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Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Policy

Safety Standards for Invasive Procedures (SSIPs)

Key Points

- This Policy details the universal approach and guidance which must be adhered to by all staff caring for patients who are undergoing invasive procedures at Great Ormond Street Hospital for Children NHS Foundation Trust.
- The guidance is based on the NHS England 2015 document National Safety Standards for Invasive Procedures (NatSSIPs). https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf and the Patient Safety Alert September 2015.

Version:	Final
Lead Author:	Safety Standards for Invasive Procedures Lead
Executive Lead:	Medical Director
Date Approved by Policy Approval Group:	July 2018
Policy Category:	Clinical Management
Review Date:	July 2021
Target Audience:	All staff involved with patients who are undergoing invasive procedures, Divisional managers, Heads of Clinical Service, Matrons, Sisters, Theatre users, Consultants and their specialty teams, Admissions teams, Anaesthetists, Theatre staff, Radiographers, International Private Patients, Ward and Clinic Procedural Teams.

Document Control	
Previous Version Information:	
Previous Title:	n/a – new policy
Previous Approval Date:	n/a – new policy
Relevant to CQC requirements:	Yes
Relevant to Information Governance Toolkit:	No
Other External Assessments	No
Consultation:	
Individual(s) Consulted:	Medical Director, Associate Medical Director, Assistant Chief Nurses, Consultant ENT, Plastics, Cardiothoracics and SNAPS Surgeons, Consultant Dermatologist, Anaesthetic Consultants, Consultant Radiologist, Theatre Matron, Radiology Matron, Cardiology Matron, NICU/PICU/CICU Matrons, Clinical Nurse Specialists in Rheumatology and Dermatology, Head of Quality and Safety, Clinical Audit Manager, Theatre Services Manager, Theatre Sisters
Department(s) Consulted:	
Committee / Group(s) Consulted:	
Amendments Made:	
Keywords:	SSIPs, NatSSIPs, LocSSIPs, Invasive procedures, Procedural team, Surgery, Surgical Safety Checklist, Safety Briefing, Sign In, Time Out, Prosthesis Verification, Prevention of Retained Foreign Objects, Sign Out, Debrief

Related Trust Documents:

- Transfer of patients for procedures under general anaesthesia and / or sedation
- Patient transfer policy
- Pregnancy testing of young females
- Surgical count policy
- Central decontamination policies /Service Level Agreements
- Access policy
- Theatre planning meeting Terms of Reference
- Emergency Theatre Standard Operating Procedure
- Nurse rostering and safe staffing
- Conduct and record a pre-op checklist
- Cancelling on the day of surgery
- Being open and duty of candour
- Safe guarding children and young people policy
- Health and Safety policy
- Incident reporting policy
- Observation and CEWS
- Policy for consultants undertaking new interventional procedures
- Patient identification policy
- Reporting an incident on DATIX

- Aseptic technique in theatres
- Standard Operating Procedure for the Management of “one of a kind” Sterile Instrument Sets
- Throat pack aide memoire
- Incident Management and Reporting Policy
- Consent Policy

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1. Introduction

1.1. This Policy has been written in order to comply with the NHS England mandate to implement the National Safety Standards for Invasive Procedures (NatSSIPs). The ultimate aim of NatSSIPs is to eradicate the occurrence of the Patient Safety Never Events, which occur around invasive procedures.

1.2. The aim of this policy is to:

- Standardise the management of invasive procedures during the pre-operative, intra-operative and post-operative period.
- Provide a clear definition of invasive procedures, multidisciplinary team roles and responsibilities.
- Provide the standard against which Local Safety Standards for Invasive Procedures (LocSSIPs) are developed within procedural areas and outside areas where procedures are performed.
- Ensure the monitoring and governance as a continuous cycle of improvement.
- Maintain a safe culture to promote team work, minimise avoidable complications, and prevent patient safety never events.

1.3. Where local procedures deviate from the Safety Standards for Invasive Procedures Policy a LocSSIP is required using the template (see Appendix 9). The Safety Standards for Invasive Procedures Policy is to be used as a basis in the creation, or modification of the LocSSIPs. Each of the LocSSIPs should include the key elements of the NatSSIPs guidance, five organisational and eight sequential steps for the patient on the pathway to undergo an invasive procedure.

1.4. The five organisational elements are guidelines and processes which support the safe delivery of the procedural care.

- Governance and audit
- Documentation of invasive procedures
- Workforce
- Scheduling and list management
- Handovers and information transfer

1.5. The eight sequential steps are a logical set of actions which should be performed for every procedure list and every patient.

- Procedural verification and site marking
- Team Brief
- Sign in
- Time out
- Prosthesis verification
- Prevention of retained foreign objects
- Sign out
- Debrief

2. Scope

2.1. This cross-divisional policy applies to all members of the multidisciplinary team who will be involved in the care of the patient during the pre-operative, intraoperative and post-operative periods of the patient who is undergoing invasive procedures.

2.2. This policy applies to all areas where invasive procedures are performed, including pre and post op areas such as the wards and recovery and including Theatres, IR, XMRI, Gastro and Radiology.

2.3. This policy includes any procedure where:

- a cut or hole has been made to gain access to the inside of the body;
- access to a body cavity (such as the digestive system, airway, or bladder) is gained without cutting into the body, for example endoscopy;
- Electromagnetic radiation is used such as with x-rays, lasers, gamma rays, ultraviolet light for treatment, for example using a laser to treat skin lesions.

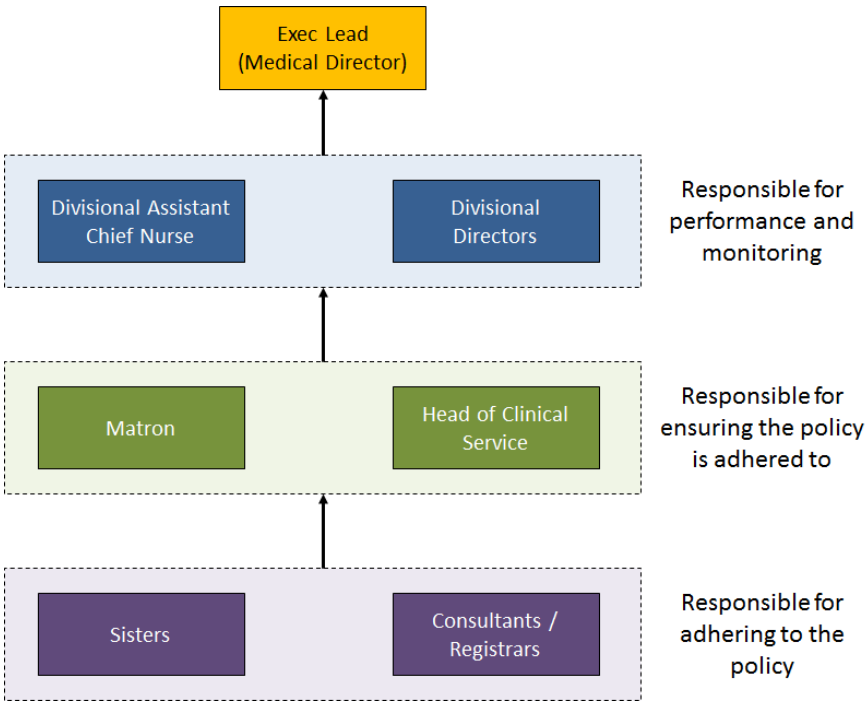
2.4. This policy excludes cannulation, nasogastric tubes and urethral catheter insertions, as they are outside the scope of the national guidance.

3. Roles and Responsibilities

3.1. Responsibility of the care of the patient is a shared responsibility and all members have a responsibility to speak up if they have concerns related to the safe delivery of care during an invasive procedure.

3.2. All staff involved in the pathway of a patient who is undergoing an invasive procedure:

- are responsible for the safe delivery of care to the patient;
- are aware of and understand the SSIP and Local Safety Standards;
- are required to follow the Safety Standards for Invasive Procedures and Local Safety Standards accurately for every patient;
- may be required to participate in the creation, implementation and audit of LocSSIPs;
- will participate fully in the agreed safety checks and the steps built into the Safety Standards;
- will participate in routine and frequent team building and team training;
- will ensure that adverse events are documented, through Datix and investigated when appropriate.



3.3. The Executive Lead (Medical Director) is responsible for:

- overseeing compliance, and governance, of the Safety Standards for Invasive Procedures and LocSSIPs.
- approving the information provided in this policy in their capacity as the Executive Lead.

3.4. The Divisional Leads for Operations and Nursing are responsible for:

- overall performance and monitoring of the Safety Standards for Invasive Procedures and Local Safety Standards for Invasive Procedures.

3.5. Heads of Clinical Service (HOCS) and Matrons are responsible for:

- ensuring the multidisciplinary team is performing as per the Safety Standards for Invasive Procedures;
- auditing, reviewing the audits and feeding back to the local teams;
- ensuring that any change in local practice or national guidance is updated and communicated to the local teams;
- ensuring that adverse events are documented through Datix, investigated using an RCA process and there is learning gained from the events which is communicated back to the local teams and SIMS training is carried out.

3.6. Team Leaders/Sisters, Consultants and Registrars are responsible for:

- adhering to the policy;
- developing Local Safety Standards (LocSSIPs) for Invasive procedure when practice differs from the policy;
- ensuring that team members are aware of, understand and are compliant with the Safety Standards for Invasive Procedures and LocSSIPs;
- ensuring appropriate escalation of non-compliance (see Appendix 2).

4. Definitions

4.1. National Safety Standards for Invasive Procedures (NatSSIPs): The national standards which were developed to set out key actions necessary to deliver safe care of patients undergoing invasive procedures. These standards allow organisations to standardise, harmonise and educate the patient care processes in order to provide safe patient care.

4.2. NatSSIPs Steering Group: the Trust committee responsible for oversight and implementation of the Safety Standards for Invasive Procedures.

4.3. Safety Standards for Invasive Procedures (SSIPs): The Trust response to the NatSSIPs.

4.4. Local Safety Standards for Invasive Procedures (LocSSIPs): Locally adapted safety standards for invasive procedures based on the Safety Standards for Invasive Procedures Policy and variations from it. Including specialty specific procedures or group of procedures for which LocSSIPs apply.

