University Hospitals of Leicester NHS
NHS Trust

SAFE SURGERY and INVASIVE PROCEDURES POLICY

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Trust Lead:	Gang Xu, Deputy Medical Director
Board Director Lead:	Andrew Furlong, Executive Medical Director
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Version 3, July 2017:

The policy has been updated into the new trust format. The following changes to the policy have been made:

- Form for team briefing and debrief appended
- Attendance of more members of team at Sign In required
- Greater clarity over where, when, who and how checklists are performed
- Addition of "learning from incidents"
- Addition of process for prosthetic verification
- Greater detail around site marking in line with national policy
- Brought into line with National Safety Standards for Invasive Procedures
- List of procedures that do not need to follow the policy removed
- Addition of audit form for quality visits to theatres

Version 4, August 2020:

- Section 4.2 – section added on the current governance structure
- Section 5.2.2 – two wristbands are now required for all patients
- Section 5.5.4 re: laterality marking in Gynaecology added
- Section 5.8 re: Stop the Line added
- Appendix 1 revised
- Appendix 4 removed
- Appendix 5 removed
- Stop the Line added as a keyword

Version 5, Nov 2021:

- Amendment to paragraph 5.7.4: surgeon must actively engage in checking the packaging

Version 6, October 2023:

- Harmonisation of the Safety Surgery Policy to include invasive procedures.
- Alignment to UHL's Patient Safety Incident Response Framework
- Changes in the policy to reflect the National Safety Standards for Invasive Procedures (NatSSIPs) 2 publication in 2023
- The emphasis is on incident prevention with a focus on Never Events.
- Appendix 4 added
- Appendix 5 added
- Updated for digital consent

KEY WORDS

Safer surgery, Safe surgery, WHO checklist, Team brief, Team debrief, Never Event, LocSSIP, NatSSIP, NatSSIPs2 Five steps to safer surgery, 5 steps to safer surgery, Stop the Line and ‘Prep, Stop, Block’. Patient Safety Incident Response Framework.

1. INTRODUCTION AND OVERVIEW

1.1. This document sets out the University Hospitals of Leicester (UHL) NHS Trust's Policy and Procedures for compliance with:

- World Health Organisation 'Safe Surgery Saves Lives' initiative launched in June 2008;
- NHS Five Steps to Safer Surgery initiative;
  Patient Safety Tip of the Week Archive
- National Safety Standards for Invasive Procedures (NatSSIPs) (https://improvement.nhs.uk/documents/5405/NatSSIPs_Final_updated_June_2019.pdf);
- CPOC 'The NatSSIPs Eight' (https://cpoc.org.uk/sites/cpoc/files/documents/2022-12/CPOC_NatSSIPs2_NatSSIPs8_2023.pdf);
- National Safety Standards for Invasive Procedures 2 (NatSSIPs 2) (https://cpoc.org.uk/sites/cpoc/files/documents/2023-02/1.%20CPOC_NatSSIPs_FullVersion_2023_0.pdf).

1.2. The World Health Organisation (WHO) 'Surgical Safety Checklist' is a core set of safety checks identified to improve team performance at safety-critical time points within the patient's perioperative care pathway. This policy translates the WHO, NatSSIPs and NatSSIPs 2 guidance into local processes (Local Safety Standards for Invasive Procedures {LocSSIPs}) to be used within The University Hospitals of Leicester NHS Trust (hereafter referred to as 'the Trust').

1.3. It enables a standardised way of working across all areas of the Trust where invasive procedures are undertaken in an operating theatre or any other area within the Trust and in accordance with the NatSSIPs 2.

1.4. Alignment of Never Event investigations to the NHS Patient Safety Incident Response Framework (PSRIF) for investigation of Never Events.

2. POLICY SCOPE

2.1. This policy is to be used by all staff, including bank and agency, and contractors employed by the Trust and involved in the perioperative care of patients.

2.2. The policy applies to all patients having surgery or an invasive procedure in the operating department by Trust-employed staff as part of Trust-governed clinical activity, including any procedure under local anaesthetic.

2.3. Other areas performing invasive procedures within UHL and the Alliance (e.g. Cardiac Catheter Labs, Imaging Suites, Endoscopy Suites, Clean Rooms, Minor Operation rooms etc.) must be guided by the principles of this policy. They are also expected to have their local surgical safety checklists and standard operating protocols in accordance with National Safety Standards for Invasive Procedures 2 (NatSSIPs 2).

2.4. This policy covers the use of the UHL WHO Safer Surgery Checklists and incorporates advice on-site marking. It should be read in tandem with other important policies that are relevant to Safer Surgery (Section 9).

3. DEFINITIONS AND ABBREVIATIONS

3.1. Invasive procedures:

An invasive procedure is a procedure that is performed where a hole or incision is made in a patient or via a patient orifice and usually where documented consent is required. Invasive procedures can occur in many healthcare specialties including surgery, radiology, medicine, maternity, emergency care, and in theatres, wards and outpatient care.

3.2. NatSSIPs 2:

The National Safety Standards for Invasive Procedures 2 (NatSSIPs2) have been published by the Centre for Perioperative Care and written by practising clinicians, from across the four UK nations, across disciplines, professions and organisations, with patient and organisational input. They incorporate safety science and learning from all UK nations' patient safety strategies and major reports and investigations.

3.3. Never Events:

The concept of 'Never Events' was introduced into the UK in 2009, with a list of eight adverse patient safety events. Never Events are defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented". The current Never Event list (January 2018) includes:

- Wrong site surgery
- Retained foreign object post-procedure
- Wrong prosthesis or implant
- Mis-selection of strong potassium solution
- Wrong route administration of medication
- Overdose of insulin due to misuse of abbreviations or the wrong device
- Overdose of methotrexate for non-cancer treatment

• Mis-selection of high-strength midazolam solution during conscious sedation.

3.4. Major or Minor procedure:

Major procedures require more checks and generally a full count (except for interventional radiology areas).

Minor procedures require fewer checks (Sign In and Time Out can be combined) and generally a proportionate count.

3.5. Pre-operative:

This refers to the period before anaesthesia/Surgery when physical and psychological preparations are made for the patient's operation per their individual needs. The Preoperative period runs from the time the patient is admitted to UHL to the time that the anaesthesia/Surgery begins.

3.6. Perioperative:

This refers to the total surgical patient pathway from preparation for surgery preoperatively, transfer to theatre, intraoperative management, and the immediate postoperative period in recovery before transfer to the postoperative ward.

3.7. Preparation for surgery checklist:

This is the checklist filled in by a registered nurse on the ward to confirm that preparations for surgery are complete before the patient leaves the ward/theatre arrivals area for their procedure.

3.8. Theatre reception check:

This is completed by theatre staff upon the patient arriving into the theatre reception area. The check confirms the patient's identity and that the preparation for surgery checklist has been completed accurately and completely.

3.9. Consent and Procedural Verification:

The process of obtaining consent and shared decision making with the patient is 'an ongoing process focussed on meaningful dialogue: the exchange of relevant information specific to the individual patient.

3.10. Team Brief:

This is the team safety briefing that occurs at the start of every procedure list. It involves all team members and considers each patient on the list in turn.

3.11. Sign In:

This is the check completed when the patient enters the anaesthetic room or theatre before their procedure.

3.12. Time out:

This is the final check that occurs before the skin incision is made (or before a limb is prepped in the case of tourniquet application). It is a check that involves all team members and must be carried out in a focused way with all team members paying attention.

