SAFE SURGERY SAVES LIVES INITIATIVE

Implementation Guidelines

“Safer Surgery Through Better Communication”

Quality in Medical Care Section
Medical Development Division
Ministry of Health Malaysia
Nov 2009
Foreword by
THE DIRECTOR-GENERAL
OF HEALTH MALAYSIA

The Ministry of Health Malaysia has a “Vision for Health” that mandates the development of a safe Malaysian healthcare system, which is attained through the coordinated and concerted efforts of all the major stakeholders, and especially that of the “front-line” staff, often termed those at the “sharp end” of health care, where unfortunate clinical incidents often manifest. These front-liners often unfairly bear the brunt of the blame heaped upon the health care system. The MOH has thus seen it fit to adopt the approach recommended by patient safety experts throughout the world i.e. the “systems approach” to patient safety which states that errors are more commonly caused by faulty systems, processes, and conditions that cause people to make mistakes or fail to prevent them.

To build a culture of safety in our health care organizations, health care leaders must ensure that, in their organizations, “incidents” such as surgical mishaps must be routinely reported without the fear of unjust retribution on the part of the unfortunate health care worker. When people are not afraid to report adverse incidents because of the existence of a “just culture” where, when things go wrong, no one is immediately assigned blame (“blame culture”), only then will we be able to collect accurate and honest data about incidents, analyse them and learn important lessons from them and, in the process, improve our systems and processes so that the care that we provide will be safer.
For 2009, I am pleased that the Ministry of Health Malaysia has undertaken a number of note-worthy patient safety projects such as the “Safe Surgery Saves Lives” campaign, led by the Peri-operative Mortality Review (POMR) Committee and ably supported by the Quality in Medical Care Section, Medical Development Division, Ministry of Health Malaysia. The POMR Committee has, to its credit, expanded its mandate from auditing peri-operative deaths to taking a pro-active approach to Risk Management by implementing patient safety solutions. Because “safety is everyone’s business”, let us all work together in the spirit of teamwork and learning to make our health care system a safer one in 2010. “Success does not consist in never making mistakes but in never making the same one a second time”.

Tan Sri Dato’ Seri Dr. Hj. Mohd Ismail Merican
Director-General of Health Malaysia
MINISTRY OF HEALTH MALAYSIA
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01 Introduction
INTRODUCTION

‘Safe Surgery Saves Lives’ (SSSL) is the second of a series of World Health Organisation’s Patient Safety Challenges initiated in 2004 after the formation of the World Alliance for Patient Safety (WAFPS). This alliance aims to promote patient safety through political as well as professional commitment to this very important element of health care quality i.e patient safety.

Four strategies were introduced by the SSSL Steering Committee to address this challenge and they include:

1. Promotion of surgical safety as a public health issue.
2. Improving communication and team building to ensure safer surgery.
3. Creation of a check list to improve the standards of surgical safety
4. Collection of ‘Surgical Vital Statistics’

The College of Surgeons Malaysia was represented by its president during the launching of this initiative on June 25th 2008 in Washington DC. This effort was endorsed during the Patient Safety Council of Malaysia meeting in May 2008. The Perioperative Mortality Review (POMR) Committee was entrusted to launch this initiative in Malaysia.

A ‘Safe Surgery Saves Lives’ Steering Committee was formed in the Ministry of Health (MOH) in September 2008, chaired by the Chairman of the Perioperative Mortality Review (POMR) Committee. Its members consists of surgeons, anaesthetists, the staff and Ministry of Health officers. This efforts are supported and coordinated by the Quality in Medical Care Section, Medical Development Division, Ministry of Health Malaysia. The committee is responsible for initiating and ensuring the implementation of this initiative in MOH hospitals.

On top of the ten objectives laid down by WHO (Refer to Appendix 1), the Committee proposed three additional objectives with emphasis on communication, namely to improve:

1. The understanding of the process of surgery by patients and relatives
2. Communication between operating team members
3. Rapport between the patient and the operating team
Thus, for this initiative, the Ministry of Health adopted the theme ‘**Safer Surgery Through Better Communication**’.

The **WHO Surgical Safety Check List** (Refer to Appendix 2), was adapted to be used in MOH hospitals after some modifications and trial runs to suit local conditions. Existing check lists in the MOH related to peri-operative care were also modified and used with the modified WHO Check List. The new and standardized Ministry of Health Check List, which will be used in all Ministry of Health hospitals, is known as the ‘Peri-operative Check List’. It consists of four components:

- ‘Pre-Transfer Check List’
- ‘Operating Team Check List’
- ‘Swab Count Form’
- ‘Post-Operative Transfer Check List’

The check list was pilot-launched in six selected hospitals in February 2009, following a workshop involving all stakeholders. This check list was evaluated on April 27th 2009. The response was very encouraging with usage ranging from 80-100%.

Among the recommendations made to improve patient safety and communication are pre-operative and post-operative visits by operating surgeons.

Data to be collected include the implementation of this initiative, information regarding incidents during surgery, resources, workload and surgical outcomes. Formats to be utilized include the following:

- Report of Incident/Instrument Failure At The Operating Room (Daily) **SSSL_1a**
- Report of Incident/Instrument Failure At The Operating Room (Monthly) **SSSL_1b**
- ‘Discovery’ Report (i.e Report On Issues Discovered Related To Check List) (Daily) **SSSL_2a**
- ‘Discovery’ Report (i.e Report On Issues Discovered Related To Check List) (Monthly) **SSSL_2b**
- ‘Surgical Vital Statistics’ - Resources & Work Load **SSSL_3**
- ‘Surgical Outcome Statistics’ **SSSL_4**
- Evaluation of ‘Peri-Operative Check List Usage (Departmental Level) **SSSL_5a**
- Evaluation of ‘Peri-Operative Check List Usage (Hospital Level) **SSSL_5b**

All the MOH hospitals are expected to use the check list by 2010. It is hoped that this effort will be able to meet its stated objectives.
REFERENCES

- A stepwise approach to make every case safe, Richard C. Karl, MD, Contemporary Surgery ©2007 Dowden Health Media VOL 63, NO 10/OCTOBER 2007
- www.who.int/safesurgery
- To err is human, even for surgeons, Felice J.Freyer, http://www.projo.com/news/content/WRONG_SITE_SURGERY_08-12-07_RD6NB7S.3391c3e.html
02 “Using The Check List”
"USING THE CHECK LIST"

ROLES AND RESPONSIBILITIES – “WHO DOES WHAT?”

This ‘Ministry of Health Peri-Operative Check List’ is a 4-page form. It consist of:

- Page 1: Pre-operative check list
- Page 2: Operating team check list
- Page 3: Swab and instrument count form
- Page 4: Pre-discharge check

The second page (i.e Operating Team Check List) is a modification of the ‘WHO Surgical Safety Check List’.

PAGE 1 PRE-OPERATIVE CHECK LIST
This check list is used before sending the patient to the theatre and at the Reception Area of the OT.