4.5. Invasive procedures include:

- All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, inpatient treatment areas, other procedural areas within the organisation, and off site on GOSH patients e.g. gamma knife treatments at the Royal National Neurology Hospital.
- Any procedure where a device has been used to gain access such as a scope to view the bladder, airway, or gastrointestinal tract.
- Invasive cardiology procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.

4.6. Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. (NPSA 2016) Never Events are a subset of serious incidents which meet the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national and local level, and have been implemented by all healthcare providers.
- Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
- Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.
- The Incident Management and Reporting Policy is to be referred to when reporting an incident.

4.7. Surgical Safety Checklist: Based on the World Health Organisation (WHO) Surgical Safety Checklist which is a core set of safety checks at critical time points set within the pathway of the patient undergoing an invasive procedure. The five steps, 'Team brief', 'Sign In', 'Time Out', 'Sign Out' and 'Debrief' are tools to initiate detailed communication between members of the multidisciplinary team in order to improve patient safety during surgery.

4.8. Procedural area: the area where invasive procedures are performed; includes the operating theatres, XMRI, Kingfisher, Interventional Radiology, Radiology, Koala, Outpatients, Magpie, NICU, PICU, CICU, IPP and any other treatment area within the organisation, including off site at the Royal National Neurology Hospital.

4.9. Procedural team: all members of the multidisciplinary team who are involved in the performance of procedures.

4.10. Operator: the person performing the procedure.

4.11. Anaesthetist: the person administering the anaesthetic during the invasive procedure.

4.12. Anaesthetic practitioner: the Registered Anaesthetic Nurse or Registered Operating Department Practitioner assisting the anaesthetist during an anaesthetic.

4.13. Scrub practitioner: the Assistant Theatre Practitioner, Anaesthetic Practitioner or Registered Nurse assisting the operator during a procedure.

4.14. Circulator: the Registered Nurse or anaesthetic practitioner in charge of the list.

4.15. Electronic patient documentation: data entry system to capture patient journey through theatres and feed into reporting tools.

4.16. Datix: a risk management system that is used for incident reporting, complaints, PALS, risk registers.

5. Governance and Audit

5.1. The organisation will ensure that all appropriate personnel are made aware of the Safety Standards for Invasive Procedures and LocSSIPs for the area of practice.

5.2. As a minimum, an annual audit will be conducted to focus on key areas of this policy:

- 'Team Brief'
- Completion of pre-operative checks
- Completion of sign-in
- Surgical Site marking
- Completion of 'Time Out'
- Staffing issues
- Any equipment /prosthesis issues
- Formal handover between ward, theatre, and recovery/ICU
- Quality of engagement in the Surgical Safety Checklist
- Audits will be led by the NatSSIPs Steering group and supported by the Clinical Audit department.
- The audit will focus on the quality to which processes are completed, and engagement in processes.

5.3. Monitoring of the effectiveness of the Safety Standards for Invasive Procedures will also be done through the learning from incident reporting Datix system, and information gained, for example, from the Risk Action Group meetings and Specialty Review Meetings and the Patient Safety and Outcomes Committee Meetings.

5.4. Incident reporting provides an opportunity for adverse events to be documented, analysed and used for learning and improvements in practice. Additional information for Datix can be found in the Incident Reporting Management Policy.

5.5. Learning points from near misses and clinical incidents will be shared on a regular basis by relevant Risk Action Groups and Specialty Review Meetings. Any trends of themes identified can be used to support decision making and learning, where improvement is required.

6. Education and training

6.1. The local induction of all staff involved in the performance of invasive procedures must include:

- Reading the the Safety Standards for Invasive Procedures policy
- Reading any relevant Local Safety Standards for Invasive Procedures.

- Referring to the Safety Standards for Invasive Procedures Intranet page (Found Clinical and research > Medical clinical guidelines)
- Completing the GOSH GOLD 'NatSSIPs 8' e-learning module.

6.2. Opportunities for regular teamwork management and human factors simulation training will be made available for all staff involved in the performance of invasive procedures.

6.3. Preparation for training will include a review of LocSSIPs and identification of learning needs from near misses and incidents.

7. Documentation

7.1. Standardised documentation should be completed in all procedural areas to ensure the recording clearly all essential information throughout the patient pathway and this includes:

- pre-procedural assessments
- clerking
- consent
- electronic patient record
- the pre-operative checklist
- perioperative/integrated care plan
- anaesthetic record
- post-operative notes
- discharge planning

7.2. Documentation should include evidence of handovers, 'Team Brief', 'Sign In', 'Time out', 'Sign Out', surgical site verification, prosthesis verification, and the prevention of the retention of foreign objects.

7.3. Staff present at each stage of the patient pathway should be identified.

7.4. All procedural activity should be captured in an electronic format. If in the event that the electronic patient record system is down, the appropriate downtime paper form should be completed.

7.5. All documentation must be clear, concise, legible, and concurrent, without falsification, timed, dated and signed.

7.6. No abbreviations should be used in any document.

7.7. Laterality must be written in full (Right, Left).

7.8. Complete all records at the time or as soon as possible after an event.

7.9. All records must be kept securely.

7.10. The time and alteration of any document must be recorded.

7.11. Documenting of adverse events and near misses should be recorded in the Datix system.

7.12. For further detail please see document titled Quality Standards for Clinical Documentation.

8. Scheduling and List Management

8.1. Patient safety during the performance of invasive procedures is dependent upon adequate preparation, the accurate scheduling of procedures and the management of the procedural lists.

8.2. This policy requires procedural teams to ensure that lists accurately reflect the plans for patients and the procedures they are planned to undergo.

8.3. The appropriate planning should ensure that theatre lists are fully utilised, which also rely heavily on having the subsequent bed base available in order to deliver the activity.

8.4. The named clinical team for the list is responsible for scheduling of the procedure/s, list management, cancellation and rescheduling. They must coordinate when other specialties are involved to be available at the correct time.

8.5. The named clinical team for the list is responsible for deciding the order of the procedures within a list. Clinical criteria are to be considered in determining the order of the list. Examples of the clinical criteria are: clinical need, urgency, age, allergies (latex), pre-existing conditions (MH), infection status or other medical conditions (diabetes, sickle cell).

8.6. Scheduling of the list must take into account the expected workload and other factors which include:

- Time must be included in the scheduling process for the 'Team Brief', 'Sign In', 'Time Out', 'Sign Out', 'Debrief' and other safety steps in the Safety Standards for Invasive Procedures.
- Induction and emergence from anaesthesia or any other anaesthetic procedure.
- Patient positioning and preparation.
- Availability and preparation of all necessary equipment and instrumentation.
- Familiarity, skill-mix and expertise of all members of the procedure team.
- Cleaning and turning over equipment, supplies and instrumentation on lists when multiple procedures are being performed.
- Multiple, concurrent, same specialty lists.

8.7. The Standard Operating Procedure for Scheduling and List management should be referred to for further details of the processes.

9. Workforce

9.1. Staffing should be based upon the Trust's Nurse Rostering and Safe Staffing policy found in the Document Library on the Trust website.

9.2. Safe staffing specific for the theatres and related areas are as follows:

9.2.1. According to Association for Perioperative Practice (AfPP) guidance minimum theatre staffing is:

- One qualified anaesthetic practitioner for every procedure requiring an anaesthetic.
- Two qualified or trained scrub practitioners as a basic requirement.

- One qualified circulating practitioner for each session unless there are 2 operative teams or 2 cavities opened simultaneously.
- This makes a minimum of two qualified staff as the scrub practitioner can also be a circulating practitioner.
- Scrub practitioners are not to be considered as 'first assistants' unless appropriately qualified.
- For procedures where staffing varies from this a LocSSIP will be required.

9.2.2. Staffing requirements for the care of patients undergoing invasive procedures should be based on:

- Skill mix and competence of the practitioners including appropriately trained assistant(s).
- Complexity of the patient's needs and/or list.
- Type and complexity of procedure.
- Medical devices, technology and equipment being used.
- Number of patients on the list.
- Time needed to turnover between patients.
- Multi skilled staff, who are competent across specialties.

9.2.3. Lists must include time:

- To set up of the theatre equipment instruments and supplies.
- To calibrate and perform safety checks on specialist equipment.
- For staff to complete safety briefing and debriefing; and the sign in, time out and sign out for each patient.
- To turnover between patients.
- For routine and infectious cleans as required.
- For patient to be handed over to the next clinical area.

9.2.4. Staffing should be reviewed on a regular basis by the appropriate team leaders and Matrons and the following should be considered:

- Any increase in patient safety incidents.
- Any increase in Healthcare acquired infections.
- Falling standards.
- Increase in staff turnover.
- Low staff morale.
- Failure to ensure staff access continued education, complete mandatory training.
- Failure to provide annual reviews.

9.3. A procedure must only begin when the required number of staff members, with the appropriate skill mix for that procedure or list is present.

9.4. The same set of staffing standards applies equally to inside and outside of normal working hours.

9.5. The person in charge for each procedural area should confirm the availability of the appropriate staffing levels and skill mix prior to the beginning of the list and report any issues to the coordinator or matron. When a procedure or list is performed with inadequate numbers a Datix form should be completed.

9.6. Staff must be familiar and trained within the area they are working, in order to facilitate an emergent situation, and the staffing needs at nights and weekends. When there are instances

where increased staffing is needed on weekends or nights, this should be escalated through the activation of the VCB and / or cardiac theatre call teams.

10. Handover and Information Transfer

10.1. There are formal handover points within the patient pathway at which professional responsibility and accountability is transferred between individuals or teams.

10.2. There are also opportunities for planned and unplanned changes in the members of the procedural team which occur during procedures or lists of procedures.

10.3. Patient safety prior to, during and after the performance of an invasive procedure is dependent upon thorough communication of information during each of the handover points of the patient pathway.