3.13. Implant:

An implant is an item intended to remain within the patient's body long term. The term prosthesis is sometimes used, but this usually implies a replacement part. The term implant is used here as it is broader and includes stents, pacemakers and similar devices.

3.14. Reconciliation of items:

The processes outlined in this standard should ensure that all items are accounted for and that no item is unintentionally retained at the invasive site, in a body cavity, on the surface of the body, or in the patient's clothing or bedding.

3.15. Sign out:

This is the check that occurs before the end of the operation or procedure, whilst all team members, including the operating surgeon, are still present in theatre with the patient.

3.16. Team Debrief:

This is the safety briefing that occurs at the end of the operating list to discuss what went well, what the team has achieved, and any issues. This is an action-focused meeting that has actions recorded and assigned with a date for follow-up.

3.17. Prepping:

The term prepping refers to preparation made at the operation site for surgery immediately before drapes are applied. For example - shaving the skin and applying antiseptic preparations.

3.18. Pre-operative site marking:

This refers to the process of marking the operative site before the operation to ensure that the correct side and site is operated on.

3.19. LocSSIPs:

Local Safety Standards for Invasive procedures (LocSSIPs) are safety checklists and standards to ensure interventional procedures are carried out with essential safety barriers in place and minimize risk to patients.

3.20. Anaesthetic practitioner:

This refers to either an Operating Department Practitioner (ODP), or a Registered Nurse in their role when they are providing anaesthetic assistance to anaesthetists.

3.21. Lead Anaesthetist:

This refers to the anaesthetist who is taking the lead anaesthetic role in an operating list. Usually this would be a consultant anaesthetist, or the most senior anaesthetist present.

3.22. Lead Surgeon:

This refers to the surgeon who is taking the lead surgical role in an operating list. Usually this would be a consultant surgeon, or the most senior surgeon present.

3.23. Scrub practitioner:

This refers to an Operating Department Practitioner, a Registered Nurse or any other trained clinical practitioner in their role when they are providing scrub assistance for the operation.

3.24. Practitioner in Charge:

This is the ODP or theatre nurse nominated to be in charge of the operating theatre.

3.25. University Hospitals of Leicester (UHL) World Health Organisation (WHO) Safer Surgery Checklist:

Throughout this document the UHL WHO checklist refers to the UHL variant of the WHO checklist. The original WHO checklist has been modified for local use.

3.26. Prosthesis:

A Prosthesis is defined as an internal or external medical device for artificial replacement of an absent or impaired structure. It is interchangeable with the term implant.

3.27. ORMIS:

Operating Room Management Information System – this is the computer system used to record processes in operating theatres.

3.28. Stop the Line:

This refers to a concept where any team member is able to “Stop the Line” meaning that if they feel that something is a risk to patient safety they are empowered to speak up and stop processes until the issue is remedied.

4. ROLES

4.1. Medical Director and Chief Nurse:

These are the executive leads for this policy and are responsible for ensuring that appropriate management mechanisms are in place across the Trust to ensure that this policy is adhered to.

4.2. Deputy Medical Director/ Chair of Safe Surgery Board:

The Deputy Medical Director for "Safe Surgery" chairs the "Safe Surgery Board" which oversees the project work linked to the Quality Strategy "Safe Surgery and Procedures" quality priority.

The Safe Surgery Board reports directly into the Executive Quality Board. The current Description and Purpose of the "Safe Surgery and Procedures" group is detailed below within Table 1. These are subject to review and approval by the Executive Quality Boards.

Table 1:

Description and Purpose

The Safe Surgery and Invasive Procedures group (SSIP) is a subgroup of the Surgical Care ProgramBoard. Its primary purpose is to provide leadership and oversight to quality improvement work relating to the Safe Surgery agenda throughout the University Hospitals of Leicester NHS Trust. The main focus of the group is incidents prevention with emphasis on never events. SSIP comprises of work related to ensuring that national safety standards pertaining to surgery and invasive procedures are implemented and are business as usual in our clinical areas. In particular its remit is to:

- To provide the necessary leadership and oversight for ensuring that the Safe Surgery and Invasive Procedure Policy is implemented and running smoothly in all UHL theatres (including the alliance) and relevant clinical areas.
- To support development and sustainability of a safety culture in clinical areas.
- To ensure that the "Stop the Line" campaign is embedded, effective and sustained in clinical areas.
- To monitor and evaluate success of the safe surgery / Stop the Line agenda and to ensure that metrics for long term assurance purposes are embedded.
- To provide corporate leadership and oversight to the trust-wide LocSSIP programme.

- To liaise closely with the Clinical Management Groups (CMGs) to ensure there is an alignment across the services to help achieve the shared common objectives, in addition to providing corporate support.
- To work closely with the Surgical Care Programme team and board to ensure that the work plan aligns with the wider objectives of the overarching programme board.

4.3. Clinical Management Group (CMG) Directors, CMG Heads of Operation, and CMG Heads of Nursing:

Shall be responsible for ensuring an appropriate infrastructure is in place to implement this policy.

4.4. Clinical Management Group (CMG) Heads ofService, Managers, Matrons and Heads of Nursing:

- Shall be responsible for ensuring all relevant staff are aware of this policy and their responsibilities
- Shall ensure a record is kept in each theatre of team brief and debrief for audit purposes.
- In addition, Heads of Service in areas other than theatres where invasive procedures are performed will be responsible for ensuring that surgical safety checklists and LocSSIPs are developed and implemented for those area.

4.5. Department and Ward Managers:

- Shall be responsible for ensuring the guidance within the policy is fully implemented.
- Managers must be assured of the competency of Practioners employed through an agency or bank. They must provide written evidence of competence. On the day of commencement the temporary staffing green book induction assessment must be completed.

4.6. Theatre Development Practice Coordinator:

- Shall be responsible for ensuring that all relevant staff receives training in the use of the 'Safer Surgery' checklist during local induction programmes
- Shall ensure access to educational material (e.g. DVD) including guidance for use of the 'Safer Surgery' checklist during this induction training.
- Shall ensure that attendance at local induction training is monitored in line with the Trust's Corporate and Local Induction policy.

4.7. All members of staff involved in the perioperative care of patients:

- Must follow the procedures laid down in this policy.
- Must accept responsibility for updating knowledge and skills to maintain

competence.

• Must “Stop the Line” if they are aware that actions are potentially causing a threat to patient safety.

• Must follow the Local Safety Standards for Invasive Procedures and ‘Protected by LocSSIPs’ Safety Checklists.

5. POLICY IMPLEMENTATION MAJOR PROCEDURES: WHAT TO DO AND HOW TO DO IT

5.1. Using the UHL ‘WHO’ Safer Surgery Checklists

5.1.1. The Trust has adapted the WHO Surgical Safety Checklist to ensure relevance to the Trust’s processes. This differs by the inclusion of both a ward and theatre reception checklist for pre-operative patient checks. It also includes elements of the previous National Patient Safety Agency guidance for correct site surgery. It is compliant with NatSSIPs and NatSSIPs2.

The aim of safe surgery pathway should include the following steps:

1	Consent
2	Team Brief
3	Sign In
4	Time Out
5	Safe and efficient use of Implants
6	Reconciliation of items in the prevention of retained foreign objects
7	Sign Out
8	Handover/Debrief

5.1.2. The UHL WHO checklist must be completed for every patient undergoing a surgical procedure (including local anaesthesia).

