative assessment visit and the surgeon and anaesthetist notified. This must be highlighted on the Consent Form. It is then the responsibility of the surgeon and anaesthetist to ensure this consent form is completed and available for verification during Sign In and Time Out.

6.12. Ward Preparation

6.12.1. Privacy and Dignity
Patients for an elective procedure should be admitted to a designated area that affords them privacy and dignity in accordance with that outlined in the Trust’s policy on Privacy & Dignity
6.12.2. Preoperative screening and testing for pregnancy in adults
It is nationally recognised that incidents of patients undergoing a planned surgical procedure without having a documented pregnancy check in the preoperative period could result in a spontaneous abortion after the procedure.

6.12.3. The common features of cases where pregnancy has not been diagnosed prior to procedures with these incidents was; the failure to systematically check for pregnancy; the failure to report to the surgeon a patient who had refused testing; and finally, a failure to robustly document the status in the patient's operative record.

6.12.4. Robust assessment and informed consent to test for pregnancy in women of child bearing age will confirm unsuspected pregnancy, at which point the risks and benefits of the surgery can be discussed with the patient. Surgery may be postponed or anaesthetic and/or surgical approaches modified if necessary. In emergency situations, confirmation of pregnancy should not delay treatment.

6.12.5. Trust position on pregnancy testing
Women of child bearing age, between menarche and menopause (who have not had a hysterectomy), should be assessed regarding pregnancy status. National Institute for Health and Care Excellence (NICE) guidance does not specify typical age ranges for women of child bearing age, but this is interpreted as being 12-55 years. This includes women who have had a sterilisation and women whose partners have had a vasectomy.

6.12.6. It may be useful to preface the conversation with the patient to include the following: “We ask these questions of all females regardless of their personal circumstance; please accept my apologies in advance if you feel that this does not apply to you.”

6.12.7. Informed consent to test the patient’s urine for pregnancy should include simple verbal information explaining why the test is necessary and include the following:

- Unrecognised pregnancy in female surgical patients is not uncommon and easily detected.
- There are risks of disruption to an undetected pregnancy following surgery and anaesthesia. The nature of this risk will depend on the surgery and gestation of the pregnancy.
- That it is our policy that we ask patients for their informed consent to test.
- The test result will be available to the female immediately.

6.12.8. Patients who decline to be tested
The Trust recognises the sensitivities of counselling patients about the likelihood of pregnancy and it is the patient’s right to decline to be tested. In the event of this, the nurse should gain a gentle understanding of the reason for
refusal and inform the patient’s surgeon. The surgeon must then make a
decision as to whether to counsel the patient further, proceed with or cancel the
surgical procedure. All decisions and outcomes should be fully documented in
the patient’s medical records and Sign Out from the ward. The patient will be
requested to sign the Sign Out documentation as a record of the informed
consent to proceed with surgery in the absence of a definitive test.

6.12.9.  In the event of an unexpected positive test

6.12.9.1. In the event of an unexpected positive test result, the nurse
should seek support from the senior nurse in charge of the ward or
admission unit. The preliminary result should be given to the patient in
private with sensitivity towards the nature of the information given. The nurse must consider the appropriateness of other persons present
when this information is provided.

6.12.9.2. The nurse should inform the patient’s surgeon immediately and
request a senior member of the surgical team attend the patient. The
surgical team should consider a repeat test using a blood sample. The
surgical team should consider contacting the gynae/obstetric team to
counsel the patient regarding any decision to proceed and/or to provide
advice following the detection of an unexpected pregnancy.

6.12.9.3. In recognition of the sensitivity of counselling young people;
any menstrual history and pregnancy testing of patients under the age of
18 should be in consultation with and at the discretion of the child’s
clinician and the senior nurse in charge of the Paediatric Department.

6.12.9.4. If surgery proceeds it is the surgeon’s responsibility to inform
the anaesthetist and theatre team. The patient should receive the leaflet,
“Having an operation whilst pregnant”. All discussions with the patient
should be fully documented and a new written informed consent to
treatment, including any new risks completed.

6.12.9.5. If surgery is cancelled, the surgeon should explain the next
steps regarding the surgical pathway with the patient. This should be
documented in a follow-up letter to the General Practitioner. This decision
will depend on the patient’s individual circumstances and the nature of the
surgery required.

6.12.9.6. The patient should be advised to contact their General Practice
at the earliest opportunity to ensure that she receives the right support and
maternal care.

6.12.9.7. The patient should be offered a meal and drink prior to leaving
the hospital.

6.12.10. Patients who are known to be pregnant (not maternity) and listed
for elective or emergency surgery
Occasionally, there are times when the benefits of surgery outweigh the risks,
for example when emergency surgery is required or when a woman develops a
condition that is considered to be a threat to her life if surgery is postponed until
after delivery. In such circumstances, and if time permits, the patient should receive the leaflet “Having an operation whilst pregnant” which fully explains the risks to the mother and foetus in such circumstances.

6.12.11. Infection Control Status
The Ward Preparation section must document any patient alert in relation to infection control, e.g. infection control status, including Methicillin-Resistant Staphylococcus Aureus (MRSA). If yes, ward staff must telephone theatres to advise them of the alert.

6.12.12. Drug Charts and Medication

6.12.12.1. Patient alerts need to be documented, e.g. allergies. In addition, EPMA must be checked to ensure that all regular medications have been given prior to leaving the ward. If a patient is noted to have taken any anticoagulant or antiplatelet drugs outside of the guideline the anaesthetist and surgeon are to be notified. Current antiplatelet drugs are aspirin, clopidogrel, dipyridamole, prasugrel, ticagrelor, and current anticoagulants are warfarin, phenindione, acenocoumarol, dabigatran, rivaroxaban, apixaban and fondaparinux.

6.12.12.2. EPMA should have all regular preoperative medications prescribed prior to the patient leaving the ward. It is not necessary to prescribe routine post-operative analgesia for elective admissions.

6.12.13. Radiological Procedures
Patients for interventional radiological procedures will require completion of the Radiology Interventional Procedures Checklist. Patient preparation for the procedure should begin on the inpatient ward with a handover to the Radiology ward after completion of the first section of the Checklist with the exception of patients undergoing EndoVascular Aneurysm Repair (EVAR) which follows the surgical pathway.

6.13. Patient Marking

6.13.1. Pre-operative marking has a significant role in correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level such as the correct finger on the correct hand.

6.13.2. Staff should be alert to the potential of children, and others, to self-mark.

6.13.3. Who is responsible for marking
The site must be marked by the person performing the procedure or suitably trained deputy who will be present in the operating theatre/radiology/endoscopy suite at the time of the patient’s procedure. The intended site of incision or site of insertion should be unambiguous. Non-operative sites should not be marked.

6.13.4. When to mark
6.13.4.1. Marking must occur prior to the patient leaving the ward/daycase unit or other setting (i.e. before Sign Out from ward).

6.13.4.2. Marking must take place before a sedative pre-medication.

6.13.5. How to mark

6.13.5.1. Information from the medical notes and/or images should be used to confirm the intended surgical site and side.

6.13.5.2. An indelible marker pen must be used.

6.13.5.3. The mark should consist of an arrow that extends to, or near to, the incision site and remain visible after the application of skin preparation.

6.13.5.4. It is desirable that the mark should also remain visible after the application of theatre drapes.

6.13.6. Where/what to mark

6.13.6.1. For digits on the hand and foot the mark must extend to the correct specific digit. Similarly for lesions and levels of the spines.