- The ‘Patient Profile’ section is filled in the ward by the ward nurse before sending the patient to the Operating Theatre (OT).
- The ‘Pre-Tranfer Check’ section under the ‘Ward’ column is filled by the ward nurse before sending the patient to OT.
- The ‘OT’ column is filled by the OT nurse at the Reception area of the OT.
- The lower section of the form, ‘INFORMATION ON OPERATING ROOM/ SURGEON / TIME OF SURGERY’ is filled in the OR by the Circulating Nurse.

PAGE 2 OPERATING TEAM CHECK LIST
This is the check list adapted from ‘WHO Surgical Safety Check List’. It is used in the Operating Room before starting till the completion of surgery.

The Checklist Co-ordinator is usually the Circulating Nurse. It can also be other members of the team if agreed by the team. The operating surgeon may also take the lead as the Co-ordinator with the circulating nurse assisting in the check list entry.
THE `SIGN-IN’

This is preferably done before Induction Of Anaesthesia

The anaesthetist checks the items in this section. The checklist coordinator then counter-checks with him if it has been done.

This section is checked with the anesthesia professional before induction of anaesthesia.

THE `TIME-OUT’

This section is done in the presence of the surgeon, scrub nurse and anaesthesia professional. This must be done before skin incision or preferably, before induction of anaesthesia.

The adherence to this section of the checklist should eliminate the possibility of the patient being induced and kept waiting for the surgeon to turn up.

“WHITE BOARD”

The White Board in the operating room shall be used to display information on the current patient and operation. This includes – name of patient, diagnosis, procedure and members of the operating team; antibiotic requirement, implant size, special positioning, on-table x-rays and other special requirement or reminders. This should be done by the operating surgical team before the start of surgery.

INTRA-OPERATIVE COMMUNICATION

This is an additional section that encourages communication between team members during the surgery. It has 4 components.

(i) CHECK-IN

• The surgeon, after having completed the cleaning and draping process, communicates with the anaesthetist and scrub nurse to determine their readiness to commence surgery. Only when both have indicated so, should the surgeon initiate the skin incision.
• This is announced verbally and is usually agreed as the time `operation commenced’.

• In practice, the surgeon asks the anaesthetist and the scrub nurse, “can we start?’

(ii) PERIODIC UPDATES

• For operations exceeding 1 hour in duration, if the surgery is running smoothly, it is a good practice to communicate the situation among the members of the operating team. This should be done at regular intervals such as half-hourly.

• The surgeon should inform the anaesthetist of the progress of the surgery. Similarly, the anaesthetist should update the surgeon about the patient’s vital signs. This will include blood pressure, pulse, temperature and urine output, depending on the nature of the surgery.

(iii) SHOUT-OUT

• This refers to the act of vocalising clearly to the appropriate team members about certain intra-operative events in order to obtain undivided attention of a specific team member to the event.

• An example is when a pack is inserted into the abdominal cavity, the surgeon should `shout-out’ “ONE PACK IN!” The scrub nurse takes note of it and repeats the `shout-out’ to the circulating nurse. The same is done when the pack is removed from the cavity. The surgeon should `shout-out’ “ONE PACK OUT!”.

• This does not replace the system of tags placed at the end of packs or other forms of reminders already in place.

• Other events that deserve `shout-outs’ are :-

When instruments, gauzes have fallen off the operating field on to the floor.

When there is critical equipment malfunction, “diathermy not coagulating!”
When there is excessive bleeding, the surgeon should `shout-out` to the anaesthetist so that he is aware of the situation. This will enable him to prepare for the worst.

When the patient turns unstable, the anaesthetist should `shout-out` the situation to the surgeon. The surgeon may want to pause or review his actions.

(iv) PRE-CLOSURE DISCLOSURE

- The surgeon informs members of the team of the conclusion of the procedure before commencing the closure of the surgical wound.
- This will enable the anesthetist to plan for reversal.
- The scrub nurse can commence the final swab and instrument count. She will inform the surgeon when this is done and correct.
- This is also an appropriate time to plan for the calling of the next case.

THE `SIGN-OUT`

- This is also called debriefing.
- The surgeon summarises the operative findings and procedure. He will verify what specimen will be sent and how it should be labelled.
- The anaesthetist will discuss any special post-operative instructions with the team at this juncture.
- Any instrument issues to be addressed will be summarised.

INFORM THE RELATIVES

Informing / communicating with relatives after the procedure is encouraged. How this is done depends on the local OT set-up and the public expectation. In some instances, operative specimens are also shown to the relatives. This usually enhances communication.
PAGE 3  SWAB AND INSTRUMENT COUNT FORM

- This is similar to most swab count forms in-use now.

- If two different operating teams operate on the same patient, two different swab count forms should be used.

- Any issues, incidences or instrument malfunctions in the Operating Room should be recorded in the “incidences” section of this form form. Example, blunt scissors, diathermy malfunction or unsatisfactory temperature/humidity. This is later transferred to a ’Faulty Instrument’ file for remedial action by the OT manager.

- If more than two scrub nurses scrub for the same case, just add the name after the first scrub nurse following a slash (/). The time that the 2nd nurse joined the team can be documented above the name. The same applies to the circulating nurse.

PAGE 4  PRE-DISCHARGE CHECK

This is done by the Ward Nurse, together with the Recovery Room Nurse before the patient leaves the OT.

*The completed Peri-Operative Check List Form will be put in the patient’s case
PERI-OPERATIVE CHECK LIST

PRE-OPERATIVE CHECK LIST

PATIENT PROFILE
(To be filled by Ward Staff)

Name: ................................................................. I.C. no.: .................................................................
Age: ........................................ Sex: ...................... Race: ...................... Reg. no.: .................................................................
Unit: ................................................................. Ward: ................................................................. Weight: .................................................................
Diagnosis: ...........................................................................................................................................................................................................
Operation: ...........................................................................................................................................................................................................
Checked by (Ward Staff): ...................... Date: ...................... Contact person & HP No.: .................................................................

PRE-TRANSFER CHECK
(to done by the Ward Nurse before sending patient to OT and at Reception Area in OT by the OT Reception Nurse)

<table>
<thead>
<tr>
<th></th>
<th>Ward</th>
<th>OT</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient’s Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Consent for</td>
<td>Surgery</td>
<td>Anaesthesia</td>
</tr>
<tr>
<td>3.</td>
<td>Check side of operation</td>
<td>LEFT</td>
<td>RIGHT</td>
</tr>
<tr>
<td>4.</td>
<td>Site (location) of operation marked?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5.</td>
<td>Last meal: Date: .......... Time: ..........</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Check for dentures, jewellery, contact lenses etc:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Premedication (with drug given)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Blood availability (write what is available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Case notes</td>
<td>Old notes</td>
<td>X-rays</td>
</tr>
</tbody>
</table>

Handed over by (Ward Nurse): .................................................................
Received by (OT Nurse): .................................................................