5.1.3. The UHL WHO checklist is a generic checklist that is applicable to all patients. It is appreciated that some specialties may benefit from the use of a more bespoke checklist that incorporates all items on the UHL WHO checklist but has the addition of more specialty-specific fields. There is a limited range of national WHO checklists variants that exist for this purpose (e.g. WHO checklist for Safer Cataract Surgery). Where appropriate, such subspecialty variants of the checklist can be used or developed provided that they meet national guidance, have no omissions from the standard checklist and are signed off by the ITAPS Quality and Safety Board, the relevant CMG Quality and Safety Board and the Safe Surgery Board. Such

checklists must be piloted before introduction and will be appended to this document after approval and prior to implementation. The UHL WHO Safer Surgery Checklist should be available within all Theatre Arrival Areas, Individual Theatre Suites and all Clinical Areas. Subsequent Variants should also be available within specialty areas such as “Safer Surgery Checklist for Cataract Surgery” within Ophthalmology. Electronic versions of the Safer Surgical Checklist will also be available via UHL InSite.

5.1.4. The checklist must be fully completed in black ballpoint pen and signed at each step by the Registered Practitioner involved in that aspect of the patient’s care.

5.1.5. A copy of the completed checklist must be retained in the patient’s notes or electronic clinical record. Under the exceptional circumstances where the checklist is not completed or is not retained, the reasons must be documented in the patient’s notes by the operating surgeon.

5.1.6. The patient’s addressograph label must be attached to the checklist (on both sides). Where this is not possible, the patient’s details must be handwritten on the document with S number, name, and date of birth as a minimum.

5.1.7. The checklist is divided into two parts. In addition the team briefing and debriefing are documented separately.

<table>
<tr><td rowspan="2">Part 1:</td><td>Preparation for surgery</td><td>Completed on the ward</td></tr>
<tr><td>Theatre reception check</td><td>Completed in theatre reception</td></tr>
<tr><td rowspan="3">Part 2:</td><td>Sign In</td><td rowspan="5">Completed in theatre</td></tr>
<tr><td>Time out</td></tr>
<tr><td>Sign out</td></tr>
<tr><td rowspan="2">Briefing documents:</td><td>Team briefing</td></tr>
<tr><td>Team debriefing</td></tr>
</table>

5.1.8. Appendix 2 makes clear the various checklists and steps involved, where, when and how they are performed.

5.2. PART ONE – PREPATION FOR SURGERY

5.2.1. This Ward section of the checklist must be performed by the Registered Nurse responsible for the patient’s care prior to transfer to the operating theatre. Signed confirmation that the nursing check has taken place is required. This section must be signed off immediately prior to patient transfer ensuring that all relevant

documentation accompanies the patient to the operating theatre.

5.2.2. The Ward section of the Safer Surgical checklist must include confirmation that the patient has been issued with two wrist bands for the purpose of positive patient identification for all patients. The patient must be advised of the requirement to wear both Identification bands for the purpose of correct patient identification and Allergy recognition.

5.2.3. The Ward section of the checklist must confirm that a valid digital consent form for the planned procedure has been completed and is available electronically (or a paper consent form for the planned procedure is in the patient's notes).

5.2.4. If a Consent Form 4 (digital or paper based) has been used for an Adult unable to give consent, then completion of the Mental Capacity Assessment on the form must also be confirmed and signed (a digital consent form 4 cannot be completed without the completion of a Mental Capacity Assessment).

5.2.5. The patient must not leave the ward/ Theatre Admissions Area (TAA) until these checks are completed.

5.2.6. The Theatre Reception Check is done by using the relevant checklist and must be performed by the Registered Practitioner who is collecting the patient from the operating theatre reception area and must include confirmation of:

1) The patient's identity (verbally and by patient ID band)
2) Operative procedure to be performed
3) Consent form correctly completed
4) Visual confirmation of Operation site to confirm it is marked. Privacy and dignity must be maintained during this check. If the site has not been marked then it must be marked before the patient proceeds into the anaesthetic room.
5) Details within the ward nursing check
6) Signed confirmation that this check has been performed is required

5.2.7. The check-in at the Theatre Reception must not proceed if the ward checks are incomplete.

5.2.8. Under normal circumstances, any significant error in patient identification, consent or operative site marking will necessitate the patient return to the ward for this to be remedied.

5.3. PART TWO – OPERATING THEATRE CHECKLIST

5.3.1. Consent and Procedural virification including site marking:

5.3.1.1. Pre-operative marking has a significant role in promoting correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level (e.g. the correct finger on the correct hand).

5.3.1.2. Surgical site marking is mandatory for all procedures for which it is possible.

5.3.1.3. An appropriate indelible skin marker pen that is not removed by use of alcohol-based skin preparation must be used. The mark must be an arrow that extends to, or near to, the incision site and should remain visible after the application of theatre drapes. It is important to ensure the mark does not extend onto the intended incision site to avoid possible permanent 'tattooing' of the patient.

5.3.1.4. Surgical operations involving one side (laterality) must be marked at, or near the intended incision. For digits on the hand and foot the mark must extend to the correct specific digit. Before marking the intended surgical site should be identified from reliable documentation and images and confirmed where possible with the patient.

5.3.1.5. When performing laparoscopic surgery the laterality of the organ / structure being treated must be indicated by a pre-operative mark on the skin in proximity to the organ / structure being operated on. In some circumstances this may mean the mark does not remain visible after the application of theatre drapes.

5.3.1.6. For procedures on paired internal organs, where the only determinant of side is radiological images, the patient must not be marked without reference to the images. In circumstances where this is not possible (i.e. unavailability of images) all available means to confirm the correct site **must** be used prior to marking (for instance clinic notes, imaging reports).

5.3.1.7. Best practice demands that marking the operative site must be undertaken by the operating surgeon performing the procedure. Where judged appropriate this task may be delegated to a nominated deputy who must be present in the operating theatre.

5.3.1.8. When the procedure is carried out. In any event, the operative site must be confirmed by the operating surgeon with the team during 'time out' prior to the start of surgery.

5.3.1.9. It is only following the 'Time Out' and identification of the correct limb that for example; application of a tourniquet, hair removal, cleansing and prepping of the limb/ knife to skin/nerve block/line or guide wire insertion should surgery commence.

5.3.1.10. If a tourniquet is to be applied there must be a time out prior to prepping and draping the limb.

5.3.1.11. The process of pre-operative marking of the intended site must involve the patient and / or family members/ significant others where possible.

5.3.1.12. The surgical site must be marked prior to the transfer of the patient to the theatre suite. There may be rare occasions where this is not possible. In these instances it is permissible for pre-operative marking to be performed in the theatre reception area prior to transfer to the anaesthetic room.

5.3.1.13. The surgical site mark must subsequently be checked at each transfer of the patient's care and finally by the operating surgeon / theatre team prior to the commencement of surgery at the Time Out.

5.3.1.14. If a patient refuses pre-operative marking the operating surgeon or nominated deputy must consult with the patient and explain the additional risks. This explanation must be fully documented in the patient's notes and / or electronic records before proceeding with the operation.

