Safe Surgery Saves Lives FAQ

We are pleased to see that you are interested in our efforts to improve global surgical safety. The first part of this document is designed to answer some general questions you may have about the Checklist and the Safe Surgery Saves Lives initiative. Once you have read these – or if you're already interested in using the Checklist at your institution – we invite you to read the second section of this document, which addresses a number of questions frequently asked by those individuals interested in implementing the Checklist.

Background FAQ

1. *Q: Why is the Checklist important?*
   A: 234 million major operations are performed annually across the world. This translates to roughly one operation per every 25 people and indicates that the safety of care is of significant public health importance. (For more on this statistic and its implications, see our article in the Lancet: www.who.int/patientsafety/safesurgery/knowledge_base/publications/en/index.html) Moreover, given previously estimated rates of major complication and death following inpatient surgery, we have postulated that – even using conservative estimates – 7 million patients suffer complications following surgery, half of which are likely to be preventable.

2. *Q: What is the Checklist and how was the Checklist developed?*
   A: The Checklist was developed by an expert group of surgeons, nurses, anesthesiologists, and patient safety experts from around the world. It identifies key safety steps during perioperative care that should be accomplished during every single operation no matter the setting or type of surgery. There were a number of guiding principles that the group had to consider when adding any safety check onto the list – simplicity, wide applicability, and measurability (that is, the ability to measure changes in the process and/or outcome of surgical care). In addition, the safety steps had to reduce the likelihood of serious, avoidable surgical harm and be unlikely to introduce unmanageable costs or additional risks to patient safety. Please view the Guideline Document, available on our website, for detailed information on each item on the checklist.

3. *Q: What does the Checklist involve? How will it impact surgical practices?*
   A: The Checklist involves the coordination of the operating team – the surgeons, anesthesia providers, and nurses – to discuss key safety checks prior to specific phases of perioperative care: a "Sign In" prior to induction of anesthesia, a "Time Out" prior to skin incision, and a "Sign Out" before the team leaves the operating room. Many of the checks are already routine in some institutions, but surprisingly, few operating teams accomplish them all consistently, even in the most advanced settings. We hope to show improvements in both the process and the outcome of care using our pilot sites to evaluate the Checklist.

4. *Q: Don't hospitals already use Checklists?*
   A: Many hospitals do already have checks in place, but their consistent use is dismayingly variable. Many developed settings perform a "Time Out" where the team confirms the patient identity, procedure, and site of operation. Teams are using this time to perform and expand briefing, but this has never been elaborated to the extent that the Safe Surgery Saves Lives project has done.

5. *Q: How do you know the Checklist works?*
   A: Pilot evaluation of the Checklist is underway in 8 hospitals in 8 countries (US, UK, Canada, New Zealand, Jordan, Philippines, India, and Tanzania), selected to represent the 6 WHO regions. Preliminary results from a thousand patients indicate that the Checklist has nearly doubled the likelihood that patients will receive proven standards of surgical care, including preoperative verification of patient identity and planned procedure, assessment of airway, anticipation of and preparation for operative blood loss, appropriate use of antibiotics to reduce the risk of infection, monitoring with continuous pulse oximetry, and reconciliation of surgical sponge counts. Use of the Checklist in pilot sites has increased adherence to these standards of care from 36% to 68% and in some hospitals to levels approaching 100%. This has thus far resulted in substantial reductions in complications and deaths in this group. Final results on the Checklist's effects are anticipated within the next few months.