INFORMATION ON OPERATING ROOM / SURGEON / TIME OF SURGERY
(Written in OT by Circulating Nurse)

Operating room no: .................................................................
Anaesthetist: .................................................................
Surgeons: .................................................................
Time start: ................................................................. Time complete: .................................................................
OPERATING TEAM CHECKLIST

BEFORE INDUCTION OF ANAESTHESIA

SIGN IN

☐ Checked patient’s
  - Identity
  - Site
  - Procedure
  - Consent

☐ SBS marked [Yes] [No] [NA]

☐ Checked GA machine

☐ Pulse oximeter on patient and functioning

☐ Checked patient’s
  - Allergy?
  - No [□] Yes [□]
  - Anaphylaxis / Aspiration risk?
  - No [□] Yes [□]
  - Risk of > 500ml blood loss (adult)
  - >7 milking in children?
  - No [□] Yes [□]
  - Adequate IV access?
  - No [□] Yes [□]

ANTICIPATED CRITICAL EVENTS

☐ Surgeon reviews any special steps, estimated duration, possible excessive blood loss?

☐ Anaesthesia team reviews any patient-specific concerns?

☐ Nursing team reviews instrument sterility confirmed, implants / prosthesis available /

DURING PROCEDURE

INTRA-OPERATIVE COMMUNICATION

☐ Check-in

☐ Periodic update

☐ Show-out

☐ Post-operative discharge

BEFORE PATIENT LEAVES OPERATING ROOM

SIGN OUT

Nurse verbally confirms with the team

☐ The final name of the procedure
  (With proper spelling)

☐ Final count of instrument, sponges and needles is correct

☐ How specimens are labelled
  (Including patient’s name)

☐ Whether there are any equipment problems to be addressed
  (Note in swab count form – incidents / equipment failure section)

☐ Any special instructions from surgeon or anaesthesia professionals during recovery and management of patient

☐ Inform the relatives

Checklist co-ordinator: _______________________________

(Name)
### SWAB & INSTRUMENT COUNT FORM

####SETS & INSTRUMENT

**Basic set:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Initial count</th>
<th>Additional</th>
<th>Extra count</th>
<th>Additional</th>
<th>2nd count</th>
<th>Additional</th>
<th>Final count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauze</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atraumatic needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loose needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dailthermy cleaner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supplementary:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Initial count</th>
<th>Additional</th>
<th>Extra count</th>
<th>Additional</th>
<th>2nd count</th>
<th>Additional</th>
<th>Final count</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Operation(s) done:**

<table>
<thead>
<tr>
<th>Specimens sent:</th>
<th>Incidents / Equipment Failure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

**1st Scrub Nurse:**

<table>
<thead>
<tr>
<th>Circulating Nurse:</th>
</tr>
</thead>
</table>

**Signature:**

<table>
<thead>
<tr>
<th>2nd Scrub Nurse:</th>
</tr>
</thead>
</table>

**Signature:**

<table>
<thead>
<tr>
<th>Circulating Nurse:</th>
</tr>
</thead>
</table>

**Signature:**

---

22 “Safe Surgery Saves Lives Initiative” Implementation Guidelines
## PRE-DISCHARGE CHECK

(Is done by the Ward Nurse with the Recovery Nurse before the patient leaves the OT)

<table>
<thead>
<tr>
<th></th>
<th>Checked</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient's name</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Identity tag</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Consciousness level:</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Alert</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Drowsy</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Intubated</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>Inform vital signs &amp; pain score</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Check operative site / dressing</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Check drains, tubes and urinary catheter</td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>Check IV lines and infusions</td>
<td>□</td>
</tr>
<tr>
<td>7.</td>
<td>Blood used and unused</td>
<td>□</td>
</tr>
<tr>
<td>8.</td>
<td>Specimens</td>
<td>□</td>
</tr>
<tr>
<td>9.</td>
<td>Case notes</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Old notes</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>X-rays</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Operative notes</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>OA form</td>
<td>□</td>
</tr>
<tr>
<td>10.</td>
<td>Check post-operative pain relief order</td>
<td>□</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>14.</td>
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**OT Nurse** : ........................................ **Ward Nurse** : ........................................

**Name**

**Date** : ........................................ **Time** : ........................................

"Safer Surgery Through Better Communication"

**Patient Safety Initiative**

Quality in Medical Care Section
Medical Development Division
Ministry of Health Malaysia
04 Summary of Roles & Responsibilities
## SUMMARY OF ROLES & RESPONSIBILITIES

### “Who To Do What, Where & When”

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<tr>
<td>1</td>
<td>Ward</td>
<td>Before sending the case to OT</td>
<td>Pre-op Check (pg1)</td>
<td>Ward Staff Nurse</td>
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<td>2</td>
<td>Reception Area in OT</td>
<td>On arrival in OT</td>
<td>Pre-transfer Check(pg1)</td>
<td>OT Reception Nurse</td>
<td>Ward Staff Nurse</td>
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<td>3</td>
<td>Operating Room</td>
<td>On arrival in OR</td>
<td>Information on OR &amp; Surgery (pg1)</td>
<td>Circulating Nurse</td>
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<td>4</td>
<td>Operating Room</td>
<td>Before the Surgeon enters</td>
<td>Sign In (Pg2)</td>
<td>Anesthetist</td>
<td>Anesthetic Assistant</td>
<td>Circulating Nurse</td>
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<td>Operating Room</td>
<td>Before Induction</td>
<td>Time Out (pg2)</td>
<td>Surgeon</td>
<td>Scrub Nurse / Anesthetist</td>
<td>Circulating Nurse</td>
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<td>6</td>
<td>Operating Room</td>
<td>During Procedure</td>
<td>Intra-op Communication (pg2)</td>
<td>Surgeon / Anesthetist</td>
<td>Scrub Nurse</td>
<td>Circulating Nurse</td>
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<td>7</td>
<td>Operating Room</td>
<td>After Closure</td>
<td>Sign Out (pg2)</td>
<td>Surgeon</td>
<td>Scrub Nurse / Anesthetist</td>
<td>Circulating Nurse</td>
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<td>8</td>
<td>Operating Room</td>
<td>Before starting, before and after closure</td>
<td>Swab &amp; Instrument Count(pg3)</td>
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<td>Surgeon / Circulating Nurse</td>
<td>Circulating Nurse</td>
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<td>Recovery Area in OT</td>
<td>Before patient leaves OT</td>
<td>Pre-discharge Check (pg4)</td>
<td>Ward Staff Nurse</td>
<td>Recovery Room Nurse</td>
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“Safer Surgery Through Better Communication” - Patient Safety Initiative, Ministry of Health
Implementing Safe Surgery Initiative
- Task of the ‘Safe Surgery’ Committee
IMPLEMENTING SAFE SURGERY INITIATIVES - TASK OF THE ‘SAFE SURGERY’ COMMITTEE

OBJECTIVES
1. To obtain top level management commitment
2. To use Ministry of Health Peri-operative Check List
3. To monitoring ‘surgical vital statistics’

PROCESS INVOLVED
1. Inform Hospital Director about ‘Safe Surgery Saves Lives’ (SSSL) Initiative.
2. Form a ‘Safe Surgery Committee’ at hospital level comprising of:
   • Heads of major discipline using the OT - anesthetist, surgeon
   • Representatives from OT sister/staff nurse
   • Representatives from ward sister/staff nurse
   • Unit Quality of Hospital
3. Launch awareness
4. Conduct a half day workshop for users – doctors, OT nurses & ward nurses
5. For State Hospital: Plan implementation of SSSL Initiative for other hospitals in the state.