5.3.1.15. SPECIAL CIRCUMSTANCES WHERE MARKING MAY NOT BE APPROPRIATE OR NEEDS A MODIFIED PROCEDURE:

It is recognised that pre-operative marking may not be appropriate in all circumstances, for example:

- Where emergency surgery would be delayed due to pre-operative marking.
- Operative procedures on teeth and mucous membranes.
- Cases of bilateral simultaneous organ surgery (e.g. squint surgery).
- Situations where the laterality of surgery needs to be confirmed following examination or X-ray under anaesthesia.
- In these instances the UHL Safer Surgery Checklist assumes greater importance in order to ensure surgery at the correct anatomical site is undertaken. The correct site for surgery must be confirmed by checking against the patient's records, consent form, operating list and, when possible, verbally with the patient. When using a verbal check for individuals with communication difficulties (e.g. hearing loss, non-English speaking, etc.), the person performing the checks must be assured of the patient's level of understanding. Assistance for interpreter services or the hearing loss services (i.e. for signing) may be required.

5.3.1.16. In the case of teeth, national guidance should be followed:

- Skin marking is appropriate to indicate laterality when only one side is to be operated on.
- Only Palmer notation should be used.

- Teeth to be removed are to be documented in full long hand on the consent form, operating list and on the theatre whiteboard using Palmer notation.
- A printout of the patient's X-ray imaging must be printed and affixed to the whiteboard. The tooth or teeth to be removed must be marked on this printout. This should remain visible to the surgeon throughout the procedure.
- The imaging should be labelled with the patient's details immediately after printing.
- Imaging must not be printed in batches to avoid labelling errors.
- Immediately prior to extraction of a tooth there should be an "extraction pause" to double check the tooth to be removed, cross-referencing the tooth against the imaging and counting out loud to confirm with the assistant the tooth number. The side and arch should also be confirmed with the assistant using the consent form, operating list and imaging on the whiteboard.
- Only when this pause and final check has occurred can the tooth be removed.
- The counting procedure must be repeated if the surgeon changes sides during the extraction procedure.

5.3.1.17. A gynaecology specific site marking policy that deals with how to mark the laterality of internal gynaecological organs is available here: uhltrnhsuk.sharepoint.com/teams/PAGL/pagdocuments/Forms/Default.aspx?id=%2Fteams%2FPAGL%2Fpagdocuments%2FSurgical Site Marking Standard Operating Procedure UHL Gynaecology Guideline%2Epdf&parent=%2Fteams%2FPAGL%2Fpagdocuments

5.3.2. Team Brief:

5.3.2.1. It has been recognised through Root Cause Analysis of adverse events that deficits in 'non- technical' skills such as poor communication, lack of situational awareness and ineffective teamwork were accountable for 60-80% of incidents. Briefing and debriefing sessions are integral to the Five Steps to Safer Surgery and it is considered mandatory for these to take place at the beginning and end of a theatre list to remedy deficits in team performance, with a record of incidents and planned actions retained by theatre staff.

5.3.2.2. The team briefing to assist in preparation for the operating list will be performed in theatre before the first patient arrives and will involve **all** members of the team (i.e. theatre staff, surgeons and anaesthetists).

5.3.2.3. Each member of the procedural team expected to be involved in the scheduled session must be named and the team brief document made easily visible throughout the session. Team members should introduce themselves to ensure that their roles and names are known and to encourage people to speak up.

5.3.2.4. The surgeon, scrub practitioner and anaesthetist if relevant must be identified for each case listed. Any changes to the team members during the day must also be recorded in this document or notice, and must be the subject of an appropriate briefing if anticipated.

5.3.2.5. The safety briefing should consider each patient on the procedural list in order from an operator, anaesthetic and practitioner perspective. A process must be in place to update the procedural team with relevant information in the case of staggered admissions, i.e. if patients are admitted after the start of the list.

5.3.2.6. The expected duration of each procedure, to include anaesthetic procedures, should be identified. This should promote a discussion about agreed plans if it appears that the duration of the planned procedures will exceed the time allocated.

5.3.2.7. Any additional concerns from an operator, anaesthetic or practitioner perspective must be discussed, and contingency plans made.

5.3.2.8. Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.

5.3.2.9. The briefing may need to be conducted on a case-by-case basis if there is a change in key team members during a procedure session.

5.3.2.10. The team brief is to be recorded on the template available in Appendix 3.

5.3.2.11. The operating list cannot proceed until a team brief has taken place.

5.3.3. Sign In:

5.3.3.1. This check must be performed by the anaesthetist, lead surgeon, and anaesthetic practitioner prior to the induction of anaesthesia.

5.3.3.2. During this check the patient's identity must be checked against their wrist band and consent form, and the procedure to be performed checked with the patient (when possible) and operating list. Correct site marking must be confirmed. The check also must include details of:

- Allergies
- Aspiration risk
- Airway concerns
- Anticipated blood loss and availability of blood products

5.3.3.3. Signed confirmation that the check has been carried out is required.

5.3.3.4. Learning from incidents

1. A 67 year man underwent surgery. Despite a documented allergy to penicillin the patient received co- amoxyclav as their prophylactic antibiotic on induction.
The learning from this incident was that the Sign In check must be performed correctly in order to ensure that patient allergies are noted by the team.

2. A 75 year old woman was undergoing surgery. The Sign In procedure failed to identify that she did not have a valid consent for the operation. The patient had to be woken up from a general anaesthetic in order to sign a consent form before surgery could proceed.
The learning from this case was that all the prescribed theatre checks need to happen correctly before anaesthetic. Lack of involvement of the surgeon at Sign In was a critical factor.

5.3.3.5. Anaesthesia must not commence until the Sign In is completed.

5.3.3.6. Rare Exceptions: There are rare and infrequent instances when completion of 'sign in' or 'time out' may not be able to occur due to justifiable reasons. For example: emergency life-saving surgery where speed is of the essence (e.g. Category 1 Caesarean section). In such circumstances, where the balance of risk appears that completing these steps may delay intervention, omission of these steps is permitted. In this instance a 'sign out' must always be completed. The reasons for omission must be documented in the operation note.

5.3.3.7. These rare occasions must be recorded onto the ORMIS care plan as 'Not Applicable'.

5.3.4. Time Out:

5.3.4.1. This is the final check before the commencement of surgery and is the final opportunity to identify the patient, the procedure to be performed and the site of the procedure. It should take place before skin incision is made and ideally before prepping and draping of the part to be operated on. It is led by the practitioner in charge.

5.3.4.2. If a tourniquet is being applied it is mandatory to perform time out before the limb is prepped.

5.3.4.3. It is crucial that the operating theatre team pause from their duties during the 'time out' in order that their attention can be focused on providing accurate responses to the scripted questions asked. A signed confirmation is required from the Registered Practitioner who has led the time out.

5.3.4.4. The operation must not start until the 'time out' is completed and documented on the ORMIS Care Plan.

5.3.4.5. Surgery must not commence until the Time Out has been completed.

5.3.4.6. If more than one site requires new prepping and draping during surgery the time out must be repeated.

5.3.4.7. When different operator teams are performing separate, sequential procedures on the same patient, a time out should be performed before each new procedure is started.

5.3.5. Safe and Efficient Use of Implants

5.3.5.1. Verification is essential for correct surgical placement of the appropriate prosthesis. Harmful effects arising from incorrect prosthesis selection may include patient factors, e.g. mortality, morbidity and further procedures, surgical factors, e.g. substandard clinical outcome, and financial costs, e.g. discarded prostheses, medico- legal repercussions, cancelled cases due to lack of prosthesis availability.

5.3.5.2. The surgeon must use the safety briefing before the start of a procedural list to confirm with the procedural team that the required prostheses, or range of implantable material such as may be needed for fracture fixation, for every patient in the procedural list, and any relevant equipment associated with their insertion, are present in the procedural area.

