



EDITORIAL

Surgical safety checklist in crisis: We do either it right or we do it right



Listado de verificación de seguridad quirúrgica o *checklist quirúrgico* en crisis: O lo hacemos bien o lo hacemos bien

D. Parés

Servicio de Cirugía General y Digestiva, Hospital Germans Trias i Pujol, Universitat Autònoma de Barcelona, Spain

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It is estimated that more than 300 million surgical procedures are performed annually worldwide. Before any surgical procedure, and in accordance with the recommendations of the World Health Organization (WHO), it is considered necessary (and even mandatory in some operating rooms) to carry out the safety checklist process using the surgical safety checklist. The objective of this procedure is to reduce preventable surgical errors, improve communication among the interdisciplinary team involved in the surgical process (anaesthesiology, surgical specialists, nursing), and ensure that each patient receives the correct treatment, in the correct location, and under optimal conditions.¹

The surgical checklist is structured in three distinct phases, with a series of steps in each: before the anesthetic procedure (sign-in), before the surgical incision at the start of the procedure (time-out), and before the patient, once the procedure is finished, is transferred from the operating room to the post-anaesthesia care unit or the hospital ward (sign-out).²

This procedure, which has parallels with the security checks performed in aviation before take-off, was demon-

strated in 2009, in an international multicentre study led by Dr. Atul Gawande, to reduce adverse effects and, especially importantly, morbidity and mortality associated with surgical procedures.^{2,3}

For this reason, the WHO, with its "Safe Surgery Saves Lives" program, considered this a necessary procedure in all surgical interventions performed worldwide and published an application manual in 2009.² Subsequently, most health-care organizations implemented this procedure and included its compliance, measured by indicators, as a mandatory element in every intervention.

However, after almost two decades of the global dissemination of its benefits and the theoretical ease of its use based solely on team communication, there are still centres where it is not performed, or even more seriously and dangerously, where it is performed inadequately or incompletely, creating a false sense of security. The crisis, in the form of its inadequate implementation, stems from various causes, grouped into human and/or cultural barriers, organizational factors, and, across the board, widespread resistance to change in the professional sphere.^{4,5} The human and cultural factors that most significantly influence the proper application of the checklist are the resistance of the staff involved due to a perceived waste of time or external imposition, a lack of commitment or a lack of belief in its value in reducing adverse effects, or hierarchical strug-

E-mail address: dapares@gmail.com

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gles in its development. Among the organizational factors that affect its implementation, insufficient training and high patient care pressure stand out.

Therefore, various initiatives in simulation-based teaching methodologies have proven effective in acquiring the necessary skills for this purpose. Corominas Iglesias et al.⁶ have published in our journal that with participation rates of 40% for Anaesthesiology, 55.5% for Surgical specialists, 75% for Traumatology and Orthopaedics specialists, and 76.5% for surgical nursing, there is a significant impact on compliance with the surgical safety protocol, including the surgical checklist, after simulation training.

Finally, resistance to change in a professional group working in surgical suites with high patient volume is a reality.⁷ To mitigate this effect and improve professional well-being, it is useful to discuss real-life cases of avoidable errors, including wrong-site surgeries (i.e. operating on the wrong knee). These strategies can reinforce confidence in the procedure and promote its appropriate application. There is no doubt that reinforce non-technical skills, as well as improving communication among interdisciplinary teams, is the cornerstone of patient safety, especially among the professionals involved in the surgical procedure.⁸ Therefore, perhaps we should also delve into innovative aspects to improve communication in an era where, paradoxically, technology helps us achieve this goal.

Meanwhile, and given the crisis stemming from the inappropriate use of the surgical checklist, information, leadership, and training must take centre stage. We must do it right, or we must do it right! Because even today, preventable adverse events, including wrong-site surgery, are a reality.

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