6.13.6.2. For eyes, the mark must be sited above the correct eye.

6.13.6.3. For facial lesions a dot must be placed adjacent to those intended for excision.

6.13.6.4. Multiple skin lesions must be marked as per facial lesions, or marked with an arrow, where that form of marking is considered to be more appropriate.

6.13.6.5. The site of anaesthetic block must be confirmed in the anaesthetic room, but not marked as this could cause confusion.

6.13.7. Involvement of others in marking

6.13.7.1. Wherever possible, pre-operative marking must take place with the patient involved, awake and aware.

6.13.7.2. In the case of children, parents should be involved in the process of marking.

6.13.7.3. Family members/significant others should be involved wherever possible and especially in the case of incapacitated or vulnerable adults.

6.13.8. Exceptions to marking

- Emergency surgery – where a delay in surgery to facilitate marking endangers a patient’s safety, a surgeon may choose to proceed at risk. This decision should be documented in the patient’s theatre notes.
- Teeth and mucous membranes.
- Cases of bilateral simultaneous surgery such as tonsillectomy, squint surgery, laparoscopic sterilisation (excluding bilateral grommets which should be marked on the ear, visible after draping).
- Situations where laterality of surgery needs to be confirmed following examination under anaesthesia or exploration in theatre.
- Certain cases performed via Endoscopy, such as cystoscopy and bronchoscopy.
- Certain cases where laterality is not an issue as only single organ, e.g. caesarean section, hysterectomy, colon surgery or gastrectomy.
- Interventional cases for which the catheter/instrument site is not pre-determined.
- If the site is traumatic.
- Where intra-procedural imaging for localisation will be used.
- Spinal surgery.
- Patient’s refusal.

6.13.9. Patient refusal of marking
If a patient refuses pre-operative skin marking staff must:

- Document the patient's request in the nursing and medical notes.
- Complete the Surgical Safety Checklist, but clearly state patient refuses marking.
- Verbally hand over the lack of marking during Sign In to the anaesthetic room and Time Out.
- Side and site must be confirmed and verified using reliable documentation (e.g. imaging, notes, consent form) at Time Out.
- The surgeon should consider the risks and benefits of proceeding.

6.13.10. Documentation
Upon Sign Out from ward section, the registered nurse should sign to confirm that the mark is present and visible or where the patient has declined marking, annotate the Checklist to indicate this.


6.14.1. The surgical site mark should be checked against the consent form and the notes to confirm it is correctly located.

6.14.2. If the site is not marked and the planned procedure does not preclude marking, the patient must not leave the ward. The surgeon or nominated deputy should be contacted to attend and mark the site.

6.14.3. Where a patient has specific requirements (e.g. learning disabilities/dementia/ acquired brain injury) and are unable to advocate for themselves or do not have capacity, it may be appropriate for a family member or carer to accompany the patient to theatre.

6.14.4. Additional general patient information must be clearly documented, e.g. are there any alerts on the inside cover of the medical notes such as prostatic stent, pacemaker, etc., implants, disabilities, communication issues, etc.
6.14.5. In extreme circumstances, where clinical need dictates, these checks may not be completed in order to facilitate urgent treatment of the patient (e.g. ruptured aortic aneurysm). All efforts must be made to confirm patient ID, allergies and blood type.

6.14.6. Where anaesthetic input is required, the patient ideally must be seen by an anaesthetist/ anaesthetic practitioner prior to leaving the ward.

6.14.7. Sign Out must be undertaken by a registered nurses on all surgical wards, for the remaining medical wards, Sign Out will be undertaken in conjunction with a trained member of theatre staff.

6.14.8. Patient identity should be confirmed by asking the patient and checking all identification document (ID) bands in situ, against the notes.

6.14.9. Consent form should be checked to ensure correct patient ID label.

6.15. STEP 2: SIGN IN TO ANAESTHETIC/PROCEDURE ROOM

6.15.1. Content from Ward Sign Out should be reviewed prior to commencing Sign In.

6.15.2. Sign In should be a two-person check. Whilst the anaesthetist retains overall responsibility for ensuring this check is completed and may wish to lead the process, the check can be undertaken by a registered member of the theatre team and theatre assistant.

6.15.3. There should be no interruptions during completion of the Sign In to the Anaesthetic/Procedure room.

6.15.4. If any aspect of the Checklist cannot be completed or if any member of staff has concerns regarding the safety to proceed then the patient should not be anaesthetised until all issues are resolved.

6.15.5. The practitioner checking in the patient must sign the bottom of the form to confirm that all checks have taken place and that all information has been verified and is correct.

6.15.6. The Sign in section is completed when the patient arrives into the anaesthetic room, prior to any intervention. It is the responsibility of the anaesthetic practitioner within that list to ensure this section is completed. All staff present within the anaesthetic room at this point must stop any activity they are carrying out and participate positively in the process.

6.15.7. The patient, their wrist band, the consent form and the surgical markings are all used to ensure that it is the right patient, having the correct operation on the correct side. There is specific mention of anaesthetic nerve blocks ‘Stop before you block’ to reduce the chance of “wrong site blocks”.

6.15.8. Anaesthetic Equipment check

- The practitioner leading the Sign In must confirm by ticking the box, and by signing the Sign In to Anaesthetic Room, to confirm that the anaesthetic equipment check has been completed.

6.15.9. Confirmation of Patient Identity
6.15.9.1. This should take place in the anaesthetic room, or if the patient goes straight to the operating or procedure room, must take place before they are anaesthetised.

6.15.9.2. If the patient is incapable of personally participating in the verification process due to specific requirements and no authorised representative is present, the member from the preceding location (who carried out the Sign Out from ward) must act as the patient’s representative for verification.

6.15.9.3. The patient must be asked:
- Full name
- Date of birth
- What procedure they are having
- Site of procedure

6.15.9.4. This information should be confirmed and be consistent with both of the patient’s ID bands, medical records, consent form and theatre list.

6.15.9.5. Any patient identified at Briefing as refusing blood or blood products should have their Consent Form for Refusal of Blood checked with the patient during Sign In and confirmation sought that this refusal stands.

6.15.9.6. In addition to the above list, additional checks will be undertaken for obstetric, cataract and interventional radiology patients in accordance with their specialty specific Surgical Safety Checklists.

6.15.10. **Confirmation of Site Mark**

6.15.10.1. The surgical site mark should be checked against reliable documentation to confirm it is correctly located and still legible.

6.15.10.2. If the site is not marked and the planned procedure does not preclude marking the surgeon must confirm the operation site using the consent form and the notes then mark the site.

6.15.10.3. In the event of marking occurring in the anaesthetic room, an incident form on datix must be completed and the event discussed with all staff involved in signing the patient out from the ward and into the anaesthetic room.

6.15.11. **Presence of surgeon**
- Prior to induction of anaesthesia the Team Leader must confirm that the surgeon is present in the building.

6.15.12. **Regional Anaesthesia**

6.15.12.1. The anaesthetist is responsible for confirming the correct site for any local anaesthetic nerve block.
6.15.12.2. Immediately prior to commencing any unilateral regional/local technique the anaesthetist must undertake a verbal Stop Before you Block check (Royal College of Anaesthetists, 2016) with the ODP. This check includes:

- Consent form – confirming correct surgery site/side
- Patient mark – confirming correct surgery/limb/side

6.15.12.3. If the check cannot be completed, then the anaesthetist must confirm any discrepancy with the surgeon prior to placing the block.