5.3.5.3. The operator must inspect the available prostheses and confirm that the correct prosthesis or range of prostheses, or range of implantable material such as may be needed for fracture fixation, is available before arranging for the patient to be brought to the procedural area.

5.3.5.4. Before removal of the prosthesis from its packaging, the scrub practitioner alerts the surgical team to '**stop and pause'** for a verbal and visual check of the prosthesis/implant. Lead surgeon MUST stop and actively engage with checking the packaging. The surgeon or scrub practitioner reads out ALL the information on the prosthesis/implant packaging for the whole team to hear:

- Type, design, style or material.
- Size.

- Laterality.
- Manufacturer.
- Expiry date.
- Sterility.
- Dioptre for lens implants.
- Compatibility of multi-component prostheses.
- Any other required characteristics.

All the surgical team MUST verify the implant is correct

5.3.5.5. Once the correct prosthesis has been selected, any prostheses not to be used for that patient should be clearly separated from the correct prosthesis to minimise the risk of confusion between prostheses at the time of implantation.

5.3.5.6. A record of the implants used must be made in the patient's notes and appropriate details should be shared with the patient after the procedure. When a manufacturer's label is available, this should be placed in the notes. When it is not, the following should be recorded:

- Manufacturer.
- Style.
- Size.
- Manufacturer's unique identifier for the prosthesis, e.g. the serial number.

5.3.5.7. Compliance with local, national and international implant registries is mandatory.

5.3.5.8. The prosthesis used is also recorded in the theatre book by placing the manufacturer's label in the record of the operation.

5.3.5.9. The prosthetic and implant check box must be filled in on the Safer Surgery checklist to confirm that these checks have occurred.

5.3.6. Reconciliation of Items in The Prevention of Retained Foreign Objects:

5.3.6.1. See Surgical Swabs, Instruments, Needles and Accountable Items UHL Policy B35/2007.

5.3.7. Sign Out

5.3.7.1. Before completion of surgery, and prior to members of the operating team leaving the operating theatre, a final check list must be read out loud to the team to ensure all necessary actions have been taken. A signed confirmation is required from the Registered Practitioner who has read out this list.

5.3.7.2. The patient must not leave theatre until Sign Out is completed and documented on ORMIS.

5.3.8. Handover/ Debrief:

5.3.8.1. The team debrief must be committed to by all team members at the start of the session. The debrief must occur at the end of each theatre list with actions recorded and escalated by the lead theatre practitioner for the theatre session. This must be recorded on the form in Appendix 3 and retained in a file in theatre for audit purposes. The manager for the theatre must regularly review the actions arising from Team Debriefs to ensure appropriate and timely completion.

5.3.8.2. The debriefing may need to be conducted on a case-by-case basis if there is a change in key team members during a procedure session.

5.3.8.3. Learning from incidents

1. A 58 year old woman was undergoing extraction of a difficult upper molar. Due to difficulty in extracting the tooth the surgeon changed to the opposite side of the operating table to better extract the tooth. The surgeon failed to recount the tooth from the midline and therefore removed the neighbouring tooth. This error was recognised immediately and the wrong tooth was able to be re-implanted and the correct tooth extracted. This was declared as a Never Event.
The learning from this incident was that the teeth should be re-counted whenever a surgeon moves side during a procedure. The need for an extraction pause was re-iterated.

2. An elderly lady fell down the stairs and required surgery to internally fix a left sided femoral fracture using an intramedullary nail. The usual implant was not available due to a national shortage so a longer nail was chosen. When this was inserted it was found that it had perforated the anterior cortex of the femur. On closer inspection this was revealed to be because a right femoral nail had been used resulting in the curvature of the nail bowing posteriorly rather than anteriorly. The nail became wedged in position meaning that the patient had to have an additional metal plate and screws used to fix the fracture.
This was identified as a Never Event. Factors in causation included the fact that the implant was checked by the Theatre Circulator and an un-scrubbed orthopaedic registrar rather than the operating surgeon. Learning from this event was to emphasise the “stop and pause” moment before implant insertion and to ensure that the necessary checks outlined in this policy are carried out in a standardised format.

5.4. STOP THE LINE:

5.4.1. Stop the Line is the UHL way of raising safety concerns in the moment in order to avert a patient safety incident.

5.4.2. Stop the Line encourages everyone to speak up to protect patient safety using the approach:

- Say WHAT you see
- Say WHAT you are concerned about
- Say WHAT you want to happen to happen next to keep the patient safe

5.4.3. In theatres it is expected that when a staff member "stops the line" that all team members safely pause what they are doing to focus on the issue that has been raised; and act together to resolve the issue.

6. POLICY IMPLEMENTATION MINOR INVASIVE PROCEDURES:

6.1. For minor Invasive procedures less checks may be required, but should follow the same principles at for Major procedures.

6.2. Local patient safety standards for invasive procedures (LocSSIPs). LocSSIPs are Standard Operating Procedures (SOPs) that ensure safe care is delivered to patients undergoing invasive procedures.

6.3. UHL have already implemented a large number of LocSSIPs these have been developed by local teams with knowledge of their area.

6.4. The SSIP will provide overall governance of LocSSIPs within the trust. CMG Quality and Safety lead will take ensure LocSSPs are developed to standards expected of NatSSIPs 2. The following serves as guidance:

- Loccsip are locally developed and approved by clinical teams, and signed off via Quality Safety board for the CMG.
- Where the Loccsip impacts multiple CMGs, the SSIP board will

review and approve the Loccsip.

7. SAFE SURGERY AND INVASIVE PROCEDURE QUALITY ASSURANCE & ACCREDITATION PROGRAMME

The aim for the Safe Surgery and Invasive Procedures Quality Assurance and Accreditation programme is to visit two (2) clinical areas each month to assess and review that the NatSSIPs Eight, NatSSIPs (National Safety Standards for Invasive Procedures) and NatSSIPs2 are embedded, to assess and review the LocSSIPs (Local Safety Standards for Invasive Procedures) and safety checklists are embedded for all invasive procedures and aligned with the Care Quality Commission Core standards.

- UHL Safe Surgery Quality Assurance & Accreditation Programme Standard Operating Procedure – Safe Surgery and Procedures - UHL - SSQAA Programme SOP UHL v1 April 2022.pdf - All Documents (sharepoint.com);
- UHL Safe Surgery Quality Assurance & Accreditation Programme LocSSIPs Tool – Safe Surgery and Procedures - UHL - SSQAA LocSSIPs Tool UHL v1 April 2022.pdf - All Documents (sharepoint.com);
- UHL Safe Surgery Quality Assurance & Accreditation Programme Criteria Standards Framework – Safe Surgery and Procedures - UHL - SSQA&Q Standards Criteria Framework UHL v1 April 2022.pdf - All Documents (sharepoint.com);

To submit monthly Safe Surgery Audit and WHOBARS assessment as per Safe Surgery Quality Assurance & Accreditation programme.

8. NEVER EVENT INVESTIGATIONS:

All Never Event investigations will follow UHLs PSRIF investigation framework as mandated by NHS England (B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk). All Never Event investigations will be carried out line with UHL PSRIF framework and supported by the SSIP teams utilizing the following structure.

Tackling each Never Event using a System Engineering Imitative for Patient Safety (SEIPS) framework, including on site walkthrough, with active engagement of effected areas to encourage curiosity and drive changes in practice.