10.4. All Handovers:

- Must be performed using the appropriate aide memoire, or handover form.
- Participation of the patient and or family should be encouraged when appropriate.
- Only one person should speak at a time, conversation should be about one patient at a time, and non-handover activities should cease.
- All members of the team should be given the opportunity to clarify information and ask questions.
- Noise and interruptions should be minimised.

10.5. There must be a formal handover of the patient from the admission unit or ward to the procedural team. This will be conducted in the anaesthetic room, procedure room or designated location in outpatients or the ward.

10.6. Intraoperative handovers between staff should be avoided wherever possible. However, there are situations which warrant a handover between members of the perioperative team during the middle of a procedure such as when a staff member goes on a break, or at the end of a shift. When this occurs a formal handover should take place as outlined below and the occurrence of a handover should be.

10.7. Handover of Patient post invasive procedure:

- A formal handover from the procedural team to the post procedural area must be performed, once the patient is monitored appropriately and clinically stable using the appropriate aide memoire or handover sheet.

10.8. Handover of Patient from Recovery to Ward:

- Once the patient meets the discharge criteria the handover between the recovery practitioner and the ward registered nurse will take place either in the recovery room or in the ward as per ward hand over aide memoire.

10.9. Handover of the patient from the procedural area to the intensive care areas:

- Children returning to the Intensive care areas will be escorted from the procedural areas by the anaesthetist, anaesthetic practitioner and scrub practitioner.

- A formal handover to the intensive care team will be performed once the patient is transferred, appropriately monitored and clinically stable as per the Transfer Aide Memoire or CICU Handover protocol.

10.10. See the Handover Standard Operating Procedure for detailed handover information between the perioperative teams.

11. Procedural Verification and Site Marking

11.1. All patients undergoing invasive procedures under general, local anaesthesia, or under sedation, must undergo safety checks that confirm the procedure to be performed, the site and the side marked when appropriate.

11.2. Surgical site marking is mandatory for all procedures for which it is possible to do so. In cases where there is an exception to site marking it should be clearly detailed on the consent form.

11.3. For dental procedures the teeth should be clearly marked on the surgical consent and on a dental x-ray which must then be displayed in the theatre.

11.4. All staff involved in the invasive procedure pathway have a responsibility to voice any discrepancies that they have observed with the theatre list, patient's consent, or site marking.

11.5. If there are any discrepancies following any of the checks, the procedure should not be commenced until clarification has been obtained.

11.6. If necessary the patient should be returned to the ward until all discrepancies have been clarified.

11.7. The procedure for surgical site marking and verification is as follows:

- The marking must be performed by the operator or a nominated deputy who will be present during the procedure.
- The operator / nominated deputy confirm patient identity with patient/parent against the patient's clinical record, the labelled consent form and the operating list in the pre-procedure area or ward.
- The operator /nominated deputy confirms procedure and procedural site with patient/parent, clinical record, consent form, investigation results such as imaging and operating list.
- Operator /nominated deputy marks site with single use permanent marker pen using an arrow only, close to the procedural field so it will be visible at all time after the prep and sterile drapes have been applied.
- If there is more than one procedural site, mark all sites with an arrow. If multiple procedures on multiple sites are planned then a body diagram should be used indicating the specific site/s and procedures.
- The arrow should be applied on the ward, not in the anaesthetic room or procedure room and documented on the consent form.
- The non-operative side must never be marked.
- Confirm with patient/parent if site marking not appropriate and document on consent form.
- An arrow to indicate the site of the procedure(s) should be checked on the ward and documented as part of the pre-op checklist.
- If an arrow is not present refer to consent form for an explanation.

- If the consent does not clearly state why the arrow is not present, the operator /nominated deputy must be contacted for clarification and the issue resolved prior to the patient going to the procedural area.
- In event of patient refusal for site marking or an inability to site mark- document in notes and consent form. Agree with parents that site marking will occur once patient anaesthetised.
- Arrow should be checked by anaesthetist and anaesthetic practitioner at 'Sign In' with patient/parent and ward nurse against consent form and operating list.
- Site marking and planned procedure should be verified by multidisciplinary team, including the operator (and the nominated deputy if the operator was not the site marker) and scrub practitioner, at the 'Time Out' against consent form, operating list, and patient's clinical record and imaging.
- For procedures when the patients position is changed or the patient is having multiple procedures performed in multiple locations the procedural site should be re-verified and the procedural arrow checked.

12. Team Brief

12.1. The 'Team Brief' must take place prior to any invasive procedure including scheduled, add-on, emergency, General Anaesthetic (GA) or non-GA in order for each member of the team to have a clear understanding of the list order, the invasive procedures being performed, the staff and equipment required and any other key issues.

12.2. This must occur after each patient has been seen by both the operator and anaesthetist.

12.3. The 'Team Brief' must be repeated throughout the day on a case by case basis in the following circumstances:

- Staggered admissions.
- New sessions.
- Change in key team members during a sessions.
- Additional patients added to the list.

12.4. The 'Team Brief' should be conducted in a location that is quiet and free from distraction that also ensures patient confidentiality. This location should preferably be in the area where the procedure will be carried out.

12.5. As many members of the whole team should be present including, but not limited to:

- Senior operator and assistant.
- Lead anaesthetist and second anaesthetist.
- Anaesthetic practitioner.
- Scrub team.
- Circulating person in charge of the list.
- Any other healthcare professionals involved in the procedure, e.g. radiographer, perfusionist, etc.

12.6. Each team member must be recorded in the patient's procedural pathway document.

12.7. Any nominated team member may lead the briefing.

12.8. Only one member of the team should speak at a time.

12.9. There should be minimal use of abbreviations. If they are used and a member of the team is unfamiliar with the term it should be clarified.

12.10. Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure

12.11. Each team member should introduce themselves and their roles.

12.12. Each member of the procedural team should be listed in a place visible throughout the session. The operator, scrub practitioner and anaesthetist if relevant must be identified for each case listed. Any changes to the team members during the day should also be recorded in this document or notice, and should be the subject of an appropriate briefing if anticipated.

12.13. Each patient should be discussed one at a time and in list order from the perspective of the operator, anaesthetist and scrub practitioner, in turn, using the printed checklist and the 'Team Brief' aide memoire (see Appendix 5). The discussion should include:

- Diagnosis and planned procedure.
- Site and side of procedure.
- Anticipated blood loss and location of blood products if required.
- Specific patient and/or procedural concerns.
- Availability of special equipment and/or resources. This includes prosthesis/ loan kits/single 'one off' instruments (please refer to SOP for the Management of 'one of a kind Sterile Instrument Sets).
- Requirement of imaging.
- Requirement of a throat pack.
- Requirement for the Surgical Site Infection bundle e.g. warming devices and antibiotics
- Infection status.
- Requirement for venous thromboembolism prophylaxis.
- Pregnancy testing.
- Can we give a drink?
- Consent for research if applicable.
- Confirmation of the operator and scrub practitioner.
- Concerns regarding staffing availability.
- Concerns regarding available time.
- Confirmation of bed availability and/or postoperative higher dependency requirement and availability.
- Confirmation of procedure list order. Any alterations will necessitate reprinting the procedures list
- Confirmation of the person who will be sending for the patients

12.14. Where specialty-specific Trust Surgical Safety Checklists exist, these should be used and the relevant printed checklist used as an aide memoire.

12.15. Any additional concerns from an operator, anaesthetic or practitioner perspective must be discussed, and contingency plans made.

12.16. The operating list should be updated to reflect any additions, cancellations, changes to the list order and changes to the procedure.

12.17. A summary of the brief should be made and displayed in the procedural area for reference during the list.

12.18. If a significant issue about the care of the patient arises during the briefing, a clear and concise note should be entered in the patient's records and if more investigations or information needs to be obtained the team should reconvene to continue the brief after the information has been obtained.

13. Sign In

13.1. The 'Sign In' is the safety check patients undergo upon arrival to the procedural area prior to an invasive procedure.

13.2. The 'Sign In' should not be performed until any omissions, discrepancies or uncertainties identified in the handover from the ward or admission area to the receiving practitioner in the procedure area or anaesthetic room have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of any omissions, discrepancies or uncertainties. Such occurrences should be reported as safety incidents.

13.3. 'Sign In' must occur prior to the induction of general anaesthesia, local anaesthesia or sedation.

13.4. When general anaesthesia is not used, 'Sign In' should occur prior to the start of the procedure.

The 'Sign In' must be performed by at least two people involved in the procedure. For procedures performed under general or regional anaesthesia, these should include the anaesthetist and anaesthetic assistant. For procedures not involving an anaesthetist, the operator and an assistant should perform the sign In. This includes involvement of the patient/parent/carer.

13.5. Safety checks included as part of the 'Sign In':

- The anaesthetist leads the 'Sign In'.
- Patient details checked with the patient (when appropriate) and/or family (when available) against the printed identity band, consent form and operating list.
- Surgical site marking to be checked with the patient (when appropriate) and/or family (when available) against the consent and operating list.
- Ensure that the ward preoperative checklist is completed, if not please refer back to the ward nurse.
- Allergy status.
- Last administration of antibiotics or paracetamol.
- Gastrostomy/nasogastric tube aspirated if present.

13.6. Procedure specific checks:

- Before performing a regional local anaesthetic block, a repeat check of the site and side of the procedure by the anaesthetist and anaesthetic practitioner is required. "Stop before you block."
- Blood availability must be checked and location confirmed.

13.7. After the 'Sign In' is completed, the preoperative checklist should be signed off by the Anaesthetic Practitioner and pre-operative ward nurse. The 'Sign In' should then be documented on the electronic patient record.

14. Time Out

14.1. The 'Time Out' represents the final opportunity to confirm the correct patient is having the correct procedure at the correct site prior to the start of the invasive procedure. It is an opportunity for any staff member to speak up with any concerns.

14.2. If the patient is having a procedure under local anaesthetic, participation of the patient (and/or parent or guardian) in the 'Time Out' should be encouraged when possible.

14.3. The 'Time Out' should not be performed until any omissions, discrepancies or uncertainties identified in the Sign In have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of any discrepancies. Such occurrences should be reported as safety incidents and a Datix form should be completed.

