



**SAFE SURGERY SAVES LIVES INTERNATIONAL CONSULTATION MEETING
WHO HEADQUARTERS, GENEVA, 10TH-11TH JANUARY 2008**

SUMMARY OF THE PRINCIPLE DISCUSSION POINTS

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The draft WHO Surgical Safety Checklist and proposed surgical “Vital Statistics” were introduced over the two-day meeting in Geneva. The guiding principles of the checklist were that it be simple, widely applicable, measurable, and effective. Below is an outline of the central points of feedback from the participants.

SURGICAL VITAL STATISTICS:

There was no resistance to the concept of a surgical surveillance system; in fact, it was felt to be important and beneficial for measuring surgical care and delivery. The proposed statistics were acceptable as an index to follow patient populations over time and felt to be useful for tracing the impact of interventions and changes to health delivery.

The principle concerns focused around several issues:

- Data collection will present a challenge to many countries in terms of capacity and ability to accurately collect such information.
- The possibility of ranking of the vital statistics from most to least important was raised, with measures of mortality being the most important.
- Practical aspects of implementation and the importance of including a toolkit on how to do this was discussed and will present a challenge.
- Clarification of the definitions was encouraged, in particular the mortality rates and defined time period for in-hospital postoperative death. (Conversely one might measure the percentage of operative patients who leave the hospital alive.)
- The possibility of measuring complications from surgery was raised as a potential added statistic.
- The possibility of adding other groups involved in surgery such as nurses and support staff was raised as a potential added statistic.
- The problem of capturing outpatients versus inpatients and the problem of capturing private hospital data was discussed.

THE SURGICAL SAFETY CHECKLIST:

The Draft Surgical Safety Checklist was introduced in its entirety and then broken down into its three component phases: the sign in, the time out, and the sign out. Each phase

was then discussed and each element of the checklist reviewed with respect to its importance, relevance, and timing.

The Sign In:

The group supported the idea of a safety check prior to induction of anesthesia. The principle concerns expressed are summarized as follows:

- The primary thrust of the checklist is to support teamwork. A suggestion of including an introduction of team members was proposed.
- Translation of documents was raised as a future concern.
- Pulse oximetry was recognized as the only check that might require a significant investment in resources where it is not generally available. However, it was agreed that the checklist makes explicit that providing anesthesia without pulse ox is not an acceptable standard of care, that the checklist and guidelines document provides a context for the relative value and high priority of this resource with respect to other social goods. It was recognized that it will take time to attain compliance and acceptance and that other efforts will need to be made in parallel to ensure provision of this resource.
- There was concern about the competing issues of keeping the checklist simple and brief versus adding in a few extra steps. In particular, the issues of hydration assessment and risk of aspiration were not addressed in the checklist and can cause catastrophic but preventable harm during induction. The lack of proper preoperative assessment by anesthesia providers was generally seen as an important issue in developing settings and its importance was noted to be heavily downplayed in many parts of the world.
- There was concern that by setting a limit of 1000cc of blood loss as a trigger for discussion of IV access, it might push some practitioners to under-prepare for major blood loss. A proposal of 500cc was made to replace the 1000cc threshold.
- Ordering of checklist items to make them more intuitive was suggested.

The Time Out:

The group supported the idea of a safety check prior to skin incision. The principle concerns expressed are summarized as follows:

- Much time was spent stressing the importance of teamwork during surgery. Numerous members supported the idea of adding an introduction by all members of the operative team to the checklist as a means of promoting communication.
- It was felt that the Instructional Manual accompanying the checklist needed a paragraph about teamwork and its importance to safe practice.
- There was a concern about the timing of antibiotic administration, particularly during cesarean section, as it is common practice to withhold administration until the umbilical cord is clamped.

The Sign Out:

The group supported the idea of a debriefing but diverged with respect to its timing. The principle concerns expressed are summarized as follows:

- There was a suggestion to liberalize the timing of the debriefing from the original language of the safety checklist, allowing the debriefing to occur at a time

- convenient to all practitioners. Suggested wording was “prior to removing the patient from the operating theatre.”
- Concern was expressed about documentation of intraoperative events and what significance it should have in patient care.
 - Consideration of equipment issues was proposed as an added check to be discussed as part of a handover process.
 - The organization of the elements in this section generated confusion and seemed not to be intuitive. A recommendation to simplify the language and reorganize the structure of the checklist elements was proposed. In particular, it was recommended that the language should bring the focus back to patient risks subsequent to the procedure. The point was made that debriefings have as their main element a discussion, not individual checks, and that such a discussion should lead to a handover process. This discussion was seen as critical since each discipline tends to function in their silos and fail to appreciate the implications of what happens during the operation. It was noted that the significance of intraoperative events is not always obvious to everyone.

Points of General Concern and Discussion:

Some general concerns were raised and discussed at length about the checklist as a whole:

- There was concern that the checklist would be impractical in short cases and especially during day cases with rapid turnover of patients.
- There was concern that there would be legal repercussions if this checklist were to become a WHO supported standard.
- There was the suggestion that the checklist should be adaptable to a computerized or automated system, and that it could also be made into a whiteboard or poster rather than a piece of paper.
- There was discussion of whether this could or should be used as an auditing tool.
- The checklist is not comprehensive, nor does it address all safety issues, but it does build a foundation of improved practice.
- The checklist should not cause other safety checks already in place at many facilities from being ignored or eliminated.
- A point was raised that many people die because of unsafe surgery and many more die because they do not get surgery at all; thus the checklist should not be a barrier to providing care.
- The biggest challenge was seen to be getting independent practitioners to incorporate safety goals and practices into their daily decision-making process.

A complete video footage of the meeting's discussions and presentations can be found by following the link:

http://www.who.int/patientsafety/events/08/10_01_2008_geneva/en/index.html