
Ruth Melville - QLD ACORN Director & Chair Standards Committee
NUM ORS –Clinical Services NGH
Achieving better patient outcomes
Best practice in QH
Basically, safer perioperative patient care
ACORN standards
• State-wide Perioperative Patient Form
• Surgical Safety Checklist (SSC)
• Impact of the new Perioperative Documentation on CSSD & ORS
• Strategies/examples of using tray checklists as part of the count process
• Alignment with ACORN standards
Standardised Documentation

Why?

• Reduce risk of staff errors due to a structured standardised approach
• Ease of transition of staff moving within perioperative settings
• Consistent information delivered to patients
• Reduced risk of retained accountable items

Therefore improved PATIENT SAFETY
Swiss Cheese Model

DEFENSES
(slices of cheese)

No Standard Procedure for pre-operative checks
Pressure to do more cases to shorten waiting list
No team briefing prior to operation being commenced
Lack of surgeon awareness of risk of incorrect surgery

FAILURES
(holes in cheese)

Mr. Sims had wrong operation
Nurse asked Mr. Smith to confirm not state his name
Patient Mr. Sims partly deaf answered “yes”

Adapted from Reason, 1990
The Journey ?

2003  - PNAQ Endorsement – Strategic Meeting
2004  - Undertook State-wide analysis of Perioperative documentation
2006  - Clinical Practice Improvement Centre (CPIC) involvement to undertake Project Plan
2007  - Completion of project plan by CPIC
2008  - Clinical Networks endorsement SWAPNET
2008  - Project management undertaken by CPIC
2009- Trial form completed
2010- Trial commenced in 47 QH sites
2011- Feedback correlated & forms updated
2011- Forms now ready to utilise
How was the gap identified?

• 2004 - During downtime at our facility, a CN was allocated
• A Comparison across the state of sample documentation and questionnaires
  – 54 Public sent out, 46 received back
  – 45 Private sent out, 35 received back
• Identified as a priority strategy from State-wide Perioperative safety Forums
What did the gap identify?

- Vast differences in styles of information recorded
- Inconsistencies in counting procedure of consumables and instrumentation
- Inconsistences with use of tray checklists for instrument trays.
- Varying sizes and throughput of HCF’s
- Therefore the need for a consistent generic state-wide approach not a facility approach
What support did the project have?

- PNAQ
- NUM support
- Patient Safety Centre – Sandy Blake & John Wakefield
- CPIC support
- SWAPNET support
What were the considerations for this document?

- Consistent language for collection of data
- Reflect - regulatory requirements (3C’s) and recommended practices (ACORN)
- Care plan to follow for work practices (pre-op checklist)
- Variance orientated therefore replace pathways
- Strategic state-wide approach not a facility approach
- Able to be used for Adult and paediatric facilities
What are the components?

• Perioperative Patient Form – A3, 3 page document which includes the Surgical Safety Checklist

• Count Sheet – double sided with intraoperative information included (ORMIS sites)

• Sterility Validation Tracking and Prosthesis Used form (sites without ORMIS)
Preoperative Checks

3 Checks should be undertaken when patient care is passed from one clinician/location to another eg Ward/Unit to Theatre transfer for example:-

Prior to Transfer to Operating Suite

On arrival to Operating Suite

To be undertaken in anaesthetic bay (if available) by anaesthetic/circulating nurse prior to transfer into Operating Theatre

Note: The location of each check may vary dependent upon the local facility.
### Allergies

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt states “An antibiotic”</td>
<td>Rash &amp; Hot</td>
</tr>
</tbody>
</table>

### Existing implants and prosthesisess

<table>
<thead>
<tr>
<th>Type</th>
<th>Site</th>
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</thead>
<tbody>
<tr>
<td>Pacemaker</td>
<td>Left Chest</td>
</tr>
</tbody>
</table>

### Variances / Other alerts / Additional notes

<table>
<thead>
<tr>
<th>Date and time</th>
<th>Actions and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/9/09 0745hr</td>
<td>Site not yet marked by surgeon,, registrar notified  R.Melville RN</td>
</tr>
</tbody>
</table>

State the allergy and the effect

Other implants and prostheses may also include Grommets, peg feeds and portacaths.