14.4. Any member of the procedural team may lead the 'Time Out'. The team member leading the 'Time Out' should verify all team members who are participating, introduce any new team members or visitors and use the Time Out section of the Surgical Safety Checklist

14.5. The team involved with the procedure must be present such as:

- Senior operator and assistant.
- Lead anaesthetist and second anaesthetist.
- Anaesthetic practitioner.
- Scrub team.
- Circulating person in charge of the list.
- Any other healthcare professionals involved in the procedure, e.g. radiographer, perfusionist, etc.

14.6. Using the 'Time Out' section of the Surgical Safety Checklist the following safety checks are included as part of the 'Time Out':

- Patient details checked with the patient (when appropriate) and/or family (when available) against the printed identity band, consent form and operating list
- Surgical site marking to be checked with the patient (when appropriate) and/or family (when available) against the consent and operating list
- Allergy status
- American Society of Anesthesiologists Scoring Status (ASA)
- Confirmation of sterility of instruments and equipment
- Confirmation of the availability of the implant if needed
- Any equipment issues or concerns
- Antibiotic prophylaxis
- Patient warming
- Thromboprophylaxis
- Local anaesthetic dose
- Any new concerns since induction

- Pressure areas checked

14.7. Any omissions, discrepancies or uncertainties identified during the 'Time Out' should be resolved before the procedure starts. If these cannot be resolved, the procedure may need to be cancelled.

15. Prosthesis/Implant Verification, One off sets and Loan kit

15.1. A prosthesis or implant is defined as an internal or external, permanent or temporary medical device used to replace or repair a structure.

15.2. A loan kit is defined as a set of specialised instruments which include implants used to replace or repair a structure.

15.3. Pre-operative planning is essential when loan kits and one off sets/instruments are required for a planned procedure to ensure the correct prosthesis equipment is available.

15.4. Pre-operative considerations:

- Identification of the prosthesis/implant/loan kit required in pre-op planning.
- Type, Design or style.
- Material.
- Size.
- Manufacturer.
- The procedure list should state the specific prosthesis/implant or implant system anticipated to be used.
- The Sister / Scrub team leader must be notified by the procedural team of Implant to be used at the time of booking the case.
- The Theatre Sister / Scrub team will confirm arrival of the correct implant. If the implant or implant system will not be available for the date of the scheduled procedure, the Sister or scrub team will notify the surgical team prior to the day of surgery.
- If a bespoke implant/prosthesis is needed, the surgeon will provide the specifications; the manufacturer will be informed and will provide an estimated date of availability in order to book the patient onto a procedural list.

15.5. Prior to the 'Team Brief' all essential instruments/equipment, prosthesis/implants, or loan kits are checked for availability and external sterility and then report an issues.

15.6. During the 'Team Brief' the operator is to inspect the available prosthesis/implant or loan kit and confirm the correct range of implant/prosthesis and any necessary instrumentation is available and in a sterile condition prior to the patient being sent to the procedural area.

15.7. All essential instruments/equipment/loan sets are opened and checked for sterility prior to the patient being anaesthetised.

15.8. Before the prosthesis/implant is placed onto the surgical field a final check by the operator to confirm the following with the team:

- Type, design, or style.
- Material Compatibility.
- Size.

- Laterality (Left, Right, Bilateral).
- Manufacturer.
- Expiry date.
- Compatibility of multi-component prosthesis.
- Any other characteristics.

15.9. Once the correct item(s) has/have been selected any prosthesis not being used should be clearly separated from those being used.

15.10. Any prosthesis used must be documented with the above information on:

- Electronic patient record.
- Intraoperative care plan.
- Service implant book.
- Devices template spread sheet.
- Patient notes and operative record.
- Devices registries.

15.11. Instances of failed prosthesis verification, wrong prosthesis insertion and 'near misses' should be recorded and openly discussed at the Debrief, a Datix should be completed and fed into local governance processes to promote learning and development of new or altered processes for patient safety.

15.12. When manufacturers labelling, packaging or implant defects contribute to the failure of prosthesis verification, or there is a defect in the implant/device the manufacturer must be informed and a Datix must be completed.

16. Prevention of Retained Foreign Objects

16.1. This standard supports safe and consistent practise in accounting for all items used during invasive procedures in order to minimise the risk of an unintentional retained item and causing harm to the patient.

16.2. The Surgical Count Policy in the document library must be followed to ensure the accounting of all items used in an invasive procedure and minimise the risk of a foreign object being retained in a patient and causing patient harm.

16.3. This must address the processes to be followed for the counting of all swabs, sharps, instruments and small items used in an invasive procedure and the points when a count is necessary to be performed.

16.4. The Surgical Count Policy addresses a clear process to be followed in the event that an item is unaccounted for during or at the end of the procedure. The process should include: consideration for a further count, communication to the operator, surgeon and procedure team, undertaking a thorough search, performing a radiological exam when necessary and not moving the patient from the procedure room until there is a resolution.

16.5. Any incorrect counts must be documented and section 10 "Count Discrepancy" of the Surgical Count Policy must be followed.

16.6. Intentionally retained item/s:

16.6.1. In the case of an intentionally retained item/s it is expected the LocSSIP must address the following:

- Notification of the patient/family, impact of the retained item on the health of the patient and completion of incident form.
- Documentation in the medical notes and perioperative care plan which includes a description of the item/s left behind, location and the plan for removal.
- If there is no plan for removal, there must be clear documentation of the item left behind and explanation to the patient/family. This should include Type, design, material and size
- A clear verbal and written handover processes of item/s left behind.

16.7. Instrumentation

16.7.1. All instrument trays must come with an up-to-date list of the items.

16.7.2. Instruments sets must undergo regular inspection as per the Trust Decontamination Policy.

16.7.3. The service terms of agreement must be followed by both the instrument processing service and the end user for the care, maintenance, cleaning, processing, identification, counting, and reconciliation of all single instruments and instrument sets.

16.7.4. Each instrument must undergo a periodic inspection to ensure they are fit for purpose. If they are found to be unfit they are to be repaired or replaced as advised.

16.7.5. Integrity of instruments should be checked before and after use.

17. Sign Out

17.1. All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, must undergo safety checks at the end of the procedure but before the handover to the post-procedure care team: the sign out.

17.2. 'Sign Out' should occur at the conclusion of the procedure and/or before emergence from general anaesthesia.

17.3. Team members should not leave the procedure room until 'Sign Out' is complete, unless there are exceptional circumstances.

17.4. When general anaesthesia is not used, 'Sign Out' should occur prior the patient leaving the procedure room.

17.5. Any member of the team can lead the 'Sign Out'.

17.6. Using the Trust Surgical Safety Checklist (see Appendix 6) as an aide memoire, the following should be checked:

- Confirmation of the procedure performed.
- Confirmation of the site and side of the procedure.
- Confirmation that all procedures on the consent form have been performed.
- Confirmation that instrument, sharps and swab counts are complete and correct.
- Confirmation against patient id band that any specimens have been labelled correctly; check the patient's name, site and side of specimen where applicable and the laboratory where the

specimen is to be sent. This information will then be placed in the specimen log by a member of the scrub team.

- The operator and anaesthetist should discuss any post-procedure patient plans and concerns
- Discussion of any issues, equipment, instruments etc.
- Procedure specific checks.

18. Debrief

18.1. 'Debrief' is an opportunity for teams for teams to facilitate reflection, conversation and learning; improve practise and patient safety at the end of all elective procedure lists, after an unscheduled procedure or emergency procedure or should be done case by case basis when there is a change in the team members involved.

18.2. The 'Debrief' emphasises the following:

- whether the Safety Standards for Invasive Procedures or LocSSIPs are being effectively implemented.
- any specific challenges and safety concerns.
- Identification of any areas where the improvements may be required.
- Identification of themes and trends to be escalated where appropriate.

18.3. The 'Debrief' should occur in a place which is free from noise, interruption and ensures patient confidentiality.

18.4. Every member of the procedural team should take part in the 'Debrief'.

18.5. Any team member may lead the 'Debrief'.

18.6. If any team member has to leave before the 'Debrief' is conducted, they should have the opportunity to comment and document any positive feedback or issues for improvement they wish to see addressed during the 'Debrief' and their absence should be recorded.

18.7. Members of the procedural team may note any key points for consideration during the procedure/ list to be discussed during the Debrief.

18.8. Any issues noted during the 'Debrief' should be followed up by the Team Leader / Nurse in Charge.

18.9. If a significant issue about the care of a patient arises during the 'Debrief', a clear and concise note should be made in the patient's records and a Datix form should be completed.

19. Development, Implementation and Review of LocSSIPs

19.1. A Local Standard for Safety Standard for Invasive Procedure (LocSSIP) is required for any invasive procedure where the process deviates from what is set out in the Safety Standards for Invasive Procedures Policy.

19.2. Any new invasive procedure introduced to the Trust or to a procedure introduced to a new procedural area must be assessed to ascertain if a LocSSIP is required.

19.3. A review must be carried out to ensure that creation of a new document is not duplicating an existing document.

19.4. There should be a local owner for each LocSSIP who is a senior and substantive member of the team involved in doing the procedure.

19.5. The LocSSIP template guide and the Safety Standards for Invasive Procedures policy are to be used for the development of a specialty/procedural LocSSIPs.

19.6. The standards covered in each LocSSIP should consider the organisational and the sequential steps included in the patient pathway from the point of decision to perform an invasive procedure, to the point of discharge from the procedural area.

19.7. In some procedural environments, the combination of two sequential steps may be logical, for example, performing a combined Sign In and Time Out for procedures when sedation is not used and the operator provides local anaesthesia. If two steps are combined, the key safety elements of both steps set out in this document should be retained in the single, combined step and a LocSSIP created.

19.8. Electronic record keeping will support the correct, complete and sequential performance of the Surgical Safety Checklist in the LocSSIPs and will provide an accurate record of both the members of the team performing the checks and the actual checks performed.

19.9. Areas will use aide memoires in the format of the Surgical Safety Checklist and ensure that every step is completed for every patient undergoing an invasive procedure.