OTHER ACTIVITIES
1. Monitor implementation of SSSL Initiative
2. Decide on printing of forms:
   a. To finish current stock of forms already printed
   b. To print new forms (i.e “Peri-operative Check List)
   c. To modify forms, as and when necessary
3. Incorporate SSSL into OT Committee agenda

ACTIVITIES AT NATIONAL LEVEL
1. National launching of SSSL Initiative together with seminar: 15-17 Nov 2009
3. Compile & analyse ‘Surgical Vital Statistics’
4. Monitor implementation of SSSL
06 Data Collection
REPORT OF INCIDENT/INSTRUMENT FAILURE AT THE OPERATING ROOM (DAILY)
(Based on information from 'Swab Count Form', of the check list)
(Form to be filled in by the Nurse at 'Recovery Area', checked daily by the Nursing Sister, "Ketua Jururawat")

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Patient</th>
<th>Type of Surgery</th>
<th>Type of Incident/Instrument Failure</th>
<th>Name of Reporting Person</th>
<th>Review &amp; Action by Nursing Sister (KJ)</th>
<th>Date of Action Taken</th>
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</thead>
</table>

Examples of incident/instrument failure:
- Incident: Air-conditioning not functioning well, sharps injuries, surgeons arrive late, error in preparing the set, late arrival of blood
- Failure of instruments: surgical instrument not functioning well, diathermy not functioning

"Safe Surgery Saves Lives Initiative" Implementation Guidelines
<table>
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<th>No</th>
<th>Type of Incident / Instrument Failure</th>
<th>Total</th>
<th>Immediate Action</th>
<th>Preventive Action</th>
<th>Notes</th>
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'DISCOVERY' REPORT (i.e REPORT ON ISSUES DISCOVERED RELATED TO CHECK LIST) (DAILY)
(Form to be filled in by the nurse at 'Recovery Area', check daily by the Sister/Ketua Jururawat)

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<th>Date</th>
<th>OR</th>
<th>Name of Patient</th>
<th>Type of Surgery</th>
<th>‘Discovery’</th>
<th>Name of Reporting Person</th>
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Examples of ‘discovery’ related to check list:
Error. e.g error in taking consent, check list not filled up, check list not being used, review findings are not similar to what being ticked in the check list. Near miss (detected before 'something bad'/incident happen).
### ‘DISCOVERY’ REPORT (i.e REPORT ON ISSUES DISCOVERED RELATED TO CHECK LIST) (MONTHLY)

Month_________/Year_________

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<th>No</th>
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**Conclusion and recommendation:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### A) Hospital Staff & Bed Strength

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Number of Functional Operating Rooms in the Hospital  

Number of Non-Functional Operating Rooms  

Total No of OT Nurses/PPP (GA + Scrub)

### B) Total No Of Operations Done (Month_____/Year____)

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<tr>
<th>Discipline</th>
<th>Month</th>
<th>Month</th>
<th>Total</th>
<th>Year</th>
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### ‘SURGICAL OUTCOME STATISTICS’

#### A) Total No of Post-Operative Wound Infection

(Month of .............. / Year ..............)

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#### B) Total No of Post-Operative Death

(Month of .............. / Year ..............)

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## EVALUATION OF PERI-OPERATIVE CHECK LIST USAGE (DEPARTMENTAL LEVEL)

**Department:** ..........................  **Duration of Data Collected:** ..........................

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<th>CASE NO</th>
<th>OP DATE</th>
<th>PATIENT'S NAME</th>
<th>PRE-OP CHECK LIST</th>
<th>SIGN IN</th>
<th>TIME OUT</th>
<th>INTRA-OP COMMUNICATION</th>
<th>SIGN OUT</th>
<th>TOTAL (OUT OF)</th>
<th>%</th>
<th>SWAB COUNT</th>
<th>PRE-DISCH CHECK</th>
<th>PRE-OP VISIT *</th>
<th>POST-OP VISIT **</th>
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</tbody>
</table>

At least 2 persons required to carry out this audit – 1 in OR (best in Recovery), the other from the ward.

PRE-OP VISIT * - Documented in case notes the operating surgeon saw the patient pre-operatively.

POST-OP VISIT ** - Documented in case notes the operating surgeon saw the patient pre-operatively. This information is sought in the ward after 1-2 days post-operatively.
<table>
<thead>
<tr>
<th>OP DATE</th>
<th>DEPT</th>
<th>NO SAMPLED</th>
<th>NUMBER COMPLIED / USED (&gt;90%)</th>
<th>AS IN BHT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>PRE-OP CHECK LIST</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>INTRA-OP</td>
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<td></td>
<td>SWAB COUNT</td>
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<td>PRE-DISCH CHECK</td>
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<td>PRE-OP VISIT</td>
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<td></td>
<td>POST-OP VISIT</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>REMARKS</td>
<td></td>
</tr>
</tbody>
</table>
‘Safe Surgery Saves Lives’ Power Point Presentation Templates
Presentation 1

WHO ‘Safe Surgery Saves Lives’
Dear Speaker,

Thank you so much for agreeing to be an ambassador for the Safe Surgery Saves Lives campaign. Now that we have entered the dissemination phase of our project, our success hinges upon the spread of knowledge and enthusiasm to stakeholders across the globe, and we cannot accomplish this without help from people like you.

This document is intended to supplement the “Speakers’ Kit PowerPoint,” providing you with both the key messages your presentation should cover as well as suggested talking points for each slide in the associated PowerPoint. Nonetheless, we understand that each speaking engagement is unique, and we encourage you to adjust the slides as well as the material covered to best serve your audience – please make the talk your own!

Finally, we suggest that you read the Safe Surgery Saves Lives FAQ (also provided) thoroughly before giving your presentation so that you are best able to answer any questions your audience may pose. Good luck, and as always, please contact us at safesurgery@hsph.harvard.edu or visit our websites, www.who.int/safesurgery and www.safesurg.org, if you have any questions.

Sincerely,

The Safe Surgery Saves Lives Team
Key Messages to Convey During Your Talk

1. Surgical safety is currently unrecognized as a public health issue.
2. Standards of care are unevenly applied in all countries and all settings.
3. The Safe Surgery Saves Lives campaign has created 10 objectives for surgical safety that have been incorporated into a simple checklist that can be implemented anywhere in the world.
4. The Checklist has been proven to dramatically decrease complications and deaths.
5. A country needs to measure its surgical services and outcomes in order to develop appropriate public health policies to address the needs of its population.

