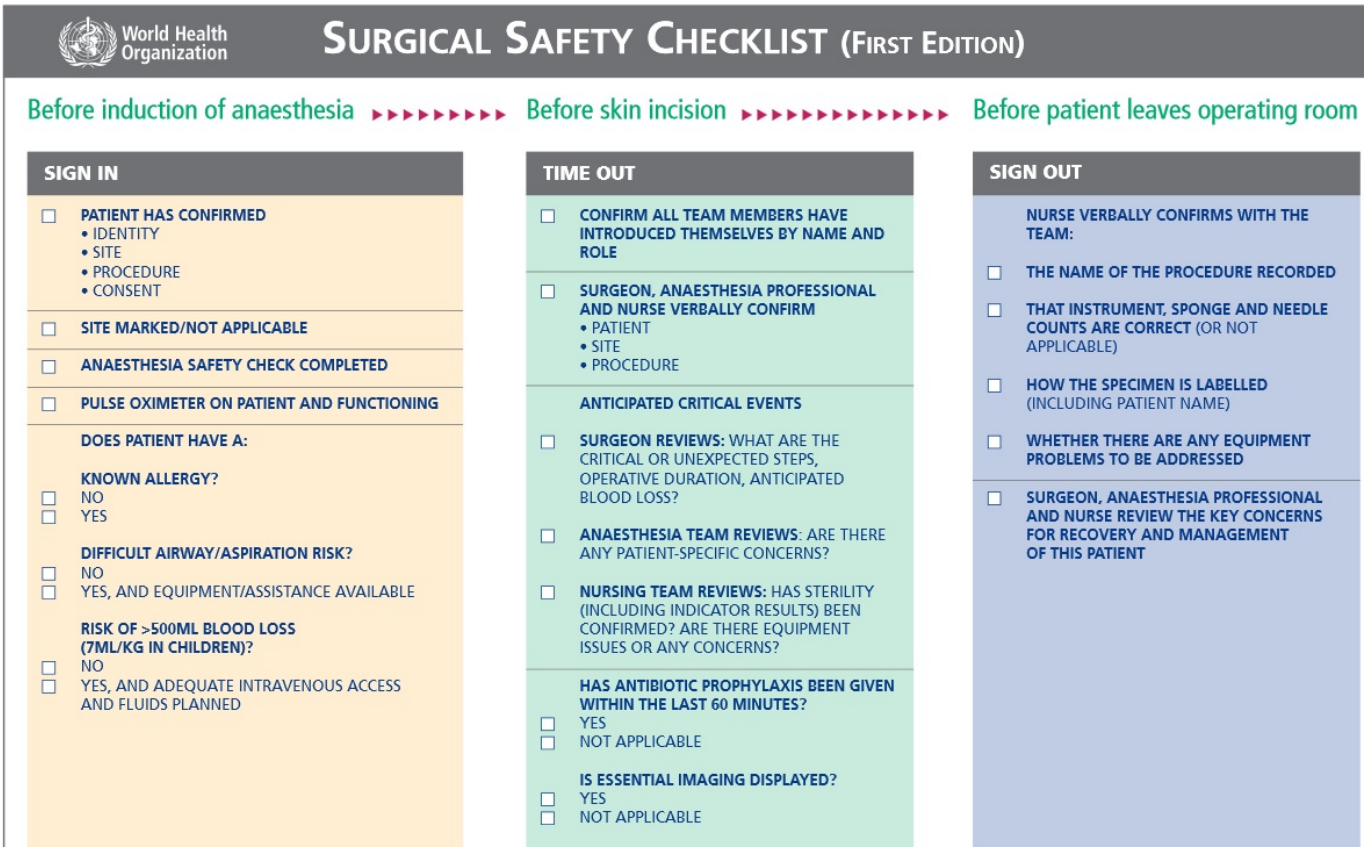
Surgical safety checklist (SSC)



The World Health Organization's surgical safety checklist is designed to improve adherence to operating room safety standards, and its use has been shown to reduce complications among surgical patients.

The SSC is an effective tool for improving safety in neurosurgical patients, which can be established in surgical departments of any hospital without increasing healthcare costs or operative time [1)].

Communication between the surgeon and the anesthesiologist was enhanced, and safety-related issues were better covered when the checklist was used. Unplanned readmissions fell from 25% to 10% after the checklist implementation ($p = 0.02$). Wound complications decreased from 19% to 8% ($p = 0.04$). The consistency of documentation of the diagnosis and the procedure improved. The use of the checklist improved safety-related performance and, contemporarily, reduced numbers of wound complications, and readmissions were observed [2)].

The implementation of a universal surgical safety checklist protocol in 2004 was intended to minimize the prevalence of wrong site surgery (WSS). However, complete elimination of WSS in the operating room continues to be a challenge. The purpose of a study is to evaluate the prevalence and etiology of WSS in the state of California. Study Design A retrospective study of all WSS reports investigated by the California Department of Public Health between 2007 and 2014.

Prevalence of overall and specialty-specific WSS, causative factors, and recommendations on further improvement are discussed.

A total of 95 cases resulted in incident reports to the California Department of Public Health and were

included in the study. The most common errors were operating on the wrong side of the patient's body (n = 60, 62%), performing the wrong procedure (n = 21, 21%), operating on the wrong body part (n = 12, 12%), and operating on the wrong patient (n = 2, 2%). WSS was most prevalent in orthopedic surgery (n = 33, 35%), followed by general surgery (n = 26, 27%) and neurosurgery (n = 16, 17%). All 3 otolaryngology WSS cases in California are associated with the ear.

WSS continues to surface despite national efforts to decrease its prevalence. Future research could establish best practices to avoid these “never events” in otolaryngology and other surgical specialties [3].

1)
Da Silva-Freitas R, Martín-Laez R, Madrazo-Leal CB, Villena-Martin M, Valduvieco-Juaristi I, Martínez-Agüeros JÁ, Vázquez Barquero A. [Establishment of a modified surgical safety checklist for the neurosurgical patient: Initial experience in 400 cases]. Neurocirugia (Astur). 2012 Mar;23(2):60-9. doi: 10.1016/j.neucir.2012.04.006. Spanish. PubMed PMID: 22578605.
2)
Lepänluoma M, Takala R, Kotkansalo A, Rahi M, Ikonen TS. Surgical safety checklist is associated with improved operating room safety culture, reduced wound complications and unplanned readmissions in a pilot study in neurosurgery. Scand J Surg. 2013 Dec 17. [Epub ahead of print] PubMed PMID: 24345978.
3)
Moshtaghi O, Haidar YM, Sahyouni R, Moshtaghi A, Ghavami Y, Lin HW, Djalilian HR. Wrong-Site Surgery in California, 2007-2014. Otolaryngol Head Neck Surg. 2017 Feb 1:194599817693226. doi: 10.1177/0194599817693226. [Epub ahead of print] PubMed PMID: 28195826.