State the variance and what you have done about it. This information is available to clinicians in the perioperative and post operative environment.
Surgical Safety checklist – Background

• Endorsed and launched by both medical and nursing peak bodies (RACS, ACORN, ANZCA, RANZCOG) and Federal Health Minister August 2009

• Endorsed by Health Ministers AHMC in November 2009

• QH Surgical Safety Checklist Policy, Standard and Manual approved for state-wide implementation by the Patient safety and Quality Executive Committee (PSQEC) on the 14th June 2011.

• Commitment to implement across Australia by 1 July 2011
Why was the checklist developed?

(To address the WHO 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 the administration of anaesthetics, while protecting the patient from harm.

3. The team will recognise and effectively prepare for life-threatening loss of airway or respiratory function.

4. The team will recognise 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 – 2009)
Why was the checklist developed?

(To address the WHO 10 Objectives for Safe Surgery)

6. The team will consistently use methods known to minimise the risk for surgical site infection.

7. The team will prevent the inadvertent retention of instruments and 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.

(WHO – 2009)
# Surgical Safety Checklist

## Before induction of anaesthesia
(with at least nurse and anaesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?
  - Yes
  - No
  - Not applicable

- Is the site marked?
  - Yes
  - No
  - Not applicable

- Is the anaesthesia machine and medication check complete?
  - Yes
  - No
  - Not applicable

- Is the pulse oximeter on the patient and functioning?
  - Yes
  - No
  - Not applicable

- Does the patient have a:
  - Known allergy?
    - Yes
    - No
  - Difficult airway or aspiration risk?
    - Yes
    - No
    - Yes, assistance available
    - No
    - Yes, and assistance available
  - Risk of >500ml blood loss (7ml/kg in children)?
    - Yes
    - No
    - Yes, and two IVs/central access and fluids planned

## Before skin incision
(with nurse, anaesthetist and surgeon)

- Confirm all team members have introduced themselves by name and role.
- Confirm the patient’s name, procedure, and where the incision will be made.
- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - No
  - Not applicable

## Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

- Nurse Verbally Confirms:
  - The name of the procedure
  - Completion of instrument, sponge and needle counts
  - Specimen labelling (read specimen labels aloud, including patient name)
  - Whether there are any equipment problems to be addressed

- To Surgeon, Anaesthetist and Nurse:
  - What are the key concerns for recovery and management of this patient?
Where was the checklist piloted?

- Toronto, Canada
- London, UK
- Amman, Jordan
- New Delhi, India
- Manila, Philippines
- Ifakara, Tanzania
- Seattle, USA
- Auckland, NZ
# Surgical Safety Checklist

**Sign in - Before anaesthesia or equivalent**

1. **Patient has confirmed:**
   - Identity AND
   - Site / Side AND
   - Procedure AND
   - Consent

2. **Site marked:**
   - Yes OR
   - Not applicable

3. **Anaesthesia safety check completed:**
   - Yes

4. **Appropriate equipment / assistance available for managing a difficult airway / aspiration risk:**
   - Yes

5. **Known allergy(ies):**
   - Yes OR
   - No

6. **Known alert(s):**
   - Yes OR
   - No

7. **Risk of blood loss of > 500mL (7mL/kg in children):**
   - Yes, and adequate planning for intravascular access and fluids OR
   - No

8. **Prosthesis (or special equipment) has been checked and confirmed:**
   - Yes OR
   - Not applicable

9. **Plan for antibiotic prophylaxis has been made:**
   - Yes OR
   - Not applicable

10. **Thromboprophylaxis:**
    - Mechanical:
      - Implemented OR
      - Not indicated
    - Medications:
      - Ordered OR
      - Not indicated

11. **Essential imaging:**
    - Choked with patient ID AND
    - Available in theatre and viewed by operator OR
    - Not applicable

**Time out - Before operative procedure or equivalent commences**

12. **Confirm all team members have:**
    - Introduced themselves by name and role OR
    - Already know each other by name and role