**6.16. STEP 3: TIME OUT**

**6.16.1. TIME OUT**

6.16.1.1. Time Out must occur as close to knife-to-skin as practicably possible.

6.16.1.2. After Time Out has taken place, the operating surgeon must not leave the theatre prior to the procedure taking place.

6.16.1.2. The surgeon has overall responsibility for ensuring Time Out is performed.

6.16.1.3. **Time Out must be performed by the whole team** with a minimum of surgeon, scrub practitioner, anaesthetist and Anaesthetic practitioner (or whoever signed the patient into the anaesthetic room) using the consent form.

6.16.1.4. When Time Out is taking place, “Active Listening” must be observed and distractions must be avoided unless absolutely essential.

6.16.1.5. **All staff must stop all other activity and ‘pause’ to conduct a final verbal verification.**

6.16.1.6. Any staff new to the theatre time since the Team Briefing must be introduced.

6.16.1.7. The team must agree the following:

- New team members have been introduced
- Presence of the correct patient
- Confirmation of correct procedure
- Correct site and side marked
- Imaging is present, correct and properly labelled
- What potential problems may arise and critical surgical steps
- Allergies
- The correct antibiotics have been given after giving consideration to IC status
- A final equipment/sterility check has been made
- Thrombo-embolic precautions
- Whether cross-matched blood is available.
6.16.1.8. The refusal of blood or blood products by any patient should be confirmed during Time Out and the completed Consent Form for Refusal of Blood should be included as part of the Time Out check.

6.16.1.9. For obstetric, cataract and interventional radiology patients, issues discussed in Time Out will vary from the above in accordance with the agreed specialty-specific checklists (see Appendix 3 onwards).

6.16.1.10. For laterality of surgery: a verbalised description of intended laterality for internal organs must be provided by the surgeon. If the surgeon’s expectations are in any way at odds with other documentation (e.g. consent form, theatre list and imaging) the team must stop and check that site, operation and side are verified and agreed by all to be correct.

6.16.1.11. If any aspect of the Checklist is non-compliant or there are any concerns raised about patient safety, the team must stop and verify that all information is correct before proceeding.

6.16.1.12. Compliance with the Time Out process must be documented on the Checklist whilst the check is undertaken by the delegated member of the operating team and recorded on RADAR.

6.16.1.13. If during the procedure subsequent interventions involving laterality are felt to be necessary, e.g. insertion of chest drain, a safety pause where side of insertion is confirmed by the surgical team should be undertaken prior to commencing the additional procedure.

6.16.1.14. In the event of a case involving two surgical teams, e.g. Head & Neck and Plastics, if one team is not present in theatre later in the case, a second Time Out must take place as close to the second knife to skin as possible.

6.17. **STEP 4: SIGN OUT**

6.17.1. **STEP 1 Sign Out** is to be completed on all patients at the end of surgery and before the patient is woken from general anaesthesia. A verbal check should be recorded on the Sign Out section of the Checklist whilst the check is undertaken. Sign out includes:

- Name and recording of the procedure with reference to the operating list.
- Confirmation of instrument counts (e.g. swabs, throat packs, sharps).
- Confirmation of how specimens should be processed in accordance with the Trust’s Specimen Labelling Procedure and the Theatres Specimen Handling in Theatre Suites Policy and Procedure.
- Any clinically significant blood loss.
- Key concerns for recovery and the ward for ongoing management of the patient including antimicrobials.
- Verification of DVT prophylaxis prescription.

6.17.2. Previous patient notes/labels must be removed from theatre before next patient arrives.
6.17.3. In the event of missing swabs or instrumentation, the actions taken to locate and resolve the situation must be clearly documented in the Care Plan and this occurrence must also be reported via Datix, the Trust’s incident reporting system.

6.17.4. If post-operative transfer to Intensive Care is required, Sign Out must also confirm that all necessary transfer equipment is available and minimum standards of monitoring can be maintained throughout the transfer.

6.17.5. If post-operative antimicrobials are indicated, the plan should be documented on the Operation Note under post-operative care (agents and duration; specific advice such as “Discuss with Microbiology” or “Chase (specified) cultures” and appropriate course prescribed onto the drug chart with an indication and duration. This is the responsibility of the operating surgeon who is a proxy for/is the consultant. It is the responsibility of the ward nursing staff and junior doctors to ensure the plan is implemented via the drug chart.

6.17.6. **STEP 2 Sign Out**

Before transfer, the anaesthetist should be satisfied that the Recovery area is adequately staffed and that staff are competent and able to take responsibility for the patient. If this cannot be assured, the anaesthetist should stay with the patient, either in the operating theatre or Recovery area, until the patient is fit to return to the ward. The anaesthetist must hand over the care of the patient to Recovery practitioners that are assessed as competent.

6.18. **STEP 5: TEAM DEBRIEF**

6.18.1. The scrub practitioner or team leader is to remind the surgeon to perform Team Debriefing.

6.18.2. Team debriefing can be led by any member of the team. It should occur at a suitable time towards the end of the theatre session and before the surgeon leaves theatre, or where there have been significant changes to theatre staffing during a theatre session (e.g. during a Confidential Enquiry into Patient Deaths [CEPOD] list).

6.18.2.1. In circumstances when there have been no issues, a simple recognition that there were no issues is sufficient.

6.18.2.2. In circumstances where there have been issues that caused a problem, disrupted the list or caused harm (or had the potential to) there should be a full discussion involving all members of the theatre team who should not be distracted by other duties.

6.18.2.3. In this event an incident form should be completed on Datix.

6.18.2.4. Debriefing documentation must be completed to record that (1) Debriefing has occurred and (2) if any actions required including equipment issues, these are noted and assigned to the relevant staff to resolve. Significant issues should be discussed at the theatres Comm Cell.
Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0

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and the Debriefing process should identify a team member to add the item to the Comm Cell discussion board.

6.18.2.5. The Team Debrief should be completed once the last patient on the theatre session has been received and handed over into recovery or alternatively prior to the last patient on the list leaving the operating theatre. The whole theatre team, including surgeon and anaesthetist should be present in the operating theatre to allow a brief discussion of the theatre session. This should highlight any areas of good practice, record any complications or concerns about the session and ensure any necessary escalation via a Datix or to the relevant personnel e.g. theatre manager is conducted.

6.19. SURGICAL CHECKLIST FOR ORGAN DONATION FROM DEAD PATIENTS

6.19.1. Please see full details of procedures to follow in the case of organ donation for DBD and DCD are available on the Intranet.

6.19.2. Patients undergoing organ donation after brain death confirmation (now known as Donation after Brain Death, DBD)

6.19.3. These patients are effectively elective cases, and require the presence of both anaesthetist and surgeon. Their management should proceed exactly as for any live patient elective case. When the patient is sent for, the anaesthetist, theatre orderly and ICU nurse should perform the usual Sign Out from Ward prior to transport to theatre.

6.19.4. Patients undergoing organ donation after cardiac death (now known as Donation after Cardiac Death, DCD)

6.19.5. This procedure is an emergency procedure that is performed as quickly as possible, after death has occurred. Further, there will be no anaesthetist/intensivist present through the whole procedure, so some surgeons will use their own local checklist prior to starting the surgery. This is quite acceptable, and should be supported by the local hospital staff.