19.10. LocSSIPs should stipulate all necessary induction, training and competencies for the procedural area prior to carrying out a role.

19.11. LocSSIPs are local standard operating procedures. They are not Trust policies and therefore should be agreed locally with the relevant clinical staff and approved by the Matron, Assistant Chief Nurse and Head of Clinical Service, prior to ratification by the NatSSIPs Steering group.

19.12. The LocSSIP owner is responsible for consulting with relevant clinical and non-clinical staff and ensuring that the minimum requirements for the content of a LocSSIP are met. The minimum content for a LocSSIP is outlined in Appendix 8..

19.13. A LocSSIP will be approved by the NatSSIPs Steering group subject to the following conditions:

- There is evidence of appropriate local consultation, and sign of from the Head of Clinical Service, Matron, and Assistant Chief Nurse.
- All sections of the LocSSIP have been completed to a satisfactory standard (see Appendix 8).
- The LocSSIP demonstrates a commitment to maintaining a safe culture to promote team work, minimise avoidable complications, and prevent patient safety never events.
- Is published with an agreed date for future review

19.14. The NatSSIPs Steering group will maintain oversight of all LocSSIPs and ensure that LocSSIPs are reviewed every three years.

19.15. LocSSIPs and specialised checklists will be published on the Safety Standards for Invasive Procedures intranet page.

20. Equality Impact Statement

20.1. This policy has been assessed for its impact on equality and will have a minimal impact on the protected groups below:

- Age.
- Disability (including learning disability).
- Race.
- Religion or belief.
- Sex.

20.2. Equality Impact Assessment – (see Appendix 10).

References:

NHS England (2015). National Safety Standards for Invasive Procedures (NatSSIPs). https://improvement.nhs.uk/uploads/documents/natssips-safety-standards.pdf

NHS England (2015). Revised Never Events Policy and Framework. https://improvement.nhs.uk/uploads/documents/never-evnts-pol-framwrk.pdf

National Institute for Health and Care Excellence (NICE) (2016). NICE interventional procedure guidance. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-interventional-procedures-guidance

Coates, T, Guckian Fisher, M. Staffing for patients in the perioperative setting. Harrogate: Association for Perioperative Practice (AfPP). www.afpp.org.uk

Association for Perioperative Practice (AfPP) (2011). Standards for recommendations for safe perioperative practice. Harrogate: Association for Perioperative Practice (AfPP) 3rd Edition. www.afpp.org.uk

National Patient Safety Agency (NPSA) (2012). Never Events. http://www.nrls.npsa.nhs.uk/resources/collections/never-events/

Appendix 1 – Pre-operative checklist

SAMPLE

Name
Hosp No
DOB

(Affix patient label)

Pre-Operative Checklist

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Date: ___ / _____ / _____ Pre-op ward: _____ Post-op ward: _____ Theatre: _____

GENERAL INFORMATION

Weight and height: **Weight:** _____ kg **Height:** _____ cm
Allergies: Please list _____

Fasting times: Last intake Food or milk: _____ Breast milk: _____ Clear fluid: _____

Observations Temp: _____ °C Sats: _____ % Pulse: _____ BP: _____
Tympanic/axilla/oral On air/O_2 _____ L/min Resps: _____ BP site: _____

MEDICATION AND TRANSFUSIONS

Paracetamol or antibiotics given in last 24 hours (hospital or home)? Yes ☐ No ☐ If yes, specify drug(s) given and time of last dose
_____

Infection control precautions required? Yes ☐ No ☐ Theatres informed? Yes ☐ Nature of alert _____

Blood or blood products given in last 24 hours? None ☐ Red cells ☐ _____ mls FFP/octoplas ☐ _____ mls
Platelets ☐ _____ mls Cryo ☐ _____ mls
Other ☐ _____

Blood products available Type: _____ Volume: _____ mls/units
Sickle cell status Unknown / +ve / -ve / trait

WARD CHECKS

Yes	N/A		Yes	
☐	☐	Implants?	☐	Clerked?
☐	☐	Loose teeth?	☐	Consented?
☐	☐	Tracheostomy?	☐	ID band in situ?
☐	☐	Toy/comforter with child?	☐	Site marked and documented?
☐	☐	Communication aid with child?	☐	EP ready for use?
☐	☐	Any existing pressure ulcers?	☐	All regular meds prescribed?
☐	☐	Drugs with child?	☐	2 sheets patient stickers?
☐	☐	Ametop/Emla applied? Time _____	☐	Bath/shower in last 24 hours?
☐	☐	Pre-med given? Time _____		
☐	☐	TED stockings on?		
☐	☐	Jewellery/nail polish removed?		

Details

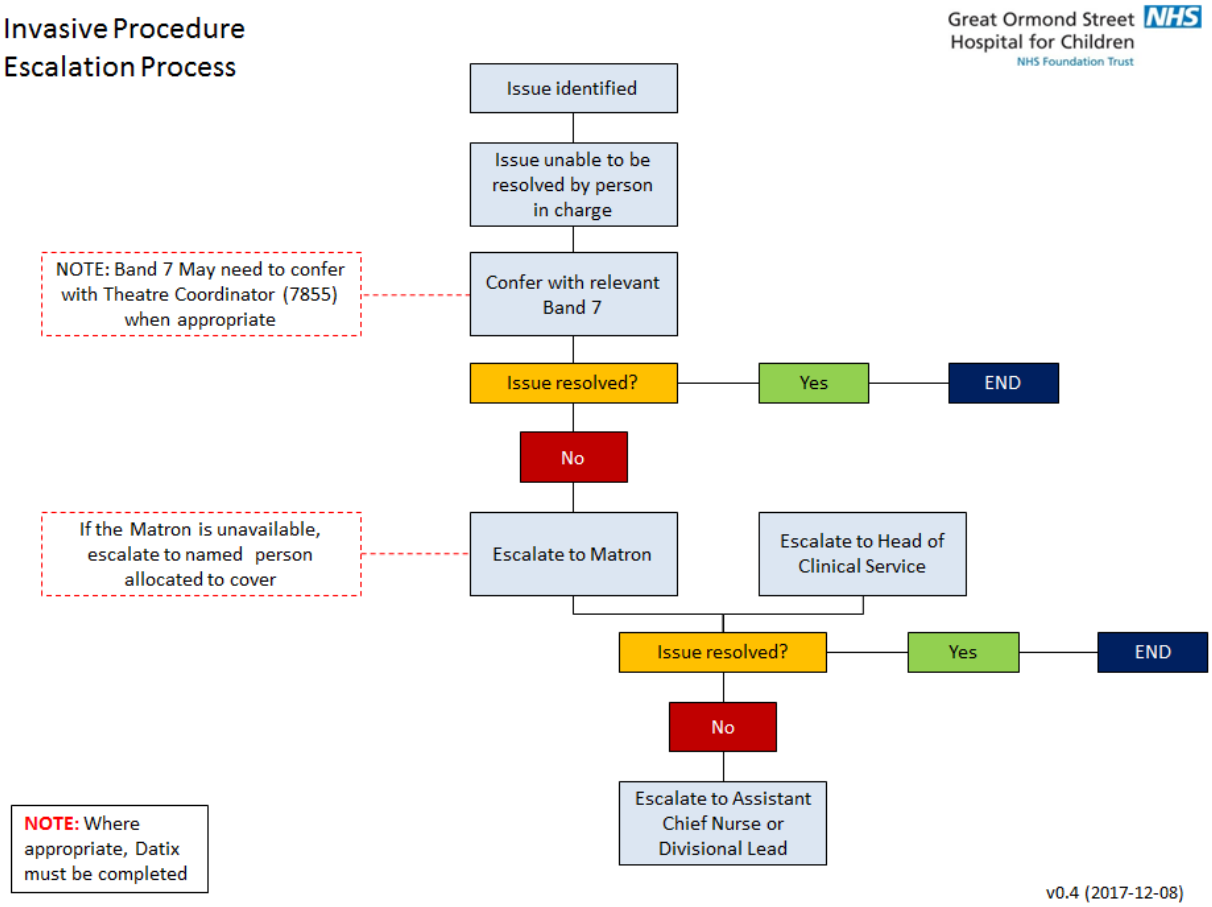
Last menstrual period: DD/MM/YYYY
+ve ☐ -ve ☐ Not done ☐

Affix βHCG test result print out here

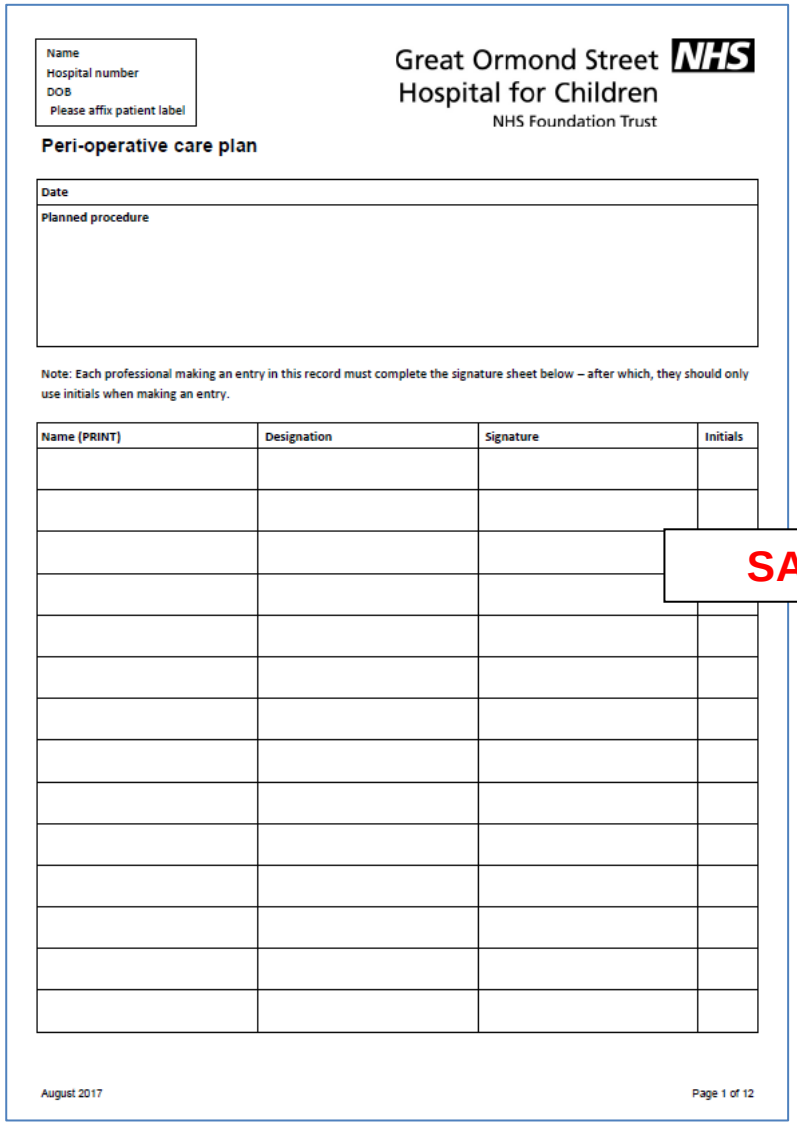
Ward: Registered Nurse Sign _____ PRINT _____
Theatre: ODP / Nurse / Doctor Sign _____ PRINT _____