13. **Surgeon, Anaesthetist and Nurse confirm**
    - Patient AND
    - Site / Side AND
    - Procedure

14. **Antibiotic prophylaxis has been given:**
    - Yes OR
    - Not applicable

15. **Pressure injury prevention plan implemented:**
    - Yes

16. **Anticipated critical events:**
    - Surgical team review:
      - Confirm the critical or non-routine steps
    - Anaesthesia team review:
      - Confirm any patient-specific concerns
    - Nursing team review:
      - Confirm sterility (including indicator results) AND
      - Confirm all equipment available

**Sign out - Before patient leaves operating room**

17. **Nurse confirms with the team:**
    - The name of the procedure documented AND
    - Accountable items count correct

18. **Specimens are correctly labelled:**
    - Yes OR
    - Not applicable

19. **Equipment problems to be addressed:**
    - Yes OR
    - Not applicable

20. **Specific concerns for post operative care including pressure injury prevention:**
    - Surgical team AND
    - Anaesthetic team AND
    - Nursing team

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Based on the WHO Surgical Safety Checklist, URL http://www.who.int/patientsafety/safesurgery/en, © World Health Organization 2008 All rights reserved.
The aim of the checklist is to:

- Reinforce accepted safety practices through better communication and teamwork between individuals

(Implementation Manual WHO Surgical Safety Checklist 2009)
ACORN(SS2) Standard Statement 2

HCF shall develop a policy, which clearly defines the counting process within their organisation and is used in conjunction with the standard.

Rationale

ACORN acknowledges that each surgical procedure carries a different risk for instruments, and other items, being retained. Therefore, the risk shall be considered, when determining those instruments, equipment and other items that shall require mandatory documentation.

Note: There may be variations within each HCF in relation to the standard and these should be included in the HCF policy.

Criteria

The multidisciplinary management committee shall develop a policy which:

2.1 clearly defines any additional items to be included in mandatory counts; and,

2.2 ensures the timely annual review of all processes and documentation.
ACORN(SS5) Standard Statement 5

- *The nurse shall utilise a tray list as a risk management and inventory management tool.*
- **Rationale**
  - The use of tray lists provides a record of instruments received prior to surgery, and those returned for reprocessing. It may also be used by the HCF as a reprocessing quality audit tool.
  - ACORN recommends the tray list be used to check instruments prior to the commencement of the surgical procedure, at the completion of the surgical procedure, and that both these checks are performed by two nurses, one of whom shall be a RN.
  - ACORN recommend a process should be developed by the HCF which accounts for additional separate instruments opened for use during a surgical procedure.
- **Criteria**
  - The two (2) nurses shall:
    - 5.1 ensure the contents of each tray are checked;
    - 5.2 utilise the tray list to confirm the presence of all instruments, prior to the commencement of the surgical procedure. This process will establish a baseline record for subsequent checks
    - 5.2.1 ensure a list is present on each instrument tray used which has been checked and signed off by the sterilising department technician, or an authorised person, prior to sterilisation
    - 5.2.2 prior to the commencement of a procedure if an instrument tray is deemed incorrect, this is noted on the tray list and the HCF APD shall be completed.
  - The tray list shall be retained to aid investigation;
5.3 utilise the tray list to confirm the presence of all instruments at the completion of the surgical procedure

5.3.1 at the completion of the surgical procedure ensure that the identification of the instrument nurse and circulating nurse, the date and the patient’s medical record number, in accordance with HCF policy, is recorded on the instrument tray list, and returned with the instrument tray for reprocessing;

Note: As a quality check, prior to reprocessing, the instrument tray shall be checked for completeness, by a sterilising department technician, or an authorised person.

For audit purposes, the tray list shall be retained, according to HCF policy, until the final processing is correct and complete.