Talking Points for Powerpoint Presentation

Slide 1 : World Alliance for Patient Safety: Safe Surgery Saves Lives
   • N/A

Slide 2 : Surgical Public Health
   • Introduction

Slide 3 : 3 Central Problems in Surgical Safety
   • Surgical safety is crippled by its lack of recognition as a public health problem, a dearth of relevant data, and a general failure to apply known standards of care consistently

Slide 4 : Problem 1: Unrecognized as public health issue
   • Estimates show that approximately 234 million major operations are performed every year – one for every 25 human beings on Earth

Slide 5 : Problem 1: Unrecognized as public health issue (cont.)
   • Already a serious public health issue, worldwide surgical volume is only expected to increase

Slide 6 : Problem 1: Unrecognized as public health issue (cont.)
   • Surgery has high rates of morbidity and mortality – at least 7 million people a year experience disabling surgical complications, and more than one million die
Slide 7: Problem 2: Lack of Data on Surgery and Outcomes
- Public health campaigns rely on data collection, and yet we lack almost any fundamental data about global surgical services and outcomes

Slide 8: Problem 3: Failure to use existing safety know-how
- Failure to consistently use proven standards of care means that problems persist with surgical site infections, anesthesia complications, and wrong-patient, wrongsite operations

Slide 9: The Safe Surgery Saves Lives Strategy
- The SSSL Campaign strives to promote surgical safety as a public health concern, to develop a checklist to address this concern, and to collect data at a national level in order to inform future public health policies.

Slide 10: WHO’s 10 Objectives for Safe Surgery
- Over a two year period, surgeons, nurses, anesthesiologists, and patient safety experts from around the world developed the following 10 objectives for safe surgery using peer-reviewed evidence and expert consensus.

Slide 11: WHO’s 10 Objectives for Safe Surgery (cont.)
- N/A

Slide 12: Reality Check
- Although you may think that your hospital already does these things, use of the checklist is vital to ensure that all necessary steps are completed consistently

Slide 13: Advantages of Using a Checklist
- Given its simplicity and effectiveness, a checklist is the perfect tool to achieve these 10 objectives

Slide 14: What is this tool that addresses the 10 objectives?
- The experts generated this surgical safety checklist, designed to address all 10 of the objectives set forth in the WHO Guidelines for Safe Surgery

Slide 15:
- Sign In – to be performed just before the patient undergoes anesthesia
Slide 16:
- Time Out – to be performed just before the first incision

Slide 17:
- Sign Out – to be performed after the surgery is complete, usually while the surgeon is closing

Slide 18: The Checklist was piloted in 8 cities
- Once developed, this surgery checklist was tested in 8 pilot cities across the globe:

  - Toronto, Canada
  - London, United Kingdom
  - Amman, Jordan
  - Manila, Philippines
  - Auckland, New Zealand
  - New Delhi, India
  - Ifakara, Tanzania
  - Seattle, USA

Slide 19: Results
- Across the board – in both the developing and the developed nations where it was tested – the Checklist was found to increase adherence to basic standards and to reduce morbidity and mortality

Slide 20: What problems does this checklist address?
- The Checklist delineates key steps during perioperative care that should be accomplished during every operation in order to ensure correct patient, operation, and operative site

Slide 21: What problems does this checklist address? (cont.)
- Elements of the Checklist also encourage safe anaesthesia practice and resuscitation

Slide 22: What problems does this checklist address? (cont.)
- The Checklist helps minimize the risk of surgical site infection

Slide 23: What problems does this checklist address? (cont.)
- The Checklist also helps foster effective teamwork, something that was
recently recognized as an important component of perioperative care

Slide 24: Data Collection at a National Level (Surgical Vital Statistics)
- In order to address the global lack of surgical data, checklist implementation has been coupled with an effort to collect Surgical Vital Statistics in the institutions and nations in which it is used

Slide 25: Goals of the Safe Surgery Saves Lives Program
- Dissemination goals include benchmarks for checklist implementation and data collection in the coming years

Slide 26: Easy Math
- With 500,000 lives on the line every year, it is imperative that we spread the Checklist widely and rapidly

Slide 27: Resources and Information Available at:
- For more information and helpful resources, visit our website
Safe Surgery Saves Lives

Surgical Public Health:

The World Health Organization (WHO) and the Safe Surgery Saves Lives Campaign

Your Name
3 Central Problems in Surgical Safety

1. Unrecognized as a public health issue
2. Lack of data on surgery and outcomes
3. Failure to use existing safety know-how

Problem 1: Unrecognized as public health issue

234 million operations are done globally each year
Problem 1: Unrecognized as public health issue (cont.)

- Burden of surgical disease is increasing worldwide
  - Cardiovascular disease
  - Traumatic injuries
  - Cancer
  - Longer life expectancies

Problem 1: Unrecognized as public health issue (cont.)

- Known surgical complications of 3-16% = At least 7 million disabling complications – including 1 million deaths – worldwide each year
- Known death rates of 0.4-0.8%
Problem 2: Lack of Data on Surgery and Outcomes

- Improvements in maternal mortality depended on routine surveillance
- Such surveillance is lacking for surgical care

Problem 3: Failure to use existing safety know-how

- High rates of preventable surgical site infection result from inconsistent timing of antibiotic prophylaxis
- Anesthetic complications are 100-1000x higher in countries that do not adhere to monitoring standards
- Wrong-patient, wrong-site operations persist despite high publicity of such events
The Safe Surgery Saves Lives Strategy

1. Promotion of surgical safety as a public health issue

2. Creation of a checklist to improve the standards of surgical safety

3. Collection of “Surgical Vital Statistics”

WHO’s 10 Objectives for Safe Surgery

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from administration of anaesthetics, while protecting the patient from pain.
3. The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function.
4. The team will recognize and effectively prepare for risk of high blood loss.
5. The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk.
WHO’s 10 Objectives for Safe Surgery (cont.)

6. The team will consistently use methods known to minimize the risk for surgical site infection.
7. The team will prevent inadvertent retention of instruments or sponges in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

Reality Check

Currently, hospitals do MOST of the right things, on MOST patients, MOST of the time.

The Checklist helps us do ALL the right things, on ALL patients, ALL the time
Advantages of Using a Checklist

- **Customizable** to local setting and needs
- **Supported** by evidence
- **Evaluated** in diverse settings around the world
- **Promotes** adherence to established safety practices
- **Minimal resources** required to implement a far-reaching safety intervention

What is this tool that addresses the 10 objectives?

![Surgical Safety Checklist](image-url)
### SIGN IN
- **Patient has confirmed**
  - Identity
  - Site
  - Procedure
  - Consent
- **Site marked/not applicable**
- **Anaesthesia safety check completed**
- **Pulse oximeter on patient and functioning**

#### Does patient have a:
- **Known allergy?**
  - No
  - Yes
- **Difficult airway/aspiration risk?**
  - No
  - Yes, and equipment/assistance available
- **Risk of >100ml blood loss**
  - No
  - Yes, and adequate intravenous access and fluids planned

### TIME OUT
- **Confirm all team members have introduced themselves by name and role**
- **Surgeon, anaesthesia professional and nurse verbally confirm**
  - Patient
  - Site
  - Procedure

#### Anticipated critical events
- **Surgeon reviews:** What are the critical or unexpected steps, operative duration, anticipated blood loss?
- **Anaesthesia team reviews:** Are there any patient-specific concerns?
- **Nursing team reviews:** Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?