IF ANY OF THE ABOVE ARE NOT COMPLETED, THE PATIENT MUST NOT LEAVE THE WARD

Appendix 2 – Invasive Procedure Escalation Process



Appendix 3 – Peri-operative care plan



Name
Hospital number
DOB
Please affix patient label

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Peri-operative care plan

Date
Planned procedure

Note: Each professional making an entry in this record must complete the signature sheet below – after which, they should only use initials when making an entry.

Name (PRINT)	Designation	Signature	Initials

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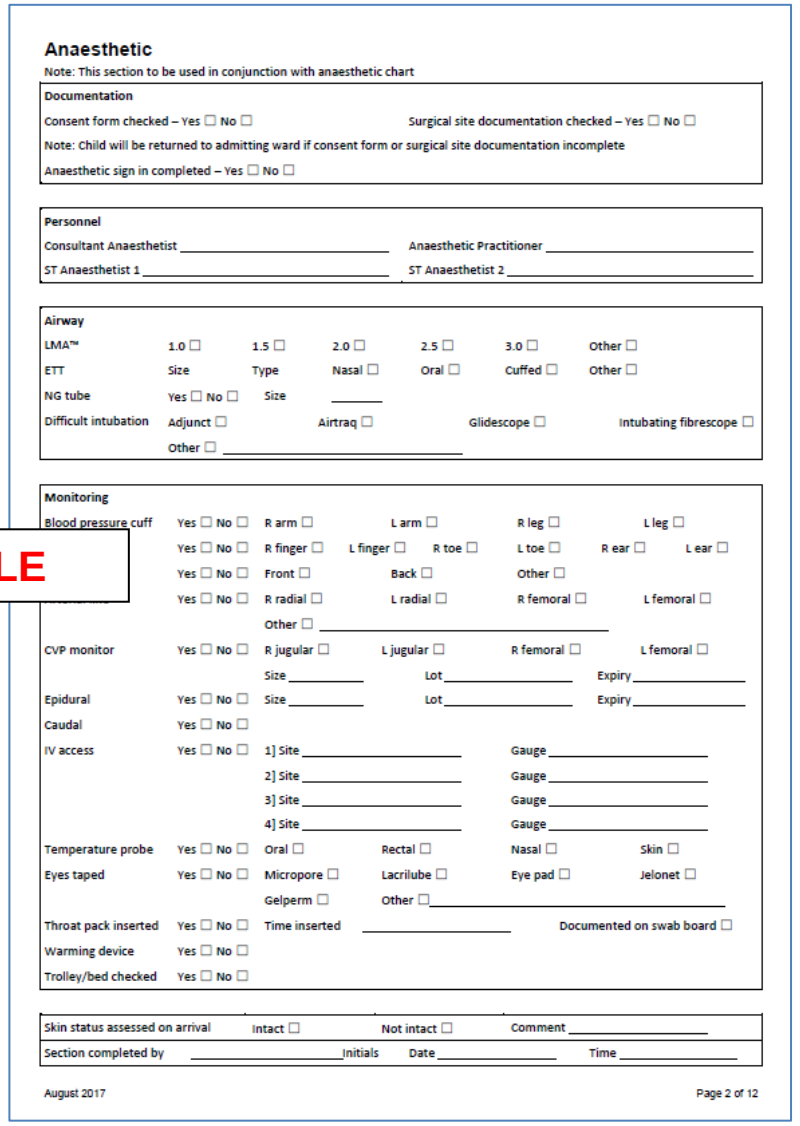

Anaesthetic

Note: This section to be used in conjunction with anaesthetic chart

Documentation

Consent form checked – Yes ☐ No ☐ Surgical site documentation checked – Yes ☐ No ☐

Note: Child will be returned to admitting ward if consent form or surgical site documentation incomplete

Anaesthetic sign in completed – Yes ☐ No ☐

Personnel

Consultant Anaesthetist _____ Anaesthetic Practitioner _____

ST Anaesthetist 1 _____ ST Anaesthetist 2 _____

Airway

LMA™ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ Other ☐

ETT Size Type Nasal ☐ Oral ☐ Cuffed ☐ Other ☐

NG tube Yes ☐ No ☐ Size _____

Difficult intubation Adjunct ☐ Airtraq ☐ Glidescope ☐ Intubating fibrescope ☐

Other ☐ _____

Monitoring

Blood pressure cuff Yes ☐ No ☐ R arm ☐ L arm ☐ R leg ☐ L leg ☐

Yes ☐ No ☐ R finger ☐ L finger ☐ R toe ☐ L toe ☐ R ear ☐ L ear ☐

Yes ☐ No ☐ Front ☐ Back ☐ Other ☐

Yes ☐ No ☐ R radial ☐ L radial ☐ R femoral ☐ L femoral ☐

Other ☐ _____

CVP monitor Yes ☐ No ☐ R jugular ☐ L jugular ☐ R femoral ☐ L femoral ☐

Size _____ Lot _____ Expiry _____

Epidural Yes ☐ No ☐ Size _____ Lot _____ Expiry _____

Caudal Yes ☐ No ☐

IV access Yes ☐ No ☐ 1] Site _____ Gauge _____

2] Site _____ Gauge _____

3] Site _____ Gauge _____

4] Site _____ Gauge _____

Temperature probe Yes ☐ No ☐ Oral ☐ Rectal ☐ Nasal ☐ Skin ☐

Eyes taped Yes ☐ No ☐ Micropore ☐ Lacrilube ☐ Eye pad ☐ Jelonet ☐

Gelperm ☐ Other ☐ _____

Throat pack inserted Yes ☐ No ☐ Time inserted _____ Documented on swab board ☐

Warming device Yes ☐ No ☐

Trolley/bed checked Yes ☐ No ☐

Skin status assessed on arrival Intact ☐ Not intact ☐ Comment _____

Section completed by _____ Initials Date _____ Time _____

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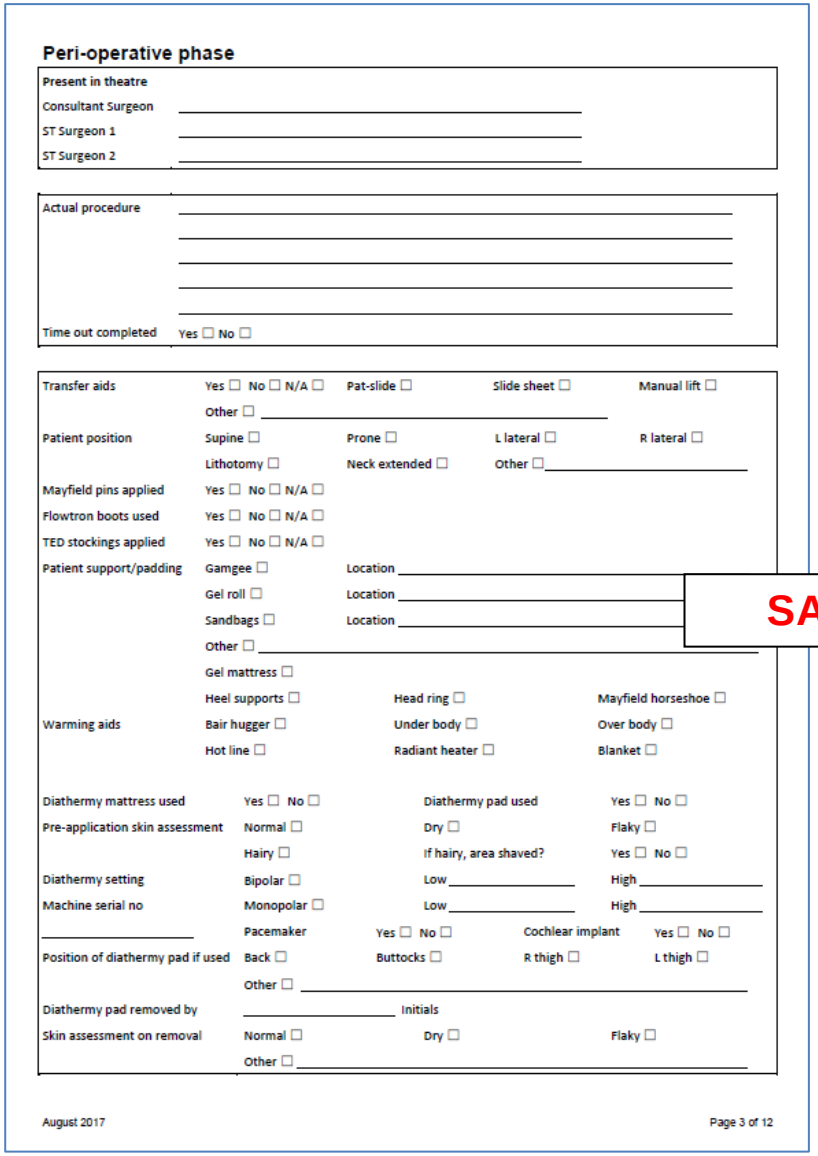


