JOINT POSITION STATEMENT

Advocacy and support for use of a Surgical Safety Checklist

Joint Position: Canadian Patient Safety Institute (CPSI), Alberta Health Services (AHS), Canadian Anesthesiologists' Society (CAS), Operating Room Nurses Association of Canada (ORNAC)

While surgical procedures are intended to save lives, unsafe surgical care can cause substantial harm

(World Health Organization, 2013)

Purpose

Healthcare professionals must make every reasonable effort to provide safe care to their patients. The purpose of this statement is to express the commitment of the undersigned organizations to prioritize perioperative patient safety by creating an environment conducive to the effective adoption and use of a Surgical Safety Checklist.

A Surgical Safety Checklist drives surgical safety by: 1) initiating, guiding, and formalizing communication among surgical team members; and 2) ensuring that critical safety steps are completed and integrated into the surgical workflow.

Effective use of surgical checklists has been shown to reduce the likelihood of complications and improve outcomes (Haynes et al., 2009; Panesar et al., 2009), as well as reduce healthcare costs (Semel et al., 2010).

While some surgical complications cannot be avoided, others are considered "never events" — serious patient safety incidents that should not occur if healthcare systems support and empower providers in their use of available preventative measures. Never events do not imply blame; "never" is a call-to-action, not a demand or an attempt to shame mistakes. Never events associated with surgical care include:

1. Surgery on the wrong body part, the wrong patient, or conducting the wrong procedure
2. Wrong tissue, biological implant or blood product given to a patient
3. Unintended foreign object left in a patient following a procedure
4. Patient death or serious harm arising from the use of improperly sterilized instruments or equipment.
5. Patient death or serious harm due to a failure to enquire about known allergies to medications, or due to administration of a medication where a patient's allergy had been identified
6. Patient death or serious harm due to the administration of the wrong medication or substance during care delivery.

Never events also damage patients' confidence in the healthcare system and may indicate problems with an organization's safety culture and its processes for learning and improvement. When used effectively by all team members, a Surgical Safety Checklist contributes to a culture of safety built on communication and teamwork that can prevent patient safety incidents.

Successful use of a Surgical Safety Checklist requires the commitment of the inter-disciplinary surgical team who are provided with training that emphasizes teamwork and communication. The support of leadership and administration is essential to ensuring continuous quality improvement that includes outcome measurement, education and feedback.

1. Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. N Engl J Med. 2009;360:491-9

2. Panesar SS, Cleary K, Sheikh A, Donaldson L. The WHO checklist: a global tool to prevent errors in surgery. Patient Safety in Surgery. 2009; 3:9

3. Semel ME, Resch S, Haynes AB, et al. Adopting a surgical safety checklist could save money and improve the quality of care in U.S. hospitals. Health Affairs. 2010; 29:1593-1599

cpsi icsp Canadian Patient Safety Institute Institut canadien pour la sécurité des patients

Alberta Health Services

Operating Room Nurses Association of Canada

Association des infirmières et infirmiers de salles d'opération du Canada

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Canadian Patient Safety Institute, Alberta Health Services, the Canadian Anesthesiologists' Society, and the Operating Room Nurses Association of Canada would like to thank the following organizations for their endorsement of the Joint Position Statement for the use of a Surgical Safety Checklist:

Surgical Safety Checklist: Smart for patients. Smart for providers.

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