#### Has antibiotic prophylaxis been given within the last 60 minutes?
- Yes
- Not applicable

#### Is essential imaging displayed?
- Yes
- Not applicable
The Checklist was piloted in 8 cities

- Toronto, Canada
- London, UK
- Amman, Jordan
- Manila, Philippines
- New Delhi, India
- Seattle, USA
- Ifakara, Tanzania
- Auckland, NZ
**SIGN IN**

- Patient has confirmed
  - Identity
  - Site
  - Procedure
  - Consent

- Site marked/not applicable

- Anaesthesia safety check completed

- Pulse oximeter on patient and functioning

**Does patient have a:**

- Known allergy?
  - No
  - Yes

- Difficult airway/aspiration risk?
  - No
  - Yes, and equipment/assistance available

- Risk of >100ml blood loss
  - Yes, and in children?
  - No
  - Yes, and adequate intravenous access and fluids planned

**TIME OUT**

- Confirm all team members have introduced themselves by name and role

- Surgeon, anaesthesia professional, and nurse verbally confirm
  - Patient
  - Site
  - Procedure

- Anticipated critical events

- Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss?

- Anaesthesia team reviews: are there any patient-specific concerns?

- Nursing team reviews: has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?

- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - No applicable

- Is essential imaging displayed?
  - Yes
  - No applicable
Results

- Increased rate of adherence to basic standards from 36% to 68% – in some hospitals to almost 100%.

- Resulted in substantial reductions in mortality and morbidity

Source: www.safesurg.org

What problems does this checklist address?

Sign In:

- PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT

- SITE MARKED/NOT APPLICABLE

Time Out:

- SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE

Sign Out:

- NURSE VERBALLY CONFIRMS WITH THE TEAM
- THE NAME OF THE PROCEDURE RECORDED

- Correct patient, operation and operative site

  - There are between 1500 and 2500 wrong site surgery incidents every year in the US.¹

  - In a survey of 1050 hand surgeons, 21% reported having performed wrong-site surgery at least once in their career.²

What problems does this checklist address? (cont.)

Sign In:
- **Safe Anaesthesia and Resuscitation**
  - An analysis of 1256 incidents involving general anaesthesia in Australia showed that pulse oximetry on its own would have detected 82% of them.¹

Time Out:
- **Minimizing risk of infection**
  - Giving antibiotics within one hour before incision can cut the risk of surgical site infection by 50%¹, ²
  - In the eight evaluation sites, failure to give antibiotics on time occurred in almost one half of surgical patients who would otherwise benefit from timely administration

What problems does this checklist address? (cont.)

- **Effective Teamwork**
  - Communication is a root cause of nearly 70% of the events reported to the Joint Commission from 1995-2005.¹
  - A preoperative team briefing was associated with enhanced prophylactic antibiotic choice and timing, and appropriate maintenance of intraoperative temperature and glycemia.²,³

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**Data Collection at a National Level (Surgical Vital Statistics)**

- Number of surgical procedures performed in the operating theatre per 100,000 population per year
- Number of Operating Theatres per 100,000 population
- Number of surgeons per 100,000 population
- Number of anesthesia professionals per 100,000 population
- Day-of-surgery mortality rate
- Postoperative in-hospital mortality rate
Goals of the Safe Surgery Saves Lives Program

- Enroll 250 hospitals in the program by January 1st, 2009 and 2,500 hospitals by 2010.
- Enroll hospitals in countries representing one fourth of the world’s population by 2009 and representing half of the world’s population by 2010.
- Collect surgical vital statistics for one country in each WHO region by 2010

Easy Math

234 million people are operated on each year, and >1 million of these individuals die from complications

+ At least ½ are avoidable with the Checklist

500,000 lives on the line each year
Resources & Information Available at:

www.who.int/safesurgery

www.safesurg.org

- Checklist
- Brochure
- FAQ
- How-to videos

- Implementation Manual
- Guidelines
- Starter Kit
Presentation 2

‘Safe Surgery Saves Lives’ Implementation Strategy (WHO Recommendations)
SSSL Implementation Strategy

WHO Recommendations

Purpose of Checklist

• Enabling consistency in safety for patients
• Introducing (or maintaining) a culture that values achieving it.
Building a team

- Commitment by team members is essential.
- Tell your colleagues about the checklist
- Start with those who are likely to be most supportive.
- Identify a core group to involve at least one member from each of the clinical disciplines.
- Work with those who are interested, rather than trying to change the most resistant people.

Meet with hospital leaders

- Support of this initiative by leaders in each of the clinical disciplines is critical to its success.
- Think about what the hospital leadership can do to promote the checklist.
Start small, then expand

- Run a campaign in specific settings
- During the original evaluation by WHO, sites that tried to implement the checklist in multiple operating rooms simultaneously or hospital-wide faced the most resistance and had the most trouble convincing staff to use the checklist effectively.
- Start small - one operating room with one team
- move forward after problems have been addressed and when enthusiasm builds.

Use the checklist

- Core team members must be using the checklist in their own operating rooms!
- Slowly encourage others to adopt the checklist
- Work through potential concerns.
- Do not hesitate to customize the checklist for your setting as necessary, but do not remove safety steps just because you are unable to accomplish them.
Track changes

- Collect data to see if the standards are being followed as the checklist is implemented in more operating rooms.
- Follow both process and outcome measures
  - e.g. In what percent of operations are we giving antibiotics at the correct time? (process)
  - How many patients get surgical site infections? (outcome)

Set public goals

- Once you have a sense of your data, try to improve your numbers by letting your whole hospital know about improvement goals you hope to achieve.
Update the hospital on progress

- Make the progress on both process and outcome measures publicly available so that hospital staff can witness improvement.

Continuity is essential

- Continue to use the checklist.
- Data collection may become less frequent as the checklist is accepted.
- A periodic check on progress will ensure that process measures stay on track and complications are minimized.
Share your experience with the Safe Surgery Saves Lives program

- You can also email us at safesurgery@hsph.harvard.edu.
We can also have our own Safe Surgery Annual Meeting
7.3

Presentation 3

Ministry of Health Malaysia
‘Safe Surgery Saves Lives Initiative’
Ministry of Health Malaysia
Safe Surgery Saves Lives

Dato’ Dr. Abd Jamil Abdullah

Chairman Safe Surgery Saves Lives Initiative
Head of Surgery
Hospital Sultanah Nur Zahirah
Kuala Terengganu

An initiative established by World Alliance For Patient Safety (WAPS) 2004 as part of WHO’s efforts to reduce the number of surgical deaths in the world.
Aims of Initiative

- To harness political commitment and clinical will to address important safety issues, which includes:
  - Inadequate anaesthetic safety practices
  - Avoidable surgical infection and
  - Poor communication among team members

The Safe Surgery Saves Lives Strategy

1. Promotion of surgical safety as a public health issue

2. Creation of a checklist to improve the standards of surgical safety

3. Collection of “Surgical Vital Statistics”
The surgical setting is one of the most potentially hazardous of clinical environments

WHO's 10 Objectives for Safe Surgery

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from administration of anaesthetics, while protecting the patient from pain.
3. The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function.
4. The team will recognize and effectively prepare for risk of high blood loss.
5. The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk.
WHO's 10 Objectives for Safe Surgery (cont.)

