



Surgical Safety Checklist Implementation Toolkit

Foreword

Ontario hospitals have a longstanding commitment to patient safety and accountability. As part of this commitment, Ontario hospitals are embracing the use of surgical safety checklists in their operating rooms.

Mandatory surgical safety checklists will help health professionals and hospitals better understand and further improve the care they provide. The Ontario Hospital Association (OHA) strongly supports public reporting on the use of checklists, knowing that they inspire performance improvement, enhance patient safety and, strengthen public confidence in Ontario's hospitals.

The OHA also believes that the surgical safety checklist is a valuable tool that promotes good communication and teamwork among health care teams, which can lead to positive clinical outcomes for patients.

To help Ontario hospitals implement and use surgical safety checklists, the OHA and the Government of Ontario are proud to present the *Surgical Safety Checklist Implementation Toolkit*, designed to help hospitals meet the specific requirements of surgical safety checklist compliance.

The OHA appreciates the efforts of Ontario hospitals as they continue to work hard, meeting their public reporting requirements, and ensuring high quality, safe patient care. Ontario hospitals have a lot to be proud of with their quality improvement records, and the adoption of surgical safety checklists in operating rooms across the province is one more positive step forward.



Tom Closson
President and CEO
Ontario Hospital Association

On May 28, 2008, the Ontario government launched a new era of transparency in Ontario hospitals with the introduction of the public reporting of patient safety indicators.

As Executive Lead - Patient Safety for the Ministry of Health and Long-Term Care, I would like to acknowledge the outstanding work of staff from hospitals, the public health system, the ministry, as well as the Ontario Hospital Association, who have dedicated themselves to helping improve patient safety in our hospitals.

Since 2008, much has been accomplished in the arena of patient safety. Ontario hospitals are now publicly reporting on eight patient safety indicators that provide valuable data on which to base effective benchmarks, best practices, and foster patient safety improvements across the province's hospital system.

The Surgical Safety Checklist, announced by the government in September of 2009, is the latest tool to further the goal of improving patient safety. The checklist provides a list of the most common tasks and items that operating room teams carry out in the peri-operative period to ensure patient safety. The consistent use of this checklist has been shown to reduce the rates of death and complications associated with surgical care.

The Surgical Safety Checklist Implementation Toolkit has been designed to help all staff in hospitals to better understand how the checklist can help improve surgical care in hospitals. The guide has been written specifically for those whose role it is to implement the program in their hospital.

I'd like to take this opportunity to thank the Ontario Hospital Association and everyone who has contributed their time and expertise in the writing of this guide. I certainly hope that each of you will find this guide both helpful and motivational as we continue to enhance patient safety and strengthen the public's confidence in Ontario hospitals.



Dr. Michael Baker C.M., O. Ont
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Disclaimer

This toolkit has been prepared by the Ontario Hospital Association (OHA) and the Government of Ontario to help hospitals implement the Surgical Safety Checklist and improve patient safety. The toolkit is intended to serve as a planning guide to assist hospitals in developing and updating a Surgical Safety Checklist program.

The materials in this toolkit are for general information purposes only and should be adapted to the circumstances of each hospital that uses them. The toolkit reflects the interpretations and recommendations regarded as valid when it was published. This toolkit is not intended as professional advice or opinion and users should seek their own professional advice and opinion in the development of their institution's program and specific plans. The OHA and the Government of Ontario assume no responsibility or liability for any harm, damage or other losses, either direct or indirect, resulting from any reliance on the use or the misuse of any information contained in this toolkit.

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Preface

In 2008, the World Health Organization (WHO) launched the *Safe Surgery Saves Lives* campaign. Its goal is to improve the safety of surgical care around the world. Part of the campaign includes promoting the use of a surgical safety checklist in all hospital operating rooms.

The aim of a surgical safety checklist is to reinforce accepted safety practices and foster better communication and teamwork among health professionals in the operating room.

The Ontario Hospital Association (OHA) and the Government of Ontario support the WHO campaign as do many other key organizations, including the Canadian Patient Safety Institute (CPSI). The CPSI has adapted the WHO's surgical safety checklist for use in Canada. On September 30th 2009 the Ontario Government announced that all hospitals with operating rooms will be required to publicly report on their compliance with a three-phase surgical safety checklist by July 30, 2010.

To help hospitals implement the checklist and implement the requirements for public reporting, the OHA and the Government of Ontario partnered to develop the *Surgical Safety Checklist Implementation Toolkit*. This toolkit provides strategies, tools, and resources that Ontario hospitals can use to improve patient safety and prevent complications arising from surgical procedures.

How to Use the Toolkit

The toolkit is designed primarily for members of the perioperative committee and checklist program leads, but parts of the toolkit will also be of interest to senior administrators, operating room (OR) clinical teams, which include surgeons, anesthesiologists, nurses, technicians and other operating room personnel involved in surgery. Patient safety, quality, and risk management leaders will also be interested in reading this toolkit.