Empowering local areas to have governance over LocSSIPs (Local Safety Standards for Invasive Procedures) and safety checklists, therefore reducing administration burden and increasing agility of the team to respond when Never Events occur.

Active engagement with patients and service users to enable co-design of services where possible. The SSIP team have taken feedback directly from families, and utilised the feedback to challenge clinical processes. This has lead to clear actions which the SSIPs team is helping to facilitate, including the piloting of digital PH meter reading for Nasogastric tube sampling to help reduce human error when manually matching PH colour strips.

Working with Affected services to deliver effective Education and Training, utilising interaction where possible to help embed learning.

9. EDUCATION AND TRAINING REQUIREMENTS:

9.1. Newly Registered (non-medical) Practitioners employed by the Trust for theatres must have completed the CMG Induction Programme, theatre induction and related Band 5 Theatre Practitioner competencies. These competencies include a preceptorship programme and assessments, theatre etiquette package, theatre safety and WHO checklist DVD/ E Video, and competency assessment to assess knowledge in relation to this policy.

9.2. New Health Care Assistants employed by the Trust must have completed the WHO checklist DVD for areas where invasive procedures are undertaken and or received appropriate training in relation to the checks required in preoperative areas/ wards.

9.3. It is the responsibility of Departmental and Ward Managers to refer staff to the policy and records of compliance and training must be kept locally for such areas across the Trust.

9.4. All staff must accept responsibility for updating knowledge and skills to maintain competence.

9.5. A verification of a professional competence must be recorded by the CMG and transferred accordingly. Managers must be assured of the competency of Practitioners employed through an agency or bank. They must provide written evidence of competence. On the day of commencement the temporary staffing green book induction assessment must be completed.

9.6. All new staff, whether on a permanent contract or a temporary contract (Bank and Agency Staff), must at date of commencement be given a copy of this policy.

9.7. New medical staff working in operating theatres must have undertaken local

induction in their CMG. Relevant competencies are included in all anaesthetic and surgical training programmes, and are a pre-requisite for inclusion on the specialist register for consultants. Consultants supervising trainees or non-consultant grade doctors are responsible for ensuring that doctors working under their supervision have received adequate training in the processes in this policy.

10. PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Percentage of compliance to completion and documentation of relevant sections of the 'WHO' Safer Surgical Checklist as per policy	Lead Nurse	Quality metrics WHOBARS	Monthly and reported monthly	Reported to Corporate Nursing Team and reported via Chief Nurse to GRMC
		Operating Room Management Information System (ORMIS)	Daily	Reported daily to Team Leader and Head of Nursing
		Incident reviews (Local CMG Level)	Weekly	Reported to CMG Board and Quality and Safety meeting
Number of reported incidents per annum of surgical harm, number of near misses of surgical harm, and number of Never Events	DHON, Head of Nursing, Matrons and Quality and Safety Team	Datix review/ Incident reports and investigations	Weekly	Immediate review if required. Weekly assessment locally by site Matrons and Q&S Team
		'Walk around' of theatres/ Departments by Q&S team to review the practical application of the UHL Safer Surgical Checklist	Annually	Direct feedback to Team Leaders/Matrons/DHON Q&S report for relevant quarter

Compliance to local educational tools and sessions	Education Team	Team Builder Reports	Quarterly monthly	Reported to CMG Board

11. EQUALITY IMPACT ASSESSMENT:

11.1. The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

11.2. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

12. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

- National Safety Standards for Invasive Procedures (NatSSIPs) NHS England Patient Safety Domain September 2015 at: content/uploads/2015/09/natssips-safety-standards.pdfhttps://www.england.nhs.uk/wp- content/uploads/2015/09/natssips-safety-standards.pdf
- National Patient Safety Agency: How to Guide: Five steps to safer surgery. 2010. Available at: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286
- National Patient Safety Agency Patient Safety Alert NPSA/2009/PSA002 'WHO Surgical safety checklist'
- National Patient Safety Agency Patient Safety Alert NPSA/2009/PSA002 'WHO Surgical safety checklist – Supporting Information'
- LocSSIPs for dental extraction available at: https://www.rcseng.ac.uk/dental- faculties/fds/publications-guidelines/
- National Safety Standards for Invasive Procedures 2 (NatSSIPs) Centre for Perioperative Care January 2023 available at: https://cpoc.org.uk/sites/cpoc/files/documents/2023-02/1.%20CPOC_NatSSIPs_FullVersion_2023_0.pdf

UHL Policies that should be read in tandem with this policy:

- UHL Management of Surgical Swabs, Instruments, Needles and Accountable Items (Swab Policy) 2015, B35/2007

- UHL Sharps Management Policy. B8/2013
- UHL Infection prevention policy: B4/2005 UHL Safety Standards for Invasive Procedures Policy: B31/2016
- UHL Guidelines for pharmacological and mechanical thromboprophylaxis for venous thrombo- embolism: B9/2016
- UHL Policy for corporate and local induction. B4/2003

13. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. The policy will be reviewed every 5 years with preceding versions archived through the Trust's PAGL system.

University Hospitals of Leicester NHS Trust

APPENDIX 1

Safer surgery checklists

Part 1	Preparation for surgery	Theatre reception check
Who	Patient (when possible)	Patient (when possible)
	Registered nurse on ward or Theatre Arrivals Area (TAA)	Registered practitioner from theatre
Where	On the ward or TAA	In theatre reception area
When	Before the patient leaves the ward area/TAA to go to theatre	On arrival in theatre reception
How	Using the Preparation for Surgery checklist	Using Theatre Reception checklist
	Patient should not leave ward unless completed	Checked against wristband, site mark and consent form
		Privacy and dignity must be ensured

Part 2	Team brief	Sign in	Time out	Sign out	Team debrief
Who	All team members	Patient (when possible)	Patient (when possible)	All team members	All team members
		Lead anaesthetist	All team members	Lead surgeon must be present	
		Lead Surgeon			
		ODP/anaesthetic nurse			
Led by	Practitioner in Charge	Anaesthetic team	Practitioner in Charge	Scrub team	Anaesthetic and/or surgeon
Where	Theatre	Anaesthetic room	Theatre	Theatre	Theatre
When	Before the theatre list 08:30am for **morning** list	On arrival into anaesthetic room	Immediately before skin incision or start of the procedure	At end of operation before patient woken up (or leaves)	At end of list
	Before the theatre list 12:30pm for **afternoon** list*	Before administration of anaesthetic			
How	Instructions	Using Sign In checklist	All team focused on checklist	Using UHL WHO checklist	Recorded on the team debrief sheet
	Structured format focusing on each patient in turn	Checked against wristband, site marked and consent form	Using UHL WHO checklist		
	Recorded on team brief sheet		Checked against consent form and wristband		

*Times may vary by local agreement

PATIENT STICKER

Safer Surgery Checklist Preparation For Surgery

Procedure: .....

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Likes to be called: ..... Consultant: .....

Language spoken (if patient cannot speak English): ..... Date: ..... Ward: .....

Nursing Checks

IDENTITY BANDS x2 ☐

CONSENT

Signed and confirmed against notes / operation list ☐

If Consent Form 4 used, Mental Capacity Assessment completed ☐

If G+S or XM requested, consent includes risks of blood transfusion (using transfusion risks sticker) ☐

OPERATION SITE MARKED ☐

BLOOD PRODUCTS (check on ICE)

N/A ☐

G+S Sample 1 ☐ Sample 2 ☐

XMATCH ☐

Number of units: .....