6.20. MANAGEMENT OF PATIENTS UNDERGOING SURGICAL PROCEDURES REQUIRING LOCAL ANAESTHETIC ONLY

6.20.1. The pre-operative/operative procedures for patients requiring local anaesthetic only should follow the same process as for all other operative procedures, that is:

- Pre-operative assessment.
- Ward Preparation (no need for pregnancy testing unless sedation planned).
- Sign Out from ward.
- Sign In to the anaesthetic room/procedure room.
- Time Out in theatre.
- Sign Out from theatre.

6.20.2. Additionally, it is imperative that patients who have undergone their surgical procedure requiring local anaesthetic only will have any medical history that impacts on patient care communicated to the recovery team post-operatively. Therefore, all patients who have undergone their surgical procedure with local anaesthetic only and who have not required an anaesthetist will have
a detailed medical history handover by the surgeon to the recovery team. The scrub practitioner will hand over the procedure that the patient has undergone and communicate information which currently is standard practice for all surgical patients.

6.20.3. Patients who come straight to theatre for a local anaesthetic procedure, bypassing the Anaesthetic Room, must have both Sign In and Time Out checks undertaken together but where the checks are duplicated, e.g. checking the patient’s name and date of birth, they should be completed only once.

6.21.   MANAGING PROCESS FAILURE

6.21.1. In the event of a wrong patient, wrong procedure or wrong site/side incident, this must be reported immediately to the Theatre Coordinator. The Care Group Management Team and Risk Management Department must be notified immediately and an incident form on datix completed, as per the Incident Reporting, Policy and Procedures.

6.21.2. If the patient’s condition permits, an immediate plan to rectify the situation should be made by the consultant in charge of care. Wherever possible, the patient and the patient’s family should be involved in the management plan.

6.21.3. If performance failure is reported on Datix, this will be reviewed through Care Group governance structures. Persistent non-compliance will be escalated through the Trust’s disciplinary process.

6.22.   THEATRE ENVIRONMENT

6.22.1. Staff should not enter the anaesthetic room or distract the anaesthetist whilst a patient is being anaesthetised; this is a high risk task-orientated process that requires complete concentration.

6.22.2. All staff in theatres have a duty of care to verbalise any concerns they may have about patient safety.

6.22.3. Wherever possible, changes to the theatre staff are to be kept to a minimum.

6.22.4. From the commencement of Sign In to Anaesthetic Room until the start of surgery, no non-essential team changes are to occur.

6.22.5. If any change of staff occurs during the day, the replacement personnel are to be introduced to the team by the nurse in charge of the theatre.

6.22.6. Theatres are restricted environments.

6.22.7. All staff entering theatre should wear scrubs (see Theatre Guidelines)
6.22.8. All mobile communications should only be used for essential/emergency communication.

6.22.9. Uncleanable equipment such as laptops should not be taken inside the patient zone in the operating theatre for infection control reasons.

6.22.10. Only personnel involved with the procedure should be in theatre.

6.22.11. All staff to be mindful of potential damage to equipment e.g. spillages.

6.22.12. Company representatives can attend theatre only at invitation of the surgeon or anaesthetist and following agreement from the theatre manager or operational service lead.

6.22.13. Tips on Theatre Etiquette sheet should be read by any visitor to theatres including students. These are available at Theatre reception.

6.23. TRAINING REQUIREMENTS

6.23.1. It is the responsibility of each Care Group to ensure that the appropriate staff are trained in, and adhere to, the standards of practice outlined in this Policy.

6.23.2. The following staff groups will be expected to undertake essential learning:
   - Operating surgeons, all grades including staff on honorary contracts
   - Anaesthetists, all grades.
   - All staff involved in interventional procedures: radiology, endoscopy, cardiology.
   - All relevant staff in outpatient departments utilising a checklist identified in this Policy.
   - All theatre/recovery staff – registered and unregistered (nurses, ODPs, HCAs, TAs).
   - Senior nurses, ward matrons, preparation for surgery and all staff involved in completing the Ward Preparation and Ward Sign Out as designated by ward matrons.

6.23.3. These groups of staff will be expected to complete the essential learning package available as a Powerpoint presentation from the Safe Surgery page on the intranet, print off the final page and sign it as assurance that they have read and understood this Policy and their responsibilities within it. By completion of the training, staff verify that:
   - I understand my role with the Safe Surgery and Interventional Procedures Policy, and
   - I agree to work and communicate as part of a team and to speak out if I have any concerns about patient safety.

6.23.4. Band 3 and 4 practitioners undertaking Ward Sign Out must complete Ward Preparation and Ward Sign Out competency module prior to undertaking these duties.
6.24.       AUDIT ARRANGEMENTS
A variety of quality audit tools have been developed for use in theatres and to ensure
that this policy is complied with. The number of audits will be kept under review by the Anaesthetics, Critical Care & Theatres Care Group Governance Group.

6.24.1.   Objectives of the quality audit tool
1. To determine that the Five Steps are being performed
2. To ensure the quality of the safety checks performed
3. To ensure that any issues or concerns raised by theatre teams are actioned

6.25.       REQUIRED BEHAVIOURS

6.25.1.   Clear announcement of safety checks: A designated member of the team leads the team through the appropriate stage of the safety check (sign in, time out, sign out). The team member is observed to use the checklist and to clearly let the team know that the safety check is taking place.

6.25.2.   Appropriate team responses: On announcement of the start of the safety check the team focus on the questions being asked. Any potential distractions such as music are eliminated. No disrespectful comments are made about the process.

6.25.3.   Checklist read out accurately: The team utilise the appropriate checklist and follow its format accurately. There are no adaptations other than those agreed by the Trust for specialist areas.

6.25.4.   Distractions or interruptions (Active Listening): A distraction or interruption can be people chatting and not focussing on the checklist, music or people entering the theatre at the time of the check. If staff enter the theatre, but do not disturb the team undertaking the check, this is not classed as an interruption.

6.25.5.   Documentation completed at the time of the check: The observer should ensure that all documentation is completed during the check. All documentation is required to be complete.

6.25.6.   NB: The Surgical Safety Checklist should be used in ‘real-time’ with team interaction, asking and answering safety critical questions. A checked box ☑ on the Surgical Safety Checklist indicates the check has been undertaken and if checks reveal any inconsistencies, the safety check should be stopped, the issue addressed/corrected and then recommenced from the beginning.