Peri-operative phase

Present in theatre

Consultant Surgeon _____

ST Surgeon 1 _____

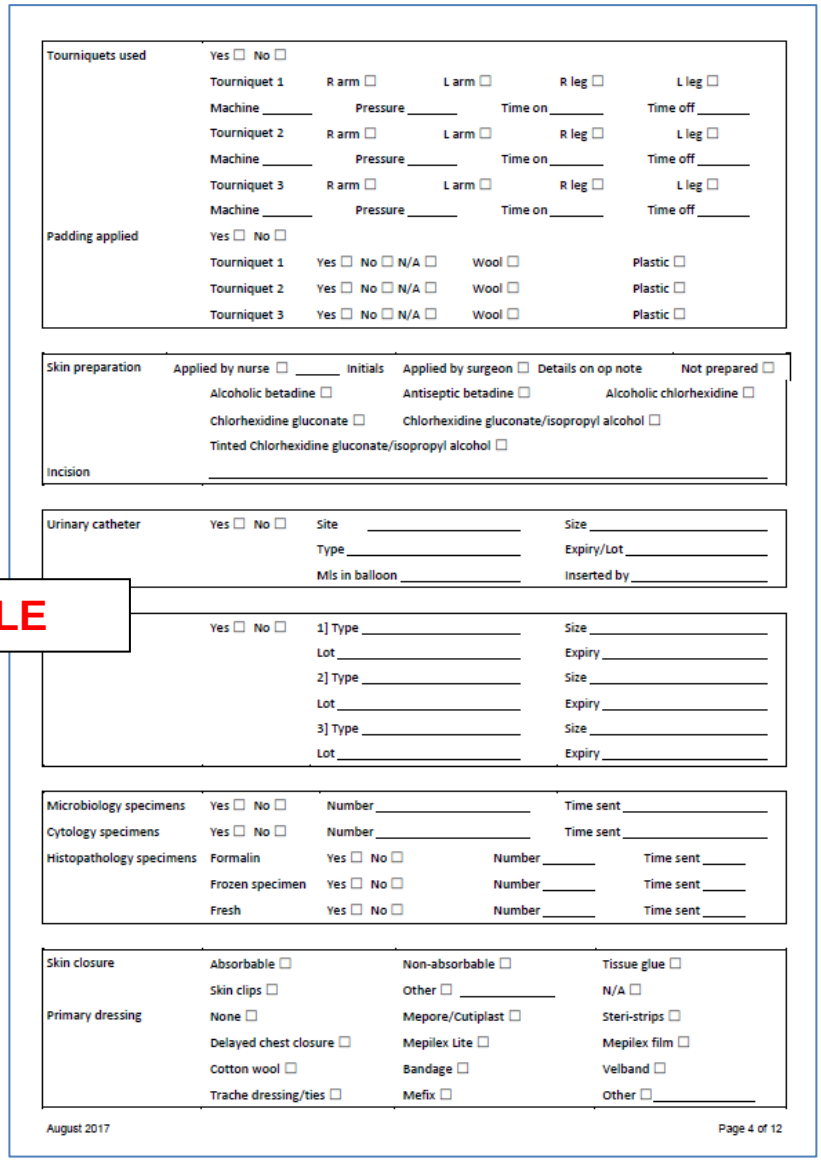
ST Surgeon 2 _____

Actual procedure _____

Time out completed Yes ☐ No ☐

Transfer aids	Yes ☐ No ☐ N/A ☐	Pat-slide ☐	Slide sheet ☐	Manual lift ☐
	Other ☐ _____			
Patient position	Supine ☐	Prone ☐	L lateral ☐	R lateral ☐
	Lithotomy ☐	Neck extended ☐	Other ☐ _____	
Mayfield pins applied	Yes ☐ No ☐ N/A ☐			
Flowtron boots used	Yes ☐ No ☐ N/A ☐			
TED stockings applied	Yes ☐ No ☐ N/A ☐			
Patient support/padding	Gamgee ☐	Location _____		
	Gel roll ☐	Location _____		
	Sandbags ☐	Location _____		
	Other ☐ _____			
	Gel mattress ☐			
	Heel supports ☐	Head ring ☐	Mayfield horseshoe ☐	
Warming aids	Bair hugger ☐	Under body ☐	Over body ☐	
	Hot line ☐	Radiant heater ☐	Blanket ☐	

Diathermy mattress used	Yes ☐ No ☐	Diathermy pad used	Yes ☐ No ☐
Pre-application skin assessment	Normal ☐	Dry ☐	Flaky ☐
	Hairy ☐	If hairy, area shaved?	Yes ☐ No ☐
Diathermy setting	Bipolar ☐	Low _____	High _____
Machine serial no	Monopolar ☐	Low _____	High _____
_____	Pacemaker	Yes ☐ No ☐	Cochlear implant Yes ☐ No ☐
Position of diathermy pad if used	Back ☐	Buttocks ☐	R thigh ☐ L thigh ☐
	Other ☐ _____		
Diathermy pad removed by	_____ Initials		
Skin assessment on removal	Normal ☐	Dry ☐	Flaky ☐
	Other ☐ _____		



Tourniquets used	Yes ☐ No ☐			
	Tourniquet 1	R arm ☐	L arm ☐	R leg ☐ L leg ☐
	Machine _____	Pressure _____	Time on _____	Time off _____
	Tourniquet 2	R arm ☐	L arm ☐	R leg ☐ L leg ☐
	Machine _____	Pressure _____	Time on _____	Time off _____
	Tourniquet 3	R arm ☐	L arm ☐	R leg ☐ L leg ☐
	Machine _____	Pressure _____	Time on _____	Time off _____
Padding applied	Yes ☐ No ☐			
	Tourniquet 1	Yes ☐ No ☐ N/A ☐	Wool ☐	Plastic ☐
	Tourniquet 2	Yes ☐ No ☐ N/A ☐	Wool ☐	Plastic ☐
	Tourniquet 3	Yes ☐ No ☐ N/A ☐	Wool ☐	Plastic ☐

Skin preparation	Applied by nurse ☐ _____ Initials	Applied by surgeon ☐	Details on op note Not prepared ☐
	Alcoholic betadine ☐	Antiseptic betadine ☐	Alcoholic chlorhexidine ☐
	Chlorhexidine gluconate ☐	Chlorhexidine gluconate/isopropyl alcohol ☐	
	Tinted Chlorhexidine gluconate/isopropyl alcohol ☐		
Incision	_____		

Urinary catheter	Yes ☐ No ☐	Site _____	Size _____
		Type _____	Expiry/Lot _____
		Mls in balloon _____	Inserted by _____
	Yes ☐ No ☐	1] Type _____	Size _____
		Lot _____	Expiry _____
		2] Type _____	Size _____
		Lot _____	Expiry _____
		3] Type _____	Size _____
		Lot _____	Expiry _____

Microbiology specimens	Yes ☐ No ☐	Number _____	Time sent _____	
Cytology specimens	Yes ☐ No ☐	Number _____	Time sent _____	
Histopathology specimens	Formalin	Yes ☐ No ☐	Number _____	Time sent _____
	Frozen specimen	Yes ☐ No ☐	Number _____	Time sent _____
	Fresh	Yes ☐ No ☐	Number _____	Time sent _____

Skin closure	Absorbable ☐	Non-absorbable ☐	Tissue glue ☐
	Skin clips ☐	Other ☐ _____	N/A ☐
Primary dressing	None ☐	Mepore/Cutiplast ☐	Steri-strips ☐
	Delayed chest closure ☐	Mepilex Lite ☐	Mepilex film ☐
	Cotton wool ☐	Bandage ☐	Velband ☐
	Trache dressing/ties ☐	Mefix ☐	Other ☐ _____

Other dressings	1] Wound site _____	Dressing _____
	2] Wound site _____	Dressing _____
	3] Wound site _____	Dressing _____

Medication

Name	Dose	Site	Infiltration	Topical	Other	Given by / Details	Time given
1]			☐	☐	☐		
2]			☐	☐	☐		
3]			☐	☐	☐		
4]			☐	☐	☐		
5]			☐	☐	☐		
6]			☐	☐	☐		
7]			☐	☐	☐		
8]			☐	☐	☐		

Chemotherapy drugs checked	Yes ☐ No ☐ N/A ☐	Checked by _____ Initials

X-rays taken	Yes ☐ No ☐ N/A ☐

Any other notes or comments

Section completed by _____ Initials	Date _____	Time _____

Implants used

Affix stickers below and document location

HSDU and procedure pack labels

Affix stickers below

Theatre counts

Procedure 1

Preliminary count	Swabs ☐	Scrub 1 initials	Needles ☐		Instruments ☐	Circ 1 initials	Misc ☐
1st closure count	Swabs ☐	Scrub 1 initials	Needles ☐		Instruments ☐	Circ 1 initials	Misc ☐
Final count	Swabs ☐	Scrub 1 initials	Needles ☐		Instruments ☐	Circ 1 initials	Misc ☐
Consolidation count (if req'd)	Swabs ☐	Scrub 1 initials	Needles ☐		Instruments ☐	Circ 1 initials	Misc ☐

Procedure 2

Preliminary count	Swabs ☐	Scrub 2 initials	Needles ☐		Instruments ☐	Circ 2 initials	Misc ☐
1st closure count	Swabs ☐	Scrub 2 initials	Needles ☐		Instruments ☐	Circ 2 initials	Misc ☐
Final count	Swabs ☐	Scrub 2 initials	Needles ☐		Instruments ☐	Circ 2 initials	Misc ☐
Consolidation count (if req'd)	Swabs ☐	Scrub 2 initials	Needles ☐		Instruments ☐	Circ 2 initials	Misc ☐

Throat pack inserted	Yes ☐ No ☐ N/A ☐	Time inserted	
Throat pack removed	Yes ☐ No ☐ N/A ☐	Time removed	

Incorrect counts	Items missing	Yes ☐ No ☐	Details	
	Patient x-rayed	Yes ☐ No ☐	Incident form completed	Yes ☐ No ☐
	If no, reasons			

Sign out completed	Yes ☐ No ☐

Handover from scrub to recovery practitioner

1 Situation	• Patient's name • Consultant team(s) • Details of procedure(s)
2 Background	• Infectious alerts • Theatre • Allergies • Personal belongings
3 Assessment	• Throat pack removed • Surgical medications given • Wound location(s), closure and dressings • Tubes, drain or packs in situ • Prostheses or implants in situ • Specimen(s) taken
4 mendation overy Area	• Post-op instructions (drains, dressings, packs, catheters and so on) • Location of post-operative/patient notes • Any questions or comments?