5.4 utilise loan sets in accordance with the patient’s surgical requirements

5.4.1 when accounting for loan sets refer to ACORN Standard S23 Handling of loan equipment.
Use of Tray Checklist as part of count Process

- Tray checklists need
  - Consistent generic format for counts
  - Process for updating
  - Information for sterile processing
  - Ability for sterility stickers to be adhered to
- Checklist can be printed on carbonated paper (duplicate)
- Uses ordinary Laser Printer
- ?jamming problems
- Paperwork attached with adhesive plastic sleeve to outside of tray after sterilisation.
- Over 500 tray checklists !!
- Safety benefits for patients & staff in ORS
  - counting in logical order
  - Not double documentation leading to errors
  - Consistent documentation therefore more educationally comprehensive, easier for beginning practioners
## Instrument Count Sheet

**Location:** Logan Hospital

### CSSD Affix Batch Label

**Instrument Count Sheet**

**Instrument Code**

<table>
<thead>
<tr>
<th>Item</th>
<th>No.</th>
<th>First Count</th>
<th>Second Count</th>
<th>Final Count</th>
<th>CSSD Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>On Pin</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.5 cm Needleholder</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 cm Needleholder</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straight green Armitage</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moynihan tissue forceps</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Pin</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison Cripp Artery Forceps</td>
<td>5</td>
<td></td>
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<tr>
<td>Crile Artery Forceps</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Pin</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 cm Straight Mayo scissors</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 cm Curved Mayo Scissor</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Towel Clips</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 4 B.P Handles</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonney forceps</td>
<td>1</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gillies toothed forceps</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Czemey retractors</td>
<td>2</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Large Kelly Retractor</td>
<td>1</td>
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<tr>
<td>Small Kelly Retractor</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Wrigley Forceps Set</td>
<td>2</td>
<td></td>
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<tr>
<td>(Check Blade No. Match)</td>
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<tr>
<td>Spongeholders</td>
<td>4</td>
<td></td>
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</tr>
</tbody>
</table>

**INDICATORS**

**YES / NO**

**CSSD INITIALS:**

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**Tray List order changed 22/2/11 As per M.Judd, CNC OT.**
### ARTHROSCOPY SET

**INSTRUMENTS FROM CSSD**

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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</thead>
<tbody>
<tr>
<td><strong>Instrument Pin</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Acufex 2.7mm Cupped Grasper</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>1 Acufex 2.7mm Straight Linear Punch</td>
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<td></td>
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<tr>
<td>1 Acufex Narrowline Upbiter 012081</td>
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<tr>
<td>1 Acufex Duckbill 012044</td>
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<td></td>
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<tr>
<td>1 Acufex duckbill left 012046</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 Acufex duckbill right 012047</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>1 Acufex duckbill upbiter Linear Punch 012014</td>
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<td></td>
</tr>
<tr>
<td><strong>Cannula Trocars</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>1 3.7mm Cannula 8303.09</td>
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<tr>
<td>1 3.7mm Blunt Trocar 8303.11</td>
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<tr>
<td><strong>Other</strong></td>
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<td></td>
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<tr>
<td>1 Acufex Probe 010001</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2 No.3 B.P Handle</td>
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<td></td>
</tr>
<tr>
<td>1 Toothed Gillies Dissecting Forceps</td>
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</tbody>
</table>

**Operating Theatre Checklist**

<table>
<thead>
<tr>
<th>First Count</th>
<th>Second Count</th>
<th>Final Count</th>
<th>Amendments</th>
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</tbody>
</table>

**Signatures & Designation**

**Revised:** 25-1-11 GC

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**Wrap & Processing**

- Ray size: 400mm x 270mm
- Kinguard size: 121.5cms x 121.5cms
- Heavy Duty
- Steam Sterilise

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The Acufex duckbill upbiter Linear Punch is not in the photo.

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Ortho x 6

Main storeroom
References

• Australian College of Operating Room Nurses (ACORN). (2010). *Standards, guidelines and policy statements*. Adelaide: ACORN.


• Queensland Health Patient Safety: From Learning to Action II 2006/7 (2008) Queensland Health


Summary

- Understand the changes with the new Perioperative Patient Form
- Recognise the Patient Safety aspects of the utilisation of the Surgical Safety Checklist and use of tray checklist as part of counting procedure
- Identify some example's of different uses of tray checklists

Thank-you & any questions