6. The team will consistently use methods known to minimize the risk for surgical site infection.
7. The team will prevent inadvertent retention of instruments or sponges in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.
The Checklist was piloted in 8 cities

Preliminary Pilot Site Results

<table>
<thead>
<tr>
<th>Site</th>
<th>Cases</th>
<th>Use of Pulse Oximeter</th>
<th>Time Out to Confirm Site/Pt</th>
<th>Objective Airway Evaluation</th>
<th>Antibx at 0-60 mins</th>
<th>IV Access &gt;500 cc EBL</th>
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<tr>
<td>1</td>
<td>377</td>
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<td>100%</td>
<td>96%</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>2</td>
<td>317</td>
<td>97%</td>
<td>8.8%</td>
<td>74%</td>
<td>52%</td>
<td>73%</td>
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<tr>
<td>3</td>
<td>232</td>
<td>96%</td>
<td>100%</td>
<td>9.5%</td>
<td>34%</td>
<td>7%</td>
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<tr>
<td>4</td>
<td>496</td>
<td>77%</td>
<td>22%</td>
<td>45%</td>
<td>25%</td>
<td>49%</td>
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<tr>
<td>5</td>
<td>338</td>
<td>97%</td>
<td>50%</td>
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<td>6</td>
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<tr>
<td>8</td>
<td>446</td>
<td>99%</td>
<td>17%</td>
<td>0.5%</td>
<td>18%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Total Cases 3234
Results

• Increased rate of adherence to basic standards from 36% to 68% – in some hospitals to almost 100%.

• Resulted in substantial reductions in mortality and morbidity

Source: www.safesurg.org
PGH Interim Data

<table>
<thead>
<tr>
<th></th>
<th>PRE</th>
<th>POST</th>
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</thead>
<tbody>
<tr>
<td>Cases</td>
<td>496</td>
<td>500</td>
</tr>
<tr>
<td>Patient Confirmation</td>
<td>21.77%</td>
<td>64.89%</td>
</tr>
<tr>
<td>Antibx at 0-60 Minutes</td>
<td>25.40%</td>
<td>55.17%</td>
</tr>
<tr>
<td>Airway Evaluation</td>
<td>46.17%</td>
<td>58.4%</td>
</tr>
<tr>
<td>2 IVs for 500cc Blood Loss</td>
<td>49.23%</td>
<td>64%</td>
</tr>
<tr>
<td>Sponge Count</td>
<td>99.40%</td>
<td>99.8%</td>
</tr>
<tr>
<td>Complication</td>
<td>10.08%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Death</td>
<td>3.63%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Survey of Clinicians

- 78% thought it was easy to use
- 79% thought it improved care
- 18% thought it took a long time
- 84% thought it improved communication
- 78% thought it reduced errors
- 93% would want a checklist used if they were having surgery

Berita CSM, Feb 08, Haynes AB
In Ministry of Health Malaysia

The POMR Committee

- Mandate to carry out SSSL initiative given by Malaysian Patient Safety Council in May 2008
- Peer Review Audit Committee started in 1992
- Looks at all post-operative deaths in selected MOH Hospitals
- Is in a position to carry out Safe Surgery initiatives
  - multiple surgical disciplines + anaesthetist
  - Data collection in place
Surgical Volume & POM

<table>
<thead>
<tr>
<th>Year</th>
<th>No of Op</th>
<th>POM</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>234,553</td>
<td>1,274</td>
<td>0.54 %</td>
</tr>
<tr>
<td>2001</td>
<td>232,592</td>
<td>1,452</td>
<td>0.62 %</td>
</tr>
<tr>
<td>2003</td>
<td>209,643</td>
<td>1,804</td>
<td>0.86 %</td>
</tr>
<tr>
<td>2004</td>
<td>216,926</td>
<td>2,164</td>
<td>1.00 %</td>
</tr>
</tbody>
</table>

The Malaysian Theme

- ‘Safer Surgery through Better Communication’

OBJECTIVES
- To improve understanding of the surgery process by patients and relatives
- To improve communication between operating team members
- Improve rapport between patient and the operating team
Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery

Dennis S. O’Leary, M.D.
President

Joint Commission on Accreditation of Healthcare Organisations (JCAHO)


Communication
Orientation/training
Patient assessment
Availability of info
Procedural compliance
OR hierarchy
Distraction

Percent of events
0 10 20 30 40 50 60 70 80

“Safe Surgery Saves Lives Initiative” Implementation Guidelines
A stepwise approach to make every case safe

Richard C. Karl, MD
Richard G. Connar Professor and Chairman, Department of Surgery, University of South Florida, Tampa

Understanding human factors and effective communication can develop a culture of safety.

Modifications to the Check List
Time Out
(Before Incision)

- Team checks
  - Patient’s ID
  - Type of procedure
  - Site, side
- Implants
- Antibiotics
- X-Rays
- ??Surgeon

The team & theme

<table>
<thead>
<tr>
<th>TIME OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>“WHITE BOARD” written</td>
</tr>
<tr>
<td>TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE</td>
</tr>
</tbody>
</table>
WHITE BOARD

- The formal `TEAM'
- Focal point
- CONTENTS
  - Patient’s Name
  - Proposed operation
  - Location or laterality of operation
  - Team Member’s name
  - Special instructions/Reminders
    - Position, Antibiotics, Equipment/Implants, Tourniquet time

Additions to checklist

DURING PROCEDURE

<table>
<thead>
<tr>
<th>INTRA OP COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHECK-IN</td>
</tr>
<tr>
<td>PERIODIC UPDATES</td>
</tr>
<tr>
<td>SHOUT - OUT</td>
</tr>
<tr>
<td>PRE-CLOSURE DISCLOSURE</td>
</tr>
</tbody>
</table>
Intra-op Communications

- Check-In
- Intermittent report
- ‘Shout it Out’
- Pre Closure disclosure
Pre-Closure Disclosure

• Final swab count
• Closing sutures
• Prepare reversal
• Plan for the next case

Additions to checklist

SIGN OUT

INFORM RELATIVES
Informing Relatives

- Informing of progress
- Showing of specimen

Additional recommendation:
Peri-Operative Review by operating surgeon / team

- Final pre-op check – new findings
- Last minute questions
- Will definitely improve communication with patients and relatives
- Confidence & rapport
Pilot launch – 5 Feb 2009

TESTING FORMS AND ACCEPTANCE

- HRPZ II and all hospitals in Kelantan
- Hospital Kemaman
- Hospital Pulau Pinang
- Hospital Raja Permaisuri Bainun, Ipoh
- Hospital Teluk Intan
- Hospital DOK, Sandakan