However, it is important to note:
“... just ticking boxes is not the ultimate goal here. Embracing a culture of teamwork and discipline is...”
Atul Gawande, The Checklist Manifesto

7.       Dissemination and Implementation
Once approved this Policy will be uploaded by Trust Document Controller and will be available under the Trust intranet site under ‘Clinical’
### 8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Implementation of the WHO checklist will be monitored through the Trusts GALAXY and RADAR systems. The quality with which the WHO checklist is being carried out will also be monitored regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Clinical Lead for Safer Surgery (to be appointed)</td>
</tr>
<tr>
<td>Tool</td>
<td>The Trusts electronic systems (GALAXY and RADAR) can be used to collate the information required</td>
</tr>
<tr>
<td>Frequency</td>
<td>A daily report detailing the compliance of each theatre with the WHO checklist for the previous day’s operating session will be produced daily. An audit detailing the quality with which each theatre carries out the WHO checklist will be carried out on a monthly (unannounced) basis. An annual report outlining compliance with this policy will be presented by the Lead Clinician for the Safer Surgery to the Trust’s Quality Assurance Committee.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The report detailing the compliance of each theatre with the WHO checklist will be sent to the theatre manager each morning. Monthly WHO compliance reports will be created by governance administrator and circulated to the trust management group.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Safer Surgery ‘task and finish’ group will act on any compliance issues. They will meet weekly. Implementation of any recommendations and action plans will be monitored by the Quality Assurance Committee, which meets monthly.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Any barriers to implementation will be risk-assessed and added to the Trust Risk Register. Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.</td>
</tr>
</tbody>
</table>
9. Updating and Review
This policy will be reviewed in 3 years’ time

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>February 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>February 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Bernadette George Interim Director Integrated Governance</td>
</tr>
<tr>
<td>Contact details:</td>
<td>07342082475</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This Policy describes the steps that must be taken to ensure that any surgical or invasive procedure is performed on the correct patient, the correct site and, if applicable, with the correct implant.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>WHO, Safe site surgery, checklist</td>
</tr>
<tr>
<td>Target Audience</td>
<td></td>
</tr>
<tr>
<td>RCHT</td>
<td>CFT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>September 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Policy to Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures V4.7</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Safe Site Surgery &amp; Interventional Procedures Task &amp; Finish Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Bernadette George</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>‘Not Required’</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: Suzanne Atkinson</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet, ✓ Intranet Only</td>
</tr>
</tbody>
</table>
Document Library Folder/Sub Folder: Clinical

Links to key external standards: Governance Team can advise

Related Documents: Theatre Scheduling Policy Version 0.9
Patient Access Policy Version 3.1

Training Need Identified?: No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Jun 10</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>29 Oct 10</td>
<td>V2.0</td>
<td>Amendment of Governance coversheet to include ‘Suggested Keywords’, ‘Training Need’ and ‘Publication Location’.</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>1 Feb 11</td>
<td>V3.0</td>
<td>Addition of Monitoring Compliance table</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>15 Jan 12</td>
<td>V4.0</td>
<td>Governance information moved to an appendix. EIA updated.</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>25 Jan 12</td>
<td>V4.1</td>
<td>Governance information amended to align with format of Document Manager Upload Form.</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>24 Jul 13</td>
<td>V4.2</td>
<td>Updated Target Audience options in App 1.</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>15 Dec 14</td>
<td>V4.3</td>
<td>Added detail to section 5 to guide authors.</td>
<td>Andrew Rogers Corporate Records Manager</td>
</tr>
<tr>
<td>16 Jan 17</td>
<td>V4.4</td>
<td>Updated Equality Impact assessment added</td>
<td>Elise James Deputy Service Manager</td>
</tr>
<tr>
<td>04 Apr 17</td>
<td>V4.5</td>
<td>EIA Prompt sheet added to front of document</td>
<td>Elise James Deputy Service Manager</td>
</tr>
<tr>
<td>03 May 17</td>
<td>V4.6</td>
<td>Updated Equality Impact assessment added</td>
<td>Elise James Deputy Service Manager</td>
</tr>
<tr>
<td>27 Feb 18</td>
<td>V4.7</td>
<td>Removal of PCH from Governance Sheet</td>
<td>Elise James Deputy Service Manager</td>
</tr>
<tr>
<td>September 2018</td>
<td>V5</td>
<td>Includes detail of areas other than theatres where safety checklists are to be used.</td>
<td>Bernadette George Interim Director of Integrated Governance</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing.

**Controlled Document**
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatres Anaesthetics and Critical Care</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernadette George</td>
<td>07342082475</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - This Policy describes the steps that must be taken to ensure that any surgical or invasive procedure is performed on the correct patient, the correct site and, if applicable, with the correct implant.

2. **Policy Objectives***
   - No avoidable harm or death of patients undergoing surgery due to:
     - Insufficient preparation before an operation
     - Poor teamwork or communication
     - Failure to robustly confirm key information relating to patient or the procedure being undertaken
     - Ensure patient safety is maintained throughout the perioperative journey

3. **Policy – intended Outcomes***
   - To provide clear guidance to all staff involved with the patients undergoing invasive procedures on the steps to follow to reduce the risk of harm

4. **How will you measure the outcome?***
   - A daily report detailing the compliance of each theatre with the WHO checklist for the previous days operating session will be produced daily
   - An audit detailing the quality with which each theatre carries out the WHO checklist will be carried out on a monthly (unannounced) basis
   - An annual report outlining compliance with this policy will be presented by the Lead Clinician for the Safer Surgery to the Trust’s Quality Assurance Committee

5. **Who is intended to benefit from the policy?***
   - Patients

6a. **Who did you consult with***

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

   **Please record specific names of groups**
   - Safe site surgery group

b. **Please identify the groups who have been consulted about this procedure.**

<table>
<thead>
<tr>
<th>What was the outcome of the consultation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy agreed</td>
</tr>
</tbody>
</table>
### 7. The Impact

Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong> - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage and Civil partnership</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this *excludes* any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>x</th>
</tr>
</thead>
</table>

9. If you are not recommending a Full Impact assessment please explain why.

No differential impacts identified.

**Signature of policy developer / lead manager / director**

Bernadette George

**Date of completion and submission**

September 2018

**Names and signatures of members carrying out the Screening Assessment**

1. Bernadette George Interim Director Integrated Governance.
2. Human Rights, Equality & Inclusion Lead

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the
Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed __ Bernadette George

Date _____ September 2018
Appendix 3. Checklists that have been produced – Interventional Radiology (non GA) ONLY

[Image of a WHO Surgical Safety Checklist]

Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0
Page 39 of 53
Appendix 4. Checklists that have been produced – Maternity ONLY

<table>
<thead>
<tr>
<th>WHO Surgical Safety Checklist</th>
<th>Maternity ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SIGN IN (To be read out loud)</strong></td>
<td><strong>TIME OUT (To be read out loud)</strong></td>
</tr>
<tr>
<td>Before induction of anaesthesia</td>
<td>Before skin incision</td>
</tr>
<tr>
<td>Has the woman confirmed her identity, procedure and consent?</td>
<td>Have all team members introduced themselves by name and role?</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>What is the caesarean section category?</td>
<td>Surgeon Anaesthetist and Nurse / ODP verbally confirm:</td>
</tr>
<tr>
<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐ (Post natal cases)</td>
<td>Patient’s name? Procedure</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>Obstetrician:</td>
</tr>
<tr>
<td>Are antibiotics needed?</td>
<td>What additional procedure(s) are planned?</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>Are critical steps?</td>
</tr>
<tr>
<td>☐ No</td>
<td>Are there any concerns about the placental site?</td>
</tr>
<tr>
<td>Does the woman have a</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Known allergy?</td>
<td>Has the maternal team been called to attend?</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No, specify</td>
<td>☐ N/A</td>
</tr>
<tr>
<td>Difficult airway/regional anaesthesia risk?</td>
<td>Is the maternal team been called to attend?</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ Yes, and equipment assistance available</td>
<td>☐ Is any resus equipment checked and ready?</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Are blood products available?</td>
<td>Has the appropriate recent antacid prophylaxis been given?</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ Is the resus team checked and ready?</td>
</tr>
<tr>
<td>Has the maternal team been called, if needed?</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Signature of ODP:</td>
<td>Signature of Maternity:</td>
</tr>
<tr>
<td><strong>Patient Details</strong></td>
<td><strong>Procedure undertaken:</strong></td>
</tr>
<tr>
<td>Last name:</td>
<td>Name:</td>
</tr>
<tr>
<td>First name:</td>
<td>Signature of Midwife:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Date:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Signature of Surgeon:</td>
</tr>
</tbody>
</table>