Nurse completing

Name: .....

Signature: .....

ALLERGIES:	YES ☐	NO ☐	
Details:			
INFECTION RISK:	YES ☐	NO ☐	
Details:			
Last Food:	Date:	Time:	
Last Fluid:	Date:	Time:	
Diabetic:	YES ☐	NO ☐	
BM: ☐	Date:	Time:	N/A ☐
LMP:	Date:		N/A ☐
Pregnancy Test:	Pos: ☐	Neg: ☐	N/A ☐
Waterlow Score: ☐			
VTE Risk Assessment: ☐			
Anti-embolism Stockings supplied: ☐			N/A ☐

	N/A	Insitu	Removed	Notes
Pacemaker / Implanted Defib.			X	
Joint Replacements / Prosthesis			X	
Dentures				
Loose Teeth / Caps / Crowns			X	
Spectacles / Contact Lenses				
Hearing Aid				
Jewellery / Body Piercing				
Makeup / Nail Polish				

ACCOMPANYING DOCUMENTS:

Medical Notes ☐ Drug Chart ☐ Best Shot ☐

Nursing Chart ☐ EWS ☐

Observations (or EWS Print Out)

	Comments:
Temp:	
Pulse:	
BP:	
RR:	
SpO2:	
EWS:	
Height:	
Weight:	
BMI:	

Theatre Reception Check

I.D. Bands: ☐ Confirm identity: ☐

Consent Valid: ☐

and as per Operation List: ☐

Operation site marked: ☐

All details in Nursing Check are confirmed: ☐

Theatre Practitioner completing

Name: .....

Signature: .....

PATIENT STICKER

UHL Safer Surgery Checklist

STOP THE LINE

NHS University Hospitals of Leicester NHS Trust

Caring at its best

SIGN IN

Prior to any anaesthetic intervention, in the presence of the ODP and surgeon, the anaesthetist should check against wristband, consent, and confirm verbally with patient or guardian.

- ☐ Confirm patient's name, date of birth and Hospital number
- ☐ Confirm procedure and site with patient
- ☐ Confirm valid consent form matches identity and expected procedure
- ☐ Surgical Site Marked and visualised ☐ N/A
- ☐ Required implants / instruments available (if relevant)
- ☐ Known allergy ☐ Yes ☐ No

.....

- ☐ Anticipated difficult airway or aspiration risk ☐ N/A
  - ☐ Equipment / assistance available
- ☐ Anticipated blood loss >500ml (>7ml/kg in a child) ☐ N/A
  - ☐ Blood products available if needed
  - ☐ Use of cell salvage considered

'STOP BEFORE YOU BLOCK' done ☐ Yes ☐ N/A

Read out by: (PRINT) .....

Signed: .....

TIME OUT

After positioning and before skin incision the Surgeon, Anaesthetist and Theatre team members should verbally confirm with reference to the consent form, and wristband;

- ☐ Team members have introduced themselves by Name /Role
- ☐ Confirm patient name, Hospital number, date of birth
- ☐ Procedure, site and position

Surgeon
- ☐ Equipment requirements
- ☐ Expected duration
- ☐ Blood loss anticipated
- ☐ Blood product availability +/- use of cell salvage ☐ N/A
- ☐ Concerns or potential critical events

Anaesthetist
- ☐ Patient's ASA status
- ☐ Patient specific concerns or serious comorbidity

Scrub Practitioner
- ☐ Sterility of instruments confirmed

Surgical site care bundle
- ☐ Antibiotic prophylaxis given within the last 60 minutes
- ☐ Patient Warming
- ☐ Glycaemic control ☐ N/A
- ☐ Hair removal with clippers

- ☐ DVT precautions discussed and undertaken ☐ N/A
- ☐ Essential imaging displayed or reviewed

INTRA-OPERATIVE PAUSES N/A ■

- ☐ Prosthetic check
  - ▪ Surgeon and scrub practitioner confirm correct implant and expiry date and details entered in the patient record
- ☐ Check before you cement - confirm with anaesthetist
- ☐ Pause before you pull
  - ▪ Surgeon and scrub practitioner confirm dental identification prior to extraction and repeat if operator switches sides

Read out by: (PRINT) .....

Signed: .....

SIGN OUT

Before any member of the team leaves the operating theatre, and not before completion of the first surgical closing count, the team should verbally confirm:

- ☐ what procedure have you performed and is it correctly recorded
- ☐ the count is correct for all instruments, swabs, throat packs and sharps
- ☐ any specimens are correctly prepared and labelled
- ☐ any equipment issues identified
- ☐ estimated blood loss
- ☐ any transfused blood products are recorded on Blood Track
- ☐ antibiotic treatment documented
- ☐ VTE care bundle discussed
- ☐ all cannulae and extensions have been flushed
- ☐ key concerns for recovery and postoperative management, including if higher level of care required
- ☐ issues for de-brief noted

Read out by: (PRINT) .....

Signed: .....

Safer Surgical Team Brief Checklist

This checklist must be filed in the theatre brief / debrief folder

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Theatre: .....

Consultant: .....

Date: .....

Time started: .....

1. Team brief:

At the beginning of the list to discuss all cases, led by the theatre team leader.

For emergency theatres: new proforma to be completed for each incoming teams, and team brief with each new team.

- ☐ All team members have introduced themselves by name and role
- ☐ Issues resolved from last debrief
- ☐ Anaesthetic machine & drugs checked & ready
- ☐ Any outstanding investigations? YES☐ NO☐
- ☐ Are the patients where the list says they are
- ☐ Any latex allergies
- ☐ Confirm list order
- ☐ All team members wearing their dosimeters N/A☐

STOP THE LINE

Patient name, Number and Procedure	Surgical Input					Nursing Input	Team Input		Anaesthetic Input
	Patient Position	Equipment Available	Essential imaging checked & available	VTE Assessment Complete / VTE Plan	Surgical Concerns / Requirements	Implants / prostheses checked & available	Antibiotics required / Infection prevention concerns	Anticipated blood loss: Blood required & availability Anticoagulation concern?	Anaesthetic Plan: Patient specific concerns
1.									
2.									
3.									
4.									
5.									

Staff present:

- ☐ HCA
- ☐ Scrub Practitioner
- ☐ Scrub Practitioner 2
- ☐ ODP
- ☐ Trainee Surgeon
- ☐ Con Surgeon
- ☐ Con Anaesthetist
- ☐ Trainee Anaesthetist
- ☐ Radiologist (if relevant)
- ☐ Other .....

Team Signature:	Print Name:	Designation:
	Date: / /	Time:

Safer Surgical Team De-Brief Checklist

This checklist must be filed in the theatre brief / debrief folder

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Theatre: .....

Consultant: .....

Date: .....

Time: .....

STOP THE LINE

- ☐ Post op debrief performed YES☐ NO☐
- ☐ Any issues arising that need to be addressed YES☐ NO☐
- ☐ If 'Yes', is Debrief Action Log complete (below)
- ☐ All 'Stop the Line' issues recorded and datixed

Issue	Action Required	Responsible person	Due date	Completed?

Achievements and what went well?	Could we have made this list more productive? How?