This toolkit is divided into three sections. The first section contains the background, evidence, and rationale for use of surgical safety checklists, including information on four important evidence-based practices that are embedded into the CPSI checklist. The material in this section will assist checklist program leads with building a case to obtain buy-in from clinicians.

The second part of this toolkit is a practical pullout “How -To” guide, outlining the recommended steps to implement and sustain a successful surgical safety checklist program in the hospital’s perioperative services.

The third section contains the appendices and provides tools and resources to assist with improving process and practices related to the surgical safety checklist program.

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This section of the toolkit provides the “What you need to know” before setting up a surgical safety checklist program in your hospital.

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The use of the Surgical Safety Checklist and the *Surgical Safety Checklist Implementation Toolkit* have been endorsed by key organizations:

Endorsements

The College of Physicians and Surgeons of Ontario (CPSO)

The College of Physicians and Surgeons of Ontario is pleased to endorse the implementation of the Surgical Safety Checklist in operating rooms. Use of this important tool will enhance patient safety, team communication and accountability.

Operating Room Nurses Association of Ontario (ORNAO)

The ORNAO endorses the implementation of the Surgical Safety Checklist in all operating rooms across Ontario. ORNAO’s mission includes “the promotion and advancement of perioperative patient care”. The Surgical Safety Checklist achieves this. ORNAO believes that patient safety is the foundation upon which the multidisciplinary surgical health care team – nurses, surgeons and anesthesiologists – provide care during the patient’s surgical experience. The use of the Surgical Safety Checklist will support the culture of safety within operating rooms by enhancing communication between team members.

Kathy Radcliffe, RN CPN(C)

ORNAO President

The Healthcare Insurance Reciprocal of Canada (HIROC)

The Healthcare Insurance Reciprocal of Canada (HIROC) is pleased to endorse the implementation and use of the *Surgical Safety Checklist Implementation Toolkit*. Since its inception, HIROC has recorded just under 2000 surgical claims. More than three quarters of these claims were related to operating room and same day surgery cases. Of these occurrences, one third could be classified as “never events” that might have been prevented by the use of a surgical safety checklist. As Canada’s largest health care liability insurer, HIROC believes safe surgery is a public health priority and strongly supports activities resulting in improved communications between surgical health care team members as well as the development of tools aimed at supporting a culture of safety and accountability within operating rooms.

Arlene Kraft, BSc, CPHRM, CHIM

Manager, Risk Management

Healthcare Insurance Reciprocal of Canada

The Association of Canadian University Departments of Anesthesia (ACUDA)

The ACUDA which represents the Departments of Anesthesia of all the university teaching hospitals, fully endorses the implementation of the Surgical Safety Checklist in operating rooms. This important initiative will enhance a culture of communication and patient safety in perioperative care in hospitals.

Dr. Davy Cheng, MD, MSc, FRCPC, FCAHS
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Institute for Safe Medication Practices Canada (ISMP Canada)

ISMP Canada is pleased to endorse the use of the Safe Surgical Checklist. Medication safety is integral to overall patient safety in the OR setting. The Surgical Safety Checklist is complementary to safe practices contained in the *ISMP Canada Operating Room Medication Safety Checklist*[®] (provided with the SSCL toolkits in the appendix), which is a program available to Ontario hospitals and supported by the Ontario Ministry of Health and Long-Term Care. Specifically, the ISMP Canada OR Medication Safety Program includes the implementation of “a safe surgery checklist” in its identified system safeguards for all OR cases.

David U, RPh, BScPhm, MScPhm,
President and CEO, ISMP Canada.

Canadian Patient Safety Institute (CPSI):

Dear Reader

Your interest in improving surgical safety is very timely, and in concert with the work of many others from Ontario, Canada, and around the world who are trying their best to ensure that patients receive the safest surgical care possible. By joining this challenge, your organization will both benefit from and contribute to the collective knowledge that can ensure safe surgery for all.

Research findings and the experience of many OR teams implementing the checklist confirm that the impact on surgical safety and especially on team communication, is unprecedented. Stories of close calls avoided are emerging as further evidence of the value of this simple tool. Dialogue is what makes this checklist different, they said.

The word dialogue comes from Greek: *dia* means between and *logos* means word or reasoning. A dialogue is therefore a flow of meaning that facilitates individuals to think together and arrive at outcomes that were not possible without it. Consider for a moment James Reason's Swiss cheese model of safety incidents. If the slices of cheese could exchange information with each other and move their position when needed the alignment of the holes would be virtually impossible. The checklist is the tool that can help facilitate the dialogue while the implementation resources available will assist you in building the strong foundation needed to start the change.

The Canadian Patient Safety Institute has partnered with key national and international stakeholders to bring teams the best knowledge available and design support systems that ensure that surgical safety is sustainably improved. We applaud the Ontario Hospital Association's efforts to create this toolkit and to develop a network of resources to support you in improving surgical safety. Now is the right time to start!

Best regards,

Dr. Chris Hayes,
Medical Officer and Chair,
Canadian Safe Surgery Saves Lives Working Group