Adapted from the NPSA report for use in Cornwall.
Appendix 5. Checklists that have been produced – ENDOSCOPY ONLY

WHO Surgical Safety Checklist

ENDOSCOPY ONLY

SIGN IN (To be read out loud by endoscopist)

Before sedation and scope insertion

- Has the team introduced themselves? Yes ☐ No ☐
- Confirm the patient’s name, DOB and address? Yes ☐ No ☐
- Confirm patient consent? Yes ☐

- Procedure:
- Has Scopio been set up to record patient procedure information? Yes ☐ No ☐
- Allergies?
- Comorbidities (ASA score, age, smoking, etc.) recorded? Yes ☐
- Anticoagulants (warfarin, clopidogrel, dabigatran, rivaroxaban, etc.)? Yes ☐ No ☐
- INR (if relevant)
- Scope number
- Confirm scope is clean? Yes ☐ No ☐
- Confirm scope & patient are recorded on track and trace? Yes ☐

* ASA score:
1. Healthy
2. Mild systemic disease
3. Severe systemic disease
4. Life-threatening systemic
5. Moribund

Patient Details

- Last name:
- First name:
- Date of birth:
- NHS Number:

Recovery plan

- Labels used from accessories and stents

- Confirmation that this WHO checklist has been entirely completed

Endoscopist:

Name:
Signature:
Date:
Appendix 6. Checklists that have been produced – ERCP ONLY
Appendix 7. Checklists that have been produced – MR Imaging +/- additional procedures under general anaesthesia
Appendix 8. Checklists that have been produced – Foot and Ankle Surgery ONLY

**WHO Surgical Safety Checklist**

**Foot and Ankle Surgery ONLY**

**SIGN IN (To be read out loud)**

- Before induction of anaesthesia
  - Has the patient confirmed his/her identity, site, procedure and consent?
  - Yes ☐️ No ☐️ Not applicable
  - Is the surgical site marked?
    - Yes ☐️ No ☐️ Not applicable
  - Is the anaesthesia machine and medication check complete?
    - Yes ☐️ No ☐️ Not applicable
  - Does the patient have a known allergy?
    - Yes ☐️ No ☐️ Not applicable
  - Does the patient have a known allergy?
    - Yes ☐️ No ☐️ Not applicable
  - Has pregnancy status been confirmed?
    - Yes ☐️ No ☐️ Not applicable
  - Difficult airway manoeuvre risk?
    - Yes ☐️ No ☐️ Not applicable
  - Yes, and equipment assistance available
  - Yes ☐️ No ☐️ Not applicable
  - Risk of >500ml blood loss (Tmilkg in children)?
    - Yes ☐️ No ☐️ Not applicable
  - Yes, and adequate access has been planned
  - Yes ☐️ No ☐️ Not applicable
  - Has temperature been measured?
    - Yes ☐️ No ☐️ Not applicable
  - Has anticoagulant status been checked?
    - Yes ☐️ No ☐️ Not applicable

**TIME OUT (To be read out loud)**

- Before start of surgical intervention
  - For example, skin incision
  - Have all team members introduced themselves by name and role?
    - Yes ☐️ No ☐️ Not applicable
  - All team members verbally confirm:
    - What is the patient’s name?
    - Yes ☐️ No ☐️ Not applicable
  - What is the patient’s age?
    - Yes ☐️ No ☐️ Not applicable
  - What procedure, site and position are planned?
    - Yes ☐️ No ☐️ Not applicable
  - Does the patient have a known allergy?
    - Yes ☐️ No ☐️ Not applicable
  - Anticipated critical events - Operating clinician:
    - Trauma site:
      - Is there any specific equipment requirements or special investigations?
        - Yes ☐️ No ☐️ Not applicable
    - Are there any critical or unexpected steps you want the team to know about?
      - Anaesthetist: Not applicable
  - Are there any patient specific concerns?
    - Yes ☐️ No ☐️ Not applicable
  - Is the patient’s ASA grade?
    - Yes ☐️ No ☐️ Not applicable
  - What monitoring equipment and other specific levels of support are required, for example blood?
    - Yes ☐️ No ☐️ Not applicable
  - Nurse/OPD:
    - Has the ability of the instrumentation been confirmed (including indicator results)?
      - Yes ☐️ No ☐️ Not applicable
    - Are there any equipment issues or concerns?
      - Yes ☐️ No ☐️ Not applicable
    - Has the surgical site infection (SSI) bundle been undertaken?
      - Yes ☐️ No ☐️ Not applicable
      - Antibiotic prophylaxis within the last 60 minutes
        - Yes ☐️ No ☐️ Not applicable
      - Postoperative • Airway management • Sibone caused control
      - Has VTE prophylaxis been undertaken?
        - Yes ☐️ No ☐️ Not applicable
        - Mechanical • Chemical
        - Is essential imaging displayed?
          - Yes ☐️ No ☐️ Not applicable
        - Further X-rays required?
          - Yes ☐️ No ☐️ Not applicable
        - Will a plaster be required at the end of surgery?
          - Yes ☐️ No ☐️ Not applicable
        - Will additional local anaesthetic be required?
          - Yes ☐️ No ☐️ Not applicable

**SIGN OUT (To be read out loud)**

- Before any member of the team leaves the operating room
  - Registered Practitioner/HCA verbally confirms with the team:
    - Any additional surgical cause for blood loss?
      - Yes ☐️ No ☐️ Not applicable
    - Have all pieces of invasive equipment/implanted devices used been accounted for?
      - Yes ☐️ No ☐️ Not applicable
    - Has it been confirmed that instruments, swabs and sharps counts are complete or not applicable?
      - Yes ☐️ No ☐️ Not applicable
    - Have the specimen been labelled (including with patient’s name)?
      - Yes ☐️ No ☐️ Not applicable
    - Have any equipment problems been identified that need to be addressed?
      - Yes ☐️ No ☐️ Not applicable

**Confirmation that this WHO checklist has been entirely completed**

- Operating surgeon:
  - Name:
  - Signature:

- Procedure:
  - Name:
  - Signature:

- Date:
Appendix 9. Checklists that have been produced – FLEXIBLE CYSTOSCOPY ONLY

<table>
<thead>
<tr>
<th>WHO Surgical Safety Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLEXIBLE CYSTOSCOPY ONLY</td>
</tr>
</tbody>
</table>

**SIGN IN (To be read out loud by endoscopist)**

- Before sedation and scope insertion:
  - Has the team introduced themselves? Yes □ No □
  - What is the patient’s name? □
  - What procedure is planned and consented for? □

- Does the patient have a known allergy? Yes □ No □
- Does the patient have any metalwork? Yes □ No □
- Has the urine dipstick been checked? Yes □ No □

**Patient Details**

- Last name: [ ]
- First name: [ ]
- Date of birth: [ ]
- NHS Number: [ ]
- *If the NHS Number is not immediately available, a temporary number should be used until it is*

