

The Use of Surgical Checklist in Operating Rooms in Taiwan

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Objectives:

A site visiting program was used to survey the use of surgical checklist in operating rooms in Taiwan.

Methods:

50 hospitals in different size were selected for the site visiting. There were 7 large size, 24 middle size and 19 small size hospitals visited from October 7th to November 5th in 2010. Task force was established by the TJCHA (Taiwan Joint Commission on Hospital Accreditation) for the site visiting surveyors to collect data and to interview with the operation team. There are four domains for the data collection, policy of implementing surgical safety, sign in before induction of anaesthesia, time out before incision, sign out after operation. Consensus about site visiting was held with visit the operating prepare room, operating room and recovering room in 2 hours. Data coding is done by two surveyors from observation of actual performances and interview of related staffs. To validate the data findings was validated to develop a tool kit in task force meetings.

Results:

There are 94% of surveyed hospitals using surgical checklist. Used wrist bracelet, for patient identification is 100%, by face- to- face confirm 76%, or self- description 70%. Details of checklist implementation are shown in Table1.

However, introducing names, roles and capabilities of the team members before incision are only performed routinely in 16%. “Debrief” after completion of operation is performed for only 26%. Comparing with WHO international standards in 2009, there exist some discrepancies in Taiwan from cultural differences, and inter-institutional differences from different sizes. In addition, the practical implementations of checklist to ensure surgical safety still leave some issues to be desired. Thus, three large-scale workshops and lectures have been held. Many benchmark interventions, such as that to motivate the surgical physician to participate actively, has been viewed and spread in Taiwan. Most hospitals hope to learn more about the standard procedure by demo video that taken and shared by peers. It is very useful to show and present the way how to do briefing, time out, debriefing by video in the team.

Conclusions:

An effective and feasible checklist is very important to improve surgical safety. Through the site visiting, surgical teams can share with each other and empower themselves by realizing the cultural differences and hospital size characteristics. From the findings, the tool kit with surgical checklist will be created and modified in the more suitable and feasible way.

Table 1. Implementation surgical checklist by hospital size

Items	Type of hospital size			Total (N=50)
	Large size (N=7)	Middle size(N=24)	Small size(N=19)	
Counseling clinics for anesthesia	100%*	25%	16%	32%
Marking operation sites by surgeons	86%	67%	79%	74%
Airway assessment or aspiration risk before anesthesia	71%	92%	89%	88%
Risk of >500 ml blood loss	86%	88%	74%	82%
Introducing names, roles and capabilities of the team members before incision	14%	25%	5%	16%
“Time-out” before incision has been performed more commonly	100%	79%	53%	72%
“Debrief” after completion of operation	14%	42%*	11%	26%
“Hand-off” between staffs of operating and recovery rooms are well implemented	100%	96%	58%*	82%
Committees about the operating safety held periodically	100%	88%	89%	90%
Monitoring for the improvement	86%	46%*	26%*	22%

*P<0.05 v.s. the other type of hospital size