Usage of checklist

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Pre-GA Check</th>
<th>Time Out</th>
<th>Sign Out</th>
<th>Pre-Op Visit</th>
<th>Post Op Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Pulau Pinang</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>Hospital Ipoh</td>
<td>98</td>
<td>90</td>
<td>-</td>
<td>79</td>
<td>57</td>
</tr>
<tr>
<td>HRPZ II</td>
<td>85</td>
<td>60-90</td>
<td>92</td>
<td>89</td>
<td>83</td>
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<tr>
<td>Hospital Teluk Intan</td>
<td>90+</td>
<td>90+</td>
<td>90+</td>
<td>67</td>
<td>67</td>
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<tr>
<td>Duchess of Kent Sandakan</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Hospital Kemaman</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>91</td>
</tr>
</tbody>
</table>
Additional efforts

- Review existing nursing forms
- Inco-operate existing forms into one
- New form will just be another work process that they’d get used to

**PERI-OPERATIVE CHECK LIST**

**PATIENT PROFILE**
(To be filled by Ward Staff)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Race</th>
<th>Reg. no.</th>
<th>Diagnosis</th>
<th>Operation</th>
<th>Checked by (ward staff)</th>
<th>Date</th>
<th>Contact person &amp; HP No.</th>
</tr>
</thead>
</table>

**PRE-TRANSFER CHECK**
(In done by the Ward Nurses before sending patient to OT and at Reception Area in OT by the OT Reception Nurse)

<table>
<thead>
<tr>
<th>1. Patient’s Name</th>
<th>Identify Tag</th>
<th>Consent for</th>
<th>Surgery</th>
<th>Anaesthesia</th>
<th>Transfusion</th>
<th>Ward</th>
<th>OT</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Consent for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Check side of operation</td>
<td>LEFT</td>
<td>RIGHT</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Site (location) of operation marked?</td>
<td>YES</td>
<td>NO</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Last meal</td>
<td>Date</td>
<td>Time</td>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Check for dentures, jewellery, contact lenses etc.</td>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Premedication</td>
<td>(Note drug given)</td>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

“Safe Surgery Saves Lives Initiative” Implementation Guidelines 89
OPERATING TEAM CHECKLIST

BEFORE INDUCTION OF ANAESTHESIA

SIGN IN

- Checked patient's
  - Identity
  - Site
  - Procedure
  - Consent

- Site marked: No NA

- Checked GA machine

- Pulse oximeter on patient and functioning

- Checked patient's:
  - Allergy?
    - No
    - Yes
  - Airway/Aspiration risk?
    - No
    - Yes
  - Risk of > 500ml blood loss (adult)
    - No
    - Yes
  - Risk of > 500ml blood loss (child)
    - No
    - Yes
  - Adequate IV access?
    - No
    - Yes

Anticipated special events

- Surgeon requires any special steps, estimated duration, possible excessive blood loss?
- Anaesthesia team requires any patient-specific concerns?
- Nursing team requires any instrument stability confirmed, implants / prosthesis available

DURING PROCEDURE

INTRA-OPEERATIVE COMMUNICATION

- Checks
- Periodic updates
- Checklist
- Procedure disclosure

BEFORE PATIENT LEAVES OPERATING ROOM

SIGN OUT

Nurse verbally confirms with the team.

SWAB & INSTRUMENT COUNT FORM

SETS & INSTRUMENT

Basic set:

1. .............................................. ..........................................................
2. .............................................. ..........................................................
3. .............................................. ..........................................................
4. .............................................. ..........................................................

Supplementary:

.............................................. ..........................................................

<table>
<thead>
<tr>
<th>Item</th>
<th>Basic</th>
<th>Additional</th>
<th>Extra</th>
<th>Additional</th>
<th>2nd</th>
<th>Additional</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauze</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atraumatic needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loops needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinfectant</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

90 “Safe Surgery Saves Lives Initiative” Implementation Guidelines
## PRE-DISCHARGE CHECK

(To be done by the Ward Nurse with the Recovery Nurse before the patient leaves the OT)

<table>
<thead>
<tr>
<th></th>
<th>Checked</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient’s name□</td>
<td>Identity tag□</td>
</tr>
<tr>
<td>2.</td>
<td>Consciousness level</td>
<td>Alert □ Drowsy □ Intubated □</td>
</tr>
<tr>
<td>3.</td>
<td>Inform vital signs &amp; pain score</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Check operative site / dressing</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Check drains, tubes and urinary catheter</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Check IV lines and infusions</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Blood used and unused</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Specimens</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Case notes □ Old notes □ X-rays □ Operative notes □ GA form □</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Check post-operative pain relief order</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
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<tr>
<td>13.</td>
<td></td>
<td></td>
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<tr>
<td>14.</td>
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<tr>
<td>15.</td>
<td></td>
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</tr>
</tbody>
</table>

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**Summary**

- SSSL initiative is fairly new to Malaysia
- Response to the effort has been encouraging
- May have to start as a ‘directive’
- Make safety culture the goal
How comforting
8.0 Appendices
Appendix 1

WHO’S 10 OBJECTIVES FOR SAFE SURGERY

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from anaesthetic administration, while protecting the patient from pain.
3. The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function.
4. The team will recognize and effectively prepare for risk of high blood loss.
5. The team will avoid inducing any allergic or adverse drug reaction known to be a significant risk for the patient.
6. The team will consistently use methods known to minimize risk of surgical site infection.
7. The team will prevent inadvertent retention of instruments or sponges in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical patient information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume, and results.

REFERENCE

Selected bibliography supporting the ten essential objectives for safe surgery
## Appendix 2

### Surgical Safety Checklist (First Edition)

#### Before Induction of Anaesthesia

**Sign In**
- **Patient has confirmed**
  - Identity
  - Site
  - Procedure
  - Consent

- **Site marked/not applicable**

- **Anaesthesia safety check completed**

- **Pulse oximeter on patient and functioning**

**Does patient have a:**
- **Known allergy?**
  - No
  - Yes

- **Difficult airway/aspiration risk?**
  - No
  - Yes, and equipment/assistance available

**Risk of > 500ml blood loss (7ml/kg in children)?**
- No

**Yes, and adequate intravenous access and fluids planned.**

#### Before Skin Incision

**Time Out**
- Confirm all team members have introduced themselves by name and role

- Surgeon, anaesthesia professional and nurse verbally confirm:
  - Patient
  - Site
  - Procedure

**Anticipated critical events**
- Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss?

**Anaesthesia team reviews: are there any patient-specific concerns?**

**Nursing team reviews: has sterility (including indicator result) been confirmed? Are there equipment issues or any concerns?**

**Has antibiotic prophylaxis been given within the last 60 minutes?**
- Yes
  - Not applicable

**Is essential imaging displayed?**
- Yes
  - Not applicable

#### Before Patient Leaves Operating Room

**Sign Out**
- Nurse verbally confirms with the team:
  - The name of the procedure recorded

- That instrument, sponge and needle counts are correct (or not applicable)

- How the specimen is labelled (including patient name)

- Whether there are any equipment problems to be addressed

- Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient

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*This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.*