**Print name:** [ ]

**Signature of Registered Practitioner:** [ ]

**Date:** [ ]

**Confirmation that this WHO checklist has been entirely completed**

**Clinician:**
- Name: [ ]
- Signature: [ ]
- Date: [ ]

**SIGN OUT (to be read out loud by endoscopist)**

**End of procedure**

- Has the name of the procedure been recorded? □
- Have all the pieces of equipment used been accounted for? □
- Have the specimens been labelled (with patient’s name)? □
- Have any equipment problems been identified that need to be addressed? □
- Have the instructions for post procedural care for this patient been agreed? □

With effect from April 2018

Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0

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Appendix 10. Checklists that have been produced – Ambulatory gynaecology ONLY

[Image of WHO Surgical Safety Checklist]

Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0
Page 46 of 53
Appendix 11. Checklists that have been produced – Paediatric interventions under general anaesthesia ONLY
Appendix 12. Checklists that have been produced – Cardiac Cath Lab procedures ONLY

**WHO Surgical Safety Checklist**
Cardiac Cath Lab procedures ONLY

<table>
<thead>
<tr>
<th>SIGN IN/TIMEOUT (To be read out loud)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before administration of local anaesthesia</strong></td>
</tr>
<tr>
<td>Has the patient confirmed his/identity, site, procedure and consent?</td>
</tr>
<tr>
<td>Have all team members introduced themselves by name and role?</td>
</tr>
<tr>
<td>Reference</td>
</tr>
<tr>
<td>Case and planned procedure outlined?</td>
</tr>
<tr>
<td>Specifics or equipment requirements identified?</td>
</tr>
<tr>
<td>IV access established and checked?</td>
</tr>
<tr>
<td>Have risk factors for bleeding and renal failure been checked?</td>
</tr>
<tr>
<td>Does the patient have a known allergy?</td>
</tr>
<tr>
<td>INR/ACT requirements met?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GA appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the anaesthetic machine check complete?</td>
</tr>
<tr>
<td>Is there a risk of difficult airway or aspiration?</td>
</tr>
<tr>
<td>What is the patient’s ASA grade?</td>
</tr>
<tr>
<td>Are there any specific anaesthetic concerns?</td>
</tr>
<tr>
<td>Is the correct monitoring equipment available?</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Signature of Registered Practitioner:</td>
</tr>
</tbody>
</table>

**PCI**

<table>
<thead>
<tr>
<th>BARE CONFIRMED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Centralisation to drug dosing systems?</td>
</tr>
</tbody>
</table>

**Aide-Memoire for team brief**

<table>
<thead>
<tr>
<th>TIP BIG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team present</td>
</tr>
<tr>
<td>Instructions by name and role</td>
</tr>
<tr>
<td>Procedure outlined, with specific risks &amp; equipment requirements</td>
</tr>
<tr>
<td>IV access established, and planned access sites reviewed</td>
</tr>
</tbody>
</table>

If applicable apply starch card sticker here

---

Support the Five Steps to Safer Surgery – Including National Safety Standards for Invasive Procedures Policy V5.0  
Page 48 of 53
Appendix 13. Checklists that have been produced – Dermatology Outpatients ONLY

WHO Surgical Safety Checklist
Dermatology Outpatients ONLY

SIGN IN (To be read out loud)
Before administration of local anaesthesia

- Have all team members introduced themselves by name and role? [ ] Yes [ ] Not applicable
- All team members verbally confirm:
  - What is the patient’s name, DOB and address? [ ] Yes [ ] Not applicable
  - What procedure, site and site plan are planned? [ ] Yes [ ] Not applicable
  - Has the patient confirmed his/her identity, site, procedure and consent? [ ] Yes [ ] Not applicable

- Is the procedural site marked? [ ] Yes [ ] Not applicable
- Is the local anaesthesia and medication check complete? [ ] Yes [ ] Not applicable
- Does the patient have a known allergy? [ ] No [ ] Yes
- Have risk factors for bleeding been checked? [ ] Yes [ ] Not applicable
- Does the patient have a cardiac pacemaker? [ ] Yes [ ] Not applicable
- Has Antibiotic prophylaxis been given? [ ] Yes [ ] Not applicable
- Is the required equipment available and in date? [ ] Yes [ ] Not applicable

SIGN OUT (To be read out loud)
Before any member of the team leaves the operating room

- Registered Practitioner/NCA verbally confirms with the team:
  - Has the name and side of the procedure been recorded? [ ] Yes [ ] Not applicable
  - Has it been confirmed that instruments, sponges and sharps counts are complete? [ ] Yes [ ] Not applicable
  - Have the specimens been labeled (including with patient’s name)? [ ] Yes [ ] Not applicable
  - Have any equipment problems been identified that need to be addressed? [ ] Yes [ ] Not applicable

Practicing clinician:
- Have the instructions for post procedural case for this patient been agreed? [ ] Yes [ ] Not applicable

Patient Details

- Last name:
- First name:
- Date of birth:
- NHS Number:

Name:

Signature of Registered Practitioner:

Confirmation that this WHO checklist has been entirely completed
Senior Operating Practitioner:

Name:

Signature:

Procedure:

Date:

Adapted from the NHS (WHO) for use in Cornwall

With effect from December 2013
Appendix 14. Checklists that have been produced – Ear, Nose and Throat (ENT) Outpatients ONLY

### WHO Surgical Safety Checklist

**Ear, Nose and Throat (ENT) Outpatients ONLY**

This MUST be completed for: Biopsies, injections, manipulation of fractured nose, myringotomy, electrocautery, quinsy, aspiration, incision and drainage of abscesses and removal of a foreign body

#### SIGN IN (To be read out loud)

**Before administration of local anaesthesia**

- Have all team members introduced themselves by name and role? □ Yes □ No
- All team members verbally confirm:
  - What is the patient's name, DOB and address? □ Yes □ No
  - What procedure, site and position are planned? □ Yes □ No
  - Has the patient confirmed his/her identity, site, procedure and consent? □ Yes □ No
- Is the procedural site marked? □ Yes □ Not applicable
- Is the local anaesthesia and medication check complete? □ Yes □ Not applicable
- Does the patient have a known allergy? □ No □ Yes
- Have risk factors for bleeding been checked? □ Yes □ Not applicable
- Is the required equipment available and in date? □ Yes □ No

**Patient Details**

- Last name: [ ]
- First name: [ ]
- Date of birth: [ ]
- NHS Number: [ ]

**Procedure Note**

- Procedure: [ ]
- Surgeon: [ ]
- Staff present: [ ]

- Local anaesthetic: [ ]
- Procedure details: [ ]

**SIGN OUT (To be read out loud)**

**Before any member of the team leaves the operating room**

- Registered Practitioners/ICA verbally confirms with the team:
  - Has the name and side of the procedure been recorded? □ Yes □ No
  - Have all pieces of equipment used been accounted for? □ Yes □ No
  - Has it been confirmed that instruments, suture and sharp counts are complete? □ Yes □ No
  - Have the prosthesis been labelled (including with patient's name)? □ Yes □ No
  - Have any equipment problems been identified that need to be addressed? □ Yes □ No
  - Practising clinician:
    - Have the instructions for post procedural care for this patient been agreed? [ ]

**Confirmation that this WHO checklist has been entirely completed**

**Senior Operating Practitioner:**

- Name: [ ]
- Signature: [ ]
- Date: [ ]
- Procedure: [ ]
- Post procedure instructions and follow-up arrangements: [ ]