Staff present:

- ☐ HCA
- ☐ Scrub Practitioner
- ☐ ODP
- ☐ Trainee Surgeon
- ☐ Other
- ☐ Con Surgeon
- ☐ Con Anaesthetist
- ☐ Trainee Anaesthetist
- ☐ Radiologist (if relevant)
- ☐ Scrub Practitioner 2

Team Signature:	Print Name:	Designation:
	Date: / /	Time:

University Hospitals of Leicester NHS Trust

Centre for Perioperative Care

The NatSSIPs Eight

NatSSIPs 2 SEQUENTIAL STEPS

Delivery of safe invasive procedures by the MDT in the patient pathway

Behaviours show
- Patient focus
- Teamwork
- Kindness
- Compassion
- Safety knowhow
- Understand HF
- Leadership

Strong communication
- Planning
- Teamwork
- Use of checklists
- Better handover
- Report excellence
- Report incidents

Team engaged in
- Solutions
- Audit
- Data
- Improvement
- Quality

Consent and procedural verification
- Laterality in full
- Consent signed by operator
- Site marked by operator

Team Brief
- Lead operator present
- Lead anaesthetist present
- Team introductions
- Plans discussed

Sign In
- Anaesthetic practitioner, anaesthetist with patient
- Checks including consent with patient

Time Out
- Whole team engaged
- Safety checks conducted
- Strong team communication

Implant check if required
- Check compatibility
- Record what is needed
- Team focus at checks
- Add to register
- Stock up

Equipment reconciliation
- Nothing unintended left behind
- Count of constituent parts
- Count at every cavity closure

Sign Out
- Confirm count correct
- Flush IV lines
- Postoperative team instructions

Debrief
- How did the day go?
- What did we learn?

Centre for Perioperative Care

NatSSIPs 2
ORGANISATIONAL STANDARDS

Organisational Standards that enable teams to deliver safe care

People *for safety*

Patients as partners
Involve patients in their care and safety
Mutual respect and compassion

Staff to deliver
Roles in safety: resourced leadership to deliver
Training in safety: appropriate and skilled staffing
MDT Teams: have safety education with human factors

Processes *for safety*

Documentation:
User friendly checklists without duplication

Scheduling:
Provides necessary information for safe care

Induction:
Covers expectations for safe reliable care

Governance:
Provides insight, learning, involvement and improvement

Performance *for safety*

Data sources:
Sequential: peer review and qualitative performance with assurance data
Organisational: education and induction delivery measures

Use of data
Quality improvement focus

Visibility of data
Board to ward with expert support and challenge

Secure in safety
Local safety strategy is visible with infrastructure following NatSSIPs

Patient involvement
Patients involved in safety improvement, education, information and design

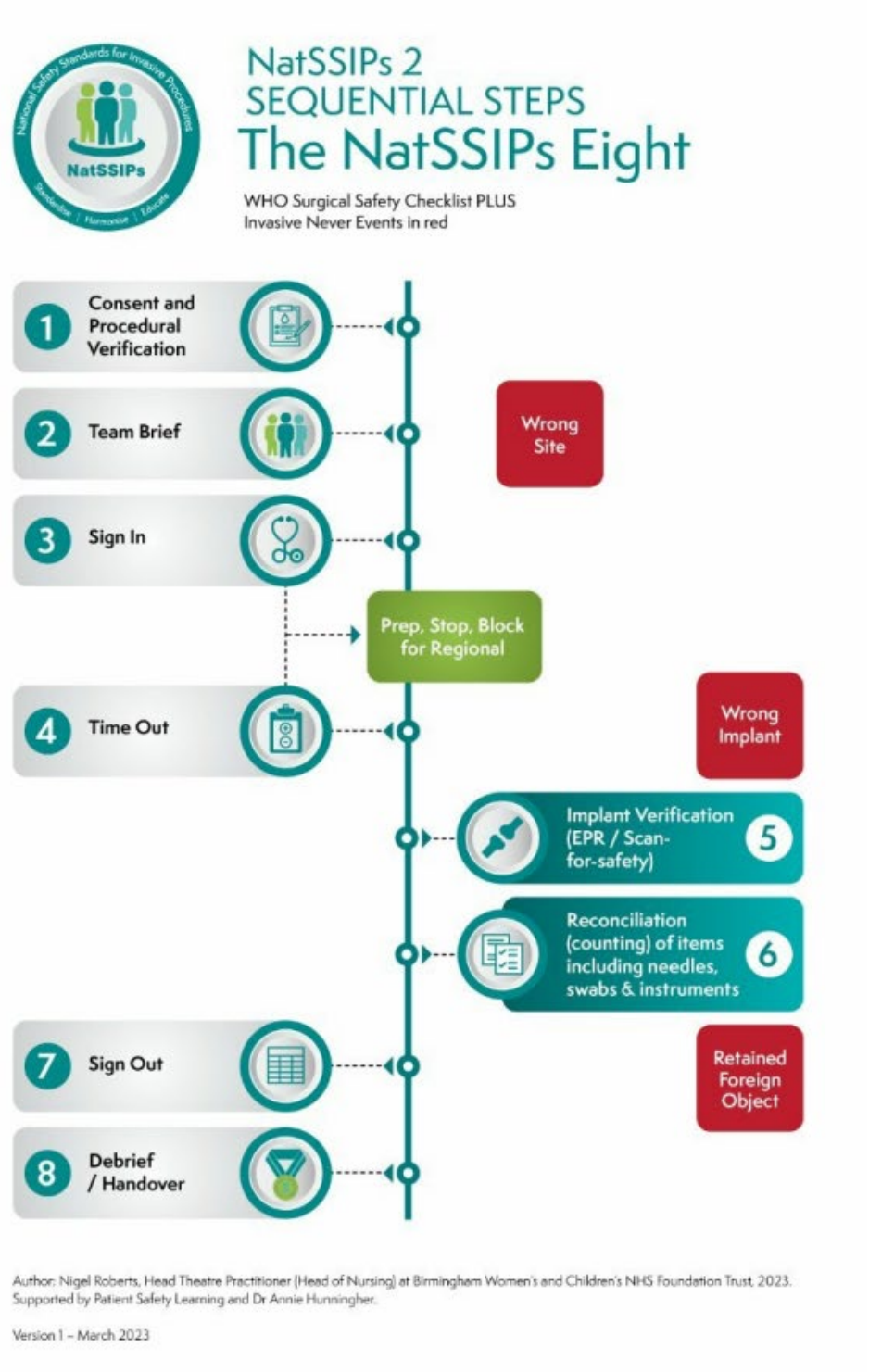
Leadership
Senior and substantive clinical leadership
Training in safety for leaders
Sufficient support and resource

Governance
Proportionate risk assessment, organisational resource, human factors expertise

Measurement for Improvement
Triangulation
Suites of measures
QI methodology

Systems design
Safe scheduling and list management
Local induction covers NatSSIPs
IT integration

APPENDIX 6


NatSSIPs 2
SEQUENTIAL STEPS
The NatSSIPs Eight
WHO Surgical Safety Checklist PLUS
Invasive Never Events in red
1 Consent and Procedural Verification
2 Team Brief
3 Sign In
4 Time Out
7 Sign Out
8 Debrief / Handover
Wrong Site
Prep, Stop, Block for Regional
Wrong Implant
Implant Verification (EPR / Scan-for-safety) 5
Reconciliation (counting) of items including needles, swabs & instruments 6
Retained Foreign Object
Author: Nigel Roberts, Head Theatre Practitioner (Head of Nursing) at Birmingham Women's and Children's NHS Foundation Trust, 2023.
Supported by Patient Safety Learning and Dr Annie Hunningher.
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