6. *Q: What has been the response to the Checklist?*
   A: To date, 246 professional societies, health organizations, ministries, and NGOs have endorsed the concept of the Safe Surgery Saves Lives Program. The task of the program now is to build on this momentum and the information we are receiving from the pilot site evaluations to promote the widespread use, implementation, and dissemination of the Checklist as a safety practice in every operation. We are hoping to build a network of participating hospitals, clinicians, organizations, and health providers through the WHO website at http://www.who.int/patientsafety/safesurgery/testing/participate/en/index.html

7. *Q: Does the Checklist apply to all settings? How does it impact developed and developing regions differently?*
   A: The most developed countries tend to have well established and codified guidelines for the process of care during the perioperative period, although these are often inconstantly applied. Other settings may lack clear guidelines and policies for directing the perioperative process. The guidelines and Checklist can help countries and facilities evaluate their own processes of care and improve surgical safety. Moreover, even in the developed world, there is variability in adhering to the six basic safety practices mentioned above.

Implementation FAQ

1. Q: *My hospital is quite large with many operating rooms. How can I implement a checklist in this environment?*
   A: The key to successful implementation is to start small. Start with a single operating room on one day and see how it works. This will guide you to strategies for altering the checklist to fit your needs, as well as identify potential barriers to adaptation.

2. *Q: We already do these things. Why should we use a checklist?*
   A: While most or all of the items on the checklist may already be done at your hospital, we have found that in most hospitals there are opportunities for improvement in consistency. The checklist helps ensure that important safety steps are followed for each and every operation.

3. *Q: What's in it for me?*
   A: By implementing the checklist, you can help to save patients' lives and decrease complications, be on the forefront of the surgical safety movement, and be a leader in your hospital.

4. *Q: Our budget is very tight. How can we implement the checklist?*
   A: Using the checklist requires very minimal resource commitment. Reproduction and distribution of the checklist is the main financial cost. There is some need for personnel commitment at the beginning, but once the checklist has spread it should sustain itself.

5. *Q: How much does it cost to implement the checklist?*
   A: The checklist is free to download, but will require input of human resources in order to implement it hospital-wide. Please read the toolkit, available on the website, to get a sense for the level of commitment this venture will require. Many of the elements of the checklist, such as a verification of patient's identification, require no money to implement and could save the hospital thousands of dollars by preventing surgical mishaps. Other items on the checklist, such as the use of antibiotics from 0 to 60 minutes prior to incision, make sure that resources that hospitals already have are used to their fullest potential.

6. *Q: We are already very busy in the operating room. Isn't this just one more task using up valuable time?*
   A: Once the checklist has become familiar to the operating teams, it requires very little extra time to perform. Most of the steps are incorporated into existing workflow and the remainder will add only one or two minutes to the OR time. However, the checklist can also save time be ensuring better coordination between the teams, minimizing slowdowns for tasks like retrieval of additional equipment.

7. *Q: While there is enthusiasm amongst some clinicians for the checklist, there are others who do not see the value of this initiative. Can we still use the checklist?*
   A: Yes. Implementation should always begin with the most enthusiastic. Go after the "low hanging fruit," those who are interested in improvement. The checklist can be implemented by an individual clinician in cases in which he or she participates, a selected service or operating room suite at a hospital, or on a hospital-wide or even system-wide basis. Focus energy on those areas and individuals who are receptive to the idea at first and as they become accustomed to the checklist and its benefits, they will help it spread to their peers.

8. *Q: We are interested in improving our hospital's performance in some perioperative measures not included on the checklist. How can we do this?*
   A: The checklist, while intended to be universally applicable, is not always a perfect fit for all institutions. Modifications can be made to include items that are deemed essential. However, we would caution against making the checklist too comprehensive. The more items added to it, the more difficult it will be to successfully implement.

9. *Q: What is the point of filling out the "Questions for Hospitals to Answer Prior to Implementing the Checklist"?*
   A: Part of using the checklist in your hospital is measuring how it improves patient safety. Having baseline data will enable you to later see how far you have come with regard to outcome and process measures. We highly recommend not simply using the checklist, but measuring how that use changes the way surgery is practiced.

10. *Q: I have additional questions not covered by the FAQ. Can I speak to someone?*
    A: We are currently setting up a network of mentors who have successfully implemented the checklist. Please visit our website again soon for updated information.