Accreditation Canada defines a Required Organizational Practice (ROP) as an essential practice that organizations must have in place to enhance patient/client/resident safety and reduce risk.

**ROP Definition:**
*The team uses a safe surgery checklist to confirm that the safety steps are completed for a surgical procedure.*

Tests for Compliance:
1. The team has agreed on a three-phase checklist to be used in the operating room.
2. The team uses the checklist for every surgical procedure.
3. The team has developed a process for the ongoing monitoring of compliance with the checklist.
4. The team evaluates the use of the checklist and shares results with staff and service providers.
5. The team uses results of the evaluation to improve the implementation of and expand the use of the checklist.

This ROP appears in the Perioperative and Invasive Procedures standards, which may be used side by side with the Acute SCI standards, particularly for teams that serve mixed patient populations. To meet this ROP, consistent use of a three-phase checklist is an expectation at a minimum for all surgical procedures performed in an OR setting. The three phases of the checklist that need to be demonstrated by the OR team include:

- Briefing: before the induction of anesthesia
- Time out: before a skin incision is made
- Debriefing: before the patient leaves the OR

In addition, using consistent procedural safety checklists for other invasive procedures performed outside of the OR, such as endoscopies, interventional radiology, and vascular access, would be considered a commendable practice.

**Meeting this ROP: what compliance looks like:**

1. **We have adopted an organization-wide Surgical Safety Checklist for all surgical procedures.**
   - The checklist is used in all 3 phases for every patient having a major surgical procedure
   - Whenever possible, the briefing component is done while the patient is still awake, and with their involvement
   - The checklist is documented for each case as part of the intraoperative record

2. **We monitor use of the Surgical Safety Checklist as a key quality metric.**
   - We have access to timely data on compliance with use of the checklist for every surgery
   - We can identify trends by site, surgical service, and each of the 3 checklist phases
FOR SITE VISITS UP TO AND INCLUDING 2015

o Measure quantitative compliance based on documentation in intraoperative record
✓ We have also engaged in qualitative evaluation of the checklist, focused on the quality of communication:
  o Observation of three phases, with timely feedback to teams

3. We use the Surgical Safety Checklist metrics and evaluation for continuous improvement.
✓ Results are shared and discussed at OR team meetings with staff and physicians
✓ Members of the OR team have clear accountability for each phase of the checklist
✓ SSCL is a key quality metric reported to our Senior Leadership (i.e. included in organizational scorecard)
✓ We have developed tools, key messages and resources for our OR teams to support sustainment

What You May Be Working On:
✓ Keeping up the good work – consistency is key, and keeping patients safe is a job that is never finished.
✓ Access to the right metrics – ensuring that the SSCL metrics are timely, granular enough to be helpful to the OR teams, and consider both quantitative compliance and quality of the process.
✓ Using the data for improvement – regularly sharing SSCL metrics with the OR teams, and engaging them in ways to boost and sustain compliance

Surveyors could:
- Observe the start of a surgical procedure for at least the first two phases
- Review your organization’s Surgical Safety Checklist and policy
- Review patient records for documentation of checklist phases
- Ask OR staff and physicians how they communicate throughout the procedure
- Ask OR staff and physicians how safety concerns or disagreements are brought up and addressed
- Ask patients about their experience being involved for the first phase of the checklist, if appropriate
- Ask OR staff and physicians how they discuss surgical safety checklist metrics as a team
- Ask OR staff and physicians for examples of improvements in their team to boost or sustain compliance with use of the checklist, or improve the quality of communication

We want to hear from you!
Share your quality improvement gems with the SCI community at accreditation@rickhanseninstitute.org