With effect from January 2013

[Diagram of checklist]
Appendix 15. Checklists that have been produced – FOR USE WITH ULTRASOUND GUIDED PROCEDURES INCLUDING FNA AND BIOPSIES

WHO Surgical Safety Checklist
FOR USE WITH ULTRASOUND GUIDED PROCEDURES INCLUDING FNA AND BIOPSIES

SIGN IN (To be read out loud)
Before start of intervention
All team members verbally confirm:
What is the patient's name? □ Yes □ No □ N/A
What procedure, site and position are planned? □ Yes □ No □ N/A
Has essential imaging been reviewed? □ Yes □ No □ N/A
Does the patient have any known allergy? □ Yes □ No □ N/A
Is the patient anticoagulated? □ Yes □ No □ N/A
Are there any critical or unexpected steps you want your team to know about? □ Yes □ No □ N/A
Is the required equipment available and in date? □ Yes □ No □ N/A

SIGN OUT (To be read out loud)
Before any team member leaves the clinical area
Registered Practitioner/ICA verbally confirms with the team:
- Have the specimens been correctly labelled (including the patient's name)?
- Are the details on the specimen request card correct?
- Have any equipment problems been identified that need to be addressed?

Confirmation that this WHO checklist has been entirely completed
Name: __________________________
Signature: _______________________
Procedure: ______________________
Date & time: _____________________

Please scan and attach patient details including procedure and location

Name: __________________________
Signature of Clinical Imaging Assistant: _______________________

Name: __________________________
Signature of Radiologist/Sonographer: _______________________

Confirm MAXIMS label matches details in middle column
□ Yes □ No
Has the probe been disinfected using Trophon? □ Yes □ No
Cycle: _______________________

Please scan and attach to patient’s CRIS record
Appendix 16. Checklists that have been produced – Theatre and all other General Anaesthetic activity ONLY

**WHO Surgical Safety Checklist**

**Theatre and all other General Anaesthetic activity ONLY**

<table>
<thead>
<tr>
<th>Before induction of anaesthesia</th>
<th>Before start of surgical intervention for example, skin incision</th>
<th>Before any member of the team leaves the operating room</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SIGN IN (To be read out loud)</strong></td>
<td><strong>TIME OUT (To be read out loud)</strong></td>
<td><strong>SIGN OUT (To be read out loud)</strong></td>
</tr>
<tr>
<td>- Has the patient confirmed his/her identity, site, procedure and consent?</td>
<td>- Have all team members introduced themselves by name and role?</td>
<td>- Registered Practitioner/HCA verbally confirms with the team:</td>
</tr>
<tr>
<td>- Is the surgical site marked?</td>
<td>- All team members verbally confirm:</td>
<td>- What have we recorded for the name of this procedure?</td>
</tr>
<tr>
<td>- Is the anaesthesia machine and medication check complete?</td>
<td>- What is the patient's name?</td>
<td>- Have all pieces of invasive equipment/implanted devices used been accounted for?</td>
</tr>
<tr>
<td>- Yes</td>
<td>- What procedure, site and position are planned?</td>
<td>- Has it been confirmed that instruments, swabs and sharps counts are complete (or not applicable)?</td>
</tr>
<tr>
<td>- No</td>
<td>- Does the patient have a known allergy?</td>
<td>- How has the specimen been labelled (including with patient's name)?</td>
</tr>
<tr>
<td>- Not applicable</td>
<td>- Yes</td>
<td>- Have any equipment problems been identified that need to be addressed?</td>
</tr>
<tr>
<td>- Yes</td>
<td>- No</td>
<td>- Practicing clinician:</td>
</tr>
<tr>
<td>Has pregnancy status been confirmed?</td>
<td>- Yes</td>
<td>- Have the instructions for post procedural care including antibiosis been agreed?</td>
</tr>
<tr>
<td>- No</td>
<td>- Not applicable</td>
<td></td>
</tr>
<tr>
<td>Difficult airway aspiration risk?</td>
<td>- Anticipated critical events</td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td></td>
<td>Operating clinicians:</td>
</tr>
<tr>
<td>- Yes</td>
<td></td>
<td>- How much blood loss is anticipated?</td>
</tr>
<tr>
<td>- Not applicable</td>
<td></td>
<td>- Are there any specific equipment requirements or special investigations?</td>
</tr>
<tr>
<td>- Yes, and equipment/attendance available</td>
<td></td>
<td>- Are there any patient specific concerns or co-morbidities?</td>
</tr>
<tr>
<td>- Yes, and additional IV access fluids planned</td>
<td></td>
<td>- What is the patient's ASA grade?</td>
</tr>
<tr>
<td>- No</td>
<td></td>
<td>- What monitoring equipment and other specific levels of support are required, for example blood?</td>
</tr>
<tr>
<td>- No</td>
<td></td>
<td>Nurse/OPD:</td>
</tr>
<tr>
<td>- No, and patient is diabetic</td>
<td></td>
<td>- Has the integrity of the instrumentation been confirmed (including indicator results)?</td>
</tr>
<tr>
<td>- Yes, what is the latest blood glucose _______</td>
<td></td>
<td>- Are there any problems with equipment or anything unusable?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Has the surgical site infection (SSI) bundle been undertaken?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Has VTE prophylaxis been undertaken?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Not applicable</td>
</tr>
</tbody>
</table>

**Patient Details**

Name: [ ]

Signature of Registered Practitioner: [ ]

**Last name:** [ ]

**First name:** [ ]

**Date of birth:** [ ]

**NHS Number:** [ ]

**X-RAY STAFF**

All relevant ERMER requirements are met

Yes

**Name:** [ ]

Signature of Registered Practitioner: [ ]

**Confirmation that this WHO checklist has been entirely completed**

Senior operating surgeon:

Name: [ ]

Signature: [ ]

**Procedure:** [ ]

**Date:** [ ]
## Appendix 17. Briefing

### Pre-List Briefing

<table>
<thead>
<tr>
<th>All Staff present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
</tr>
<tr>
<td>Anaesthetist</td>
</tr>
<tr>
<td>Theatre staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Briefing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
</tr>
<tr>
<td>Skill mix</td>
</tr>
<tr>
<td>Additional personnel</td>
</tr>
<tr>
<td>Breaks/recovery</td>
</tr>
<tr>
<td>List Order</td>
</tr>
<tr>
<td>Overrun</td>
</tr>
<tr>
<td>Equipment (e.g. specific table/lighting/cell salvage)</td>
</tr>
<tr>
<td>Recovery Handover</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>List run-through each patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned procedure</td>
</tr>
<tr>
<td>Specific equipment</td>
</tr>
<tr>
<td>Anaesthetic concerns</td>
</tr>
<tr>
<td>Blood availability</td>
</tr>
<tr>
<td>Post-op destination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When to debrief?</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. End of list/during closure of final case/after each case</td>
</tr>
</tbody>
</table>

### Post-List briefing

<table>
<thead>
<tr>
<th>All Staff present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
</tr>
<tr>
<td>Anaesthetist</td>
</tr>
<tr>
<td>Theatre staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was briefing effective?</th>
</tr>
</thead>
</table>

| Were WHO checks done and were they effective? |  |

| What worked well (teamwork, timing, preparation)? |  |

| Was communication effective and were there any misunderstandings? |  |

| Were there any problems or issues? (e.g. staffing, scheduling, equipment) |  |

| Is there a plan to address the issues? |  |

---

*On completion please hand this sheet to the theatre/department manager.*