



Why use briefings and the Checklist?

Project SAVED - Surgical checklist and improving the experiences of Doctors in training

Why use briefings and the Who Surgical Safety Checklist in surgery?

1. Current situation

Errors due to unreliable systems and human factors are surprisingly common in healthcare, and surgery is no exception. Many of these errors cause harm to patients or place them at risk of poorer outcomes.

The systems we operate to deliver our clinical processes often function at less than 60% reliability.

Many serious errors occur due to a failure of communication and poor teamwork and because we fail to recognise the importance of human factors in the complex environments in which we work.

Human factors are the issues that make mistakes more likely when humans work in complex systems. These include trying to remember a long list of items without writing them down, working with frequent interruptions, fatigue and stress, equipment design and challenges such as changes to the order of the operating list.

2. Is there any evidence that we can do something about it?

In other high-risk industries such as aviation, nuclear and some healthcare organisations recognition of the importance of human factors has produced dramatic improvements, through system design and improved teamwork and communication.

In healthcare, better teamwork has been found to improve clinical outcome, reduce staff turnover, reduce the risk of serious errors and associated harm and make operating lists more efficient.

Teams function well when there is leadership, formal methods of communication, little sense of hierarchy, confidence in being able to speak up particularly if something seems wrong, familiarity and a shared plan.

The ability to deliver these relies upon non-technical skills such as leadership, communication, decision making and situation awareness.

Making the **safety** of patients everyone's highest **priority**

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3. How can we do this in surgery?

Performing a safety **briefing** before the start of a list creates a sense of familiarity and confidence amongst team members. It ensures everyone understands plan A and plan B. It reduces glitches and delays by focusing team members on the purpose of the day. It prepares everyone for specific moments when a plan may change or higher risk steps are taken. It allows those with a specific reason for suboptimal performance to express it early on eg: previous night on call duty or anxiety about domestic issues.

A '**Sign In**' prior to anaesthesia ensures adequate discussion about anaesthesia related issues; that preparation is made for any anticipated airway difficulties and that the expected patient is about to receive anaesthesia.

The '**Time Out**' just prior to incision, provides an opportunity to cross check that everything is in place that should be for the procedure to take place in the safest environment possible. It is an extra check enabling the team to qualify that the right procedure is about to be performed on the right patient, that everyone knows what the surgeon and anaesthetist are thinking or expecting, that the right equipment is available, required imaging is displayed and that appropriate infection and VTE prophylaxis has been administered.

The '**Sign Out**' ensures that essential information regarding the patient's continuing care is prioritised to be shared with recovery staff, and it provides an opportunity to verify that all instrument, swab and needle counts are correct and that key specimens are correctly labelled.

The '**De-brief** at the end of the list, creates an opportunity for the team to learn from the events of the day and record any issues that made it difficult to run the list safely and efficiently. It also creates a safe environment for reflection on the team's performance.

4. Summary

Briefings and the elements of the checklist are tools to deliver a step change in teamwork and the reliability of perioperative care.

Where the Checklist is focused on as a tick box exercise, improvements will not occur. When used purposefully to improve the way the team communicates, performs and assures itself what should happen has happened, the checklist not only gives the patient the best opportunity of a good outcome but delivers an enhanced experience for everyone in the team.

Project SAVED is the opportunity to test this out yourself and tell us what went well and what did not. We look forward to hearing about your experience.

Related documents: Background information, Step-by-Step guide