

Do Patients Arrive to the Trauma Orthopaedic Theatre With All of the Necessary Checklist Items? A Closed-Loop Audit

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Background

Surgical safety has recently received increasing attention with the implementation of the 'Surgical Safety Checklist' and 'Surgical Pause.' Research has shown that these factors significantly decrease patient morbidity and mortality.

Aim of project

To identify the number of patients who arrive to our orthopaedic trauma theatre with missing or incomplete checklist items, including X-rays, notes, clerking, blood results, and surgical site marking.

Study design

- Trauma documentation arriving with patients at the theatre barrier audited between 20th August and 28th September 2009.
- Each patient's documentation was checked against the required theatre checklist of items including consent form, blood results, notes, clerking, marked operation site and X-Rays.
- Results were presented in a departmental meeting and a "Reminder Checklist" was created. This included a list of all of the necessary items and was attached to the front of each patient clerking.
- PACS (Picture Archiving Communication Systems) commenced in December 2009.
- The re-audit was carried out from 2nd July to 1st October 2010 and established whether any delay or cancellation was due to missing items and clarified reasons for missing blood results.

Results

Forty-nine patients (n=49) were included in the first cycle

- 53% of patients arrived with all of the required checklist items.
- 14% had no operation site marked
- 14% did not have necessary blood results
- 12% had no notes and 4% had no clerking
- 10% had no X-rays
- 1 consent form was missing (2%)
- 1 consent form was unsigned (2%)
- 1 had missing operation site documentation (2%)

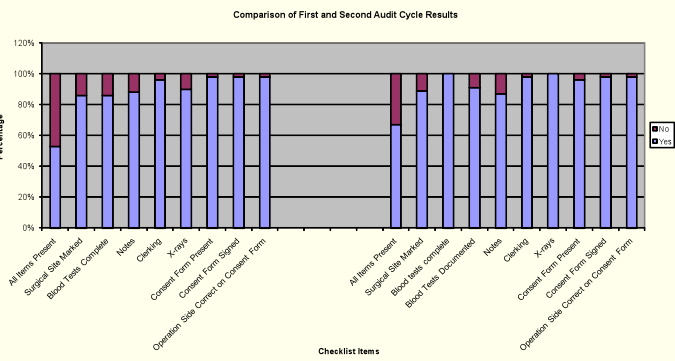
In the re-audit (n=46)

- 67% of patients arrived with all items
- 11% of surgical sites were not marked
- All blood tests were complete, though 9% reported as missing were simply not documented.
- 13% of notes and 2% of clerkings were missing
- All X-rays were present
- 4% of consent forms were missing
- 2% not signed and 2% incorrect
- No operations were cancelled or delayed due to missing factors.

Acknowledgements:
With thanks to theatre staff for assistance in completing this audit

Discussion

- The 'Surgical Safety Checklist' and 'Surgical Pause' were highlighted as part of a government initiative, the Scottish Patient Safety Programme.
- The World Health Organisation (WHO) initiative entitled "Safe Surgery Saves Lives" advised hospitals to have guidelines based on their universal protocol; patient verification, surgical site marking and a surgical pause.
- Evidence shows implementation of the surgical safety checklist has significantly reduced mortality.
- Absence of surgical site marking can lead to the disastrous consequence of "Wrong-Site Surgery", the majority of which is reported to occur in orthopaedics. Studies suggest that surgical site marking reduces the incidence of this.



Conclusion

Improved results were observed for consent forms and surgical site marking. In the re-audit all blood tests were complete but not documented. No operations were delayed or cancelled as a result of missing items. Further change and re-audit is required to ensure all checklist items are present.