Skin status on transfer to recovery	No change from initial anaesthetic room assessment ☐	
	Red marks ☐	Location
	Rash ☐	Location
	Pressure area ☐	Location
	Comments	

Packs left in situ for removal	Yes ☐ No ☐ N/A ☐				
	Type		Number		Location
	Type		Number		Location

Confirmation of handover by scrub practitioner		Initials
Confirmation of handover to recovery practitioner		Sign
		Designation

Recovery care and handover

Airway on arrival

Self-maintained ☐ Obstructed needing support ☐ Artificial ☐

Type _____ Time removed _____

Tracheostomy size _____ Suction to _____

Nasal prong size _____ Suction to _____

Comments

Breathing on arrival

Spontaneous and symmetrical Yes ☐ No ☐

Nasal flaring Yes ☐ No ☐ Recession Yes ☐ No ☐

Breath sounds (wheeze, grunt, stridor) Yes ☐ No ☐

Cough Yes ☐ No ☐ CPAP/IPPV required Yes ☐ No ☐

Circulation

Capillary refill 1 sec ☐ 2 sec ☐ 3+ sec ☐

Action taken _____

IV access in situ Yes ☐ No ☐ Flushed in theatre ☐ in recovery ☐

Wound site clean and dry Yes ☐ No ☐ Drain in situ Yes ☐ No ☐

Fluid balance Note: Refer to anaesthetic chart for intra-operative fluids

IV fluids prescribed Yes ☐ No ☐

Running Yes ☐ No ☐ Rate _____ mls/hr

Oral fluids given Yes ☐ No ☐ NBM ☐ Volume _____ mls

Total fluids given in recovery Volume _____ mls

Passed urine Yes ☐ No ☐ Nappy ☐ Catheter in situ Yes ☐ No ☐

NG/NJ tube in situ Yes ☐ No ☐ Position checked Yes ☐ No ☐ pH _____

Nausea/vomiting Yes ☐ No ☐

Pain

NCA ☐ PCA ☐ Epidural ☐ Caudal ☐ Local ☐ Vocal cords sprayed ☐

Infusion checked and correct Yes ☐ No ☐

Pain scale used FLACC ☐ Revised FLACC ☐

Patient verbal reporting ☐ Parent verbal reporting ☐

Analgesia required in recovery Yes ☐ No ☐

Additional information

Blood glucose checked Yes ☐ No ☐ Result _____

Hb checked Yes ☐ No ☐ Result _____

X-ray taken Yes ☐ No ☐

X-ray checked Yes ☐ No ☐ Reviewed by

Blood gases checked Yes ☐ No ☐ If yes, record on anaesthetic chart

O_2 required for discharge to ward Yes ☐ No ☐

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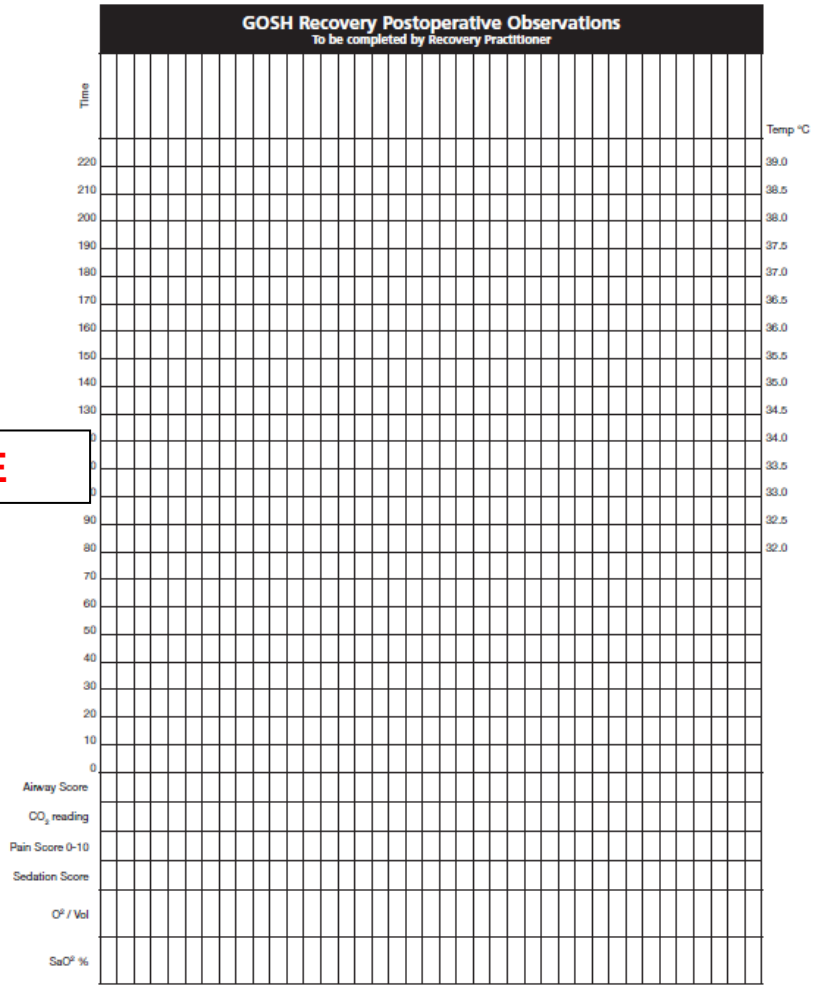
SAMPLE

Affix sticker here:
Patient Name:
Hospital No.:
Date of birth:

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

GOSH Recovery Postoperative Observations
To be completed by Recovery Practitioner



Airway Score		Pain Score 0 – 10	Sedation Score	
Crying/Talking	2		Fully awake	1
Maintaining good airway	1		Drowsy	2
Required maintenance	0		Asleep, Rousable	3
			Asleep, Unrousable	4

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Family centred care		Comments
Time parents called	_____	
Care given by parents	Cuddling ☐ Verbal reassurance ☐ Feeding ☐	
	Other ☐ _____	

Discharge criteria		Comments
Patient has spontaneous, regular respiration and a safe airway	Yes ☐ No ☐	CEWS = _____
The SpO_2 is within normal patient limits and oxygen has been prescribed as necessary	Yes ☐ No ☐	
The CEWS is 3 or below	Yes ☐ No ☐	
NerveCentre complete	Yes ☐ No ☐	
Heart rate and blood pressure are stable and within pre-operative limits	Yes ☐ No ☐	
Patient's central temperature is within normal limits and they are warm peripherally	Yes ☐ No ☐	
Patient is awake or easily rousable	Yes ☐ No ☐	
Patient is comfortable with any pain adequately controlled	Yes ☐ No ☐	
Nausea/vomiting is absent or adequately controlled	Yes ☐ No ☐	
Wound is dry or exudates normal	Yes ☐ No ☐	
Catheter and/or drains are patent and drainage is within anticipated limits	Yes ☐ No ☐	
Post-operative hydration therapy has been prescribed if required	Yes ☐ No ☐	
Electronic prescribing has been checked and all medications prescribed	Yes ☐ No ☐	
If appropriate, patient is free from neurovascular compromise	Yes ☐ No ☐	
If appropriate, patient is neurologically stable or has been reviewed	Yes ☐ No ☐	
Documentation is complete, including operation note and any post-operative instructions	Yes ☐ No ☐	

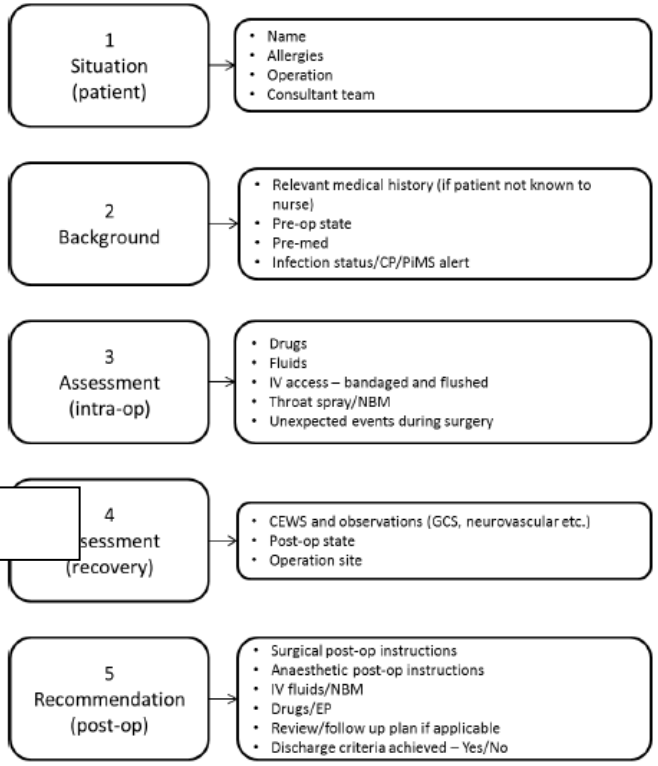
Skin status	No change from initial anaesthetic room assessment ☐	Comments
	Red marks ☐ Location _____	
	Rash ☐ Location _____	
	Pressure area ☐ Location _____	
	Comments _____	

Note: Ward should only be called when all above criteria met unless previously agreed

Confirmation of discharge from recovery	_____ Initials
Confirmation of ward handover	_____ Sign
	_____ Designation

SAMPLE

Ward handover aide memoire



Appendix 4 – Prosthesis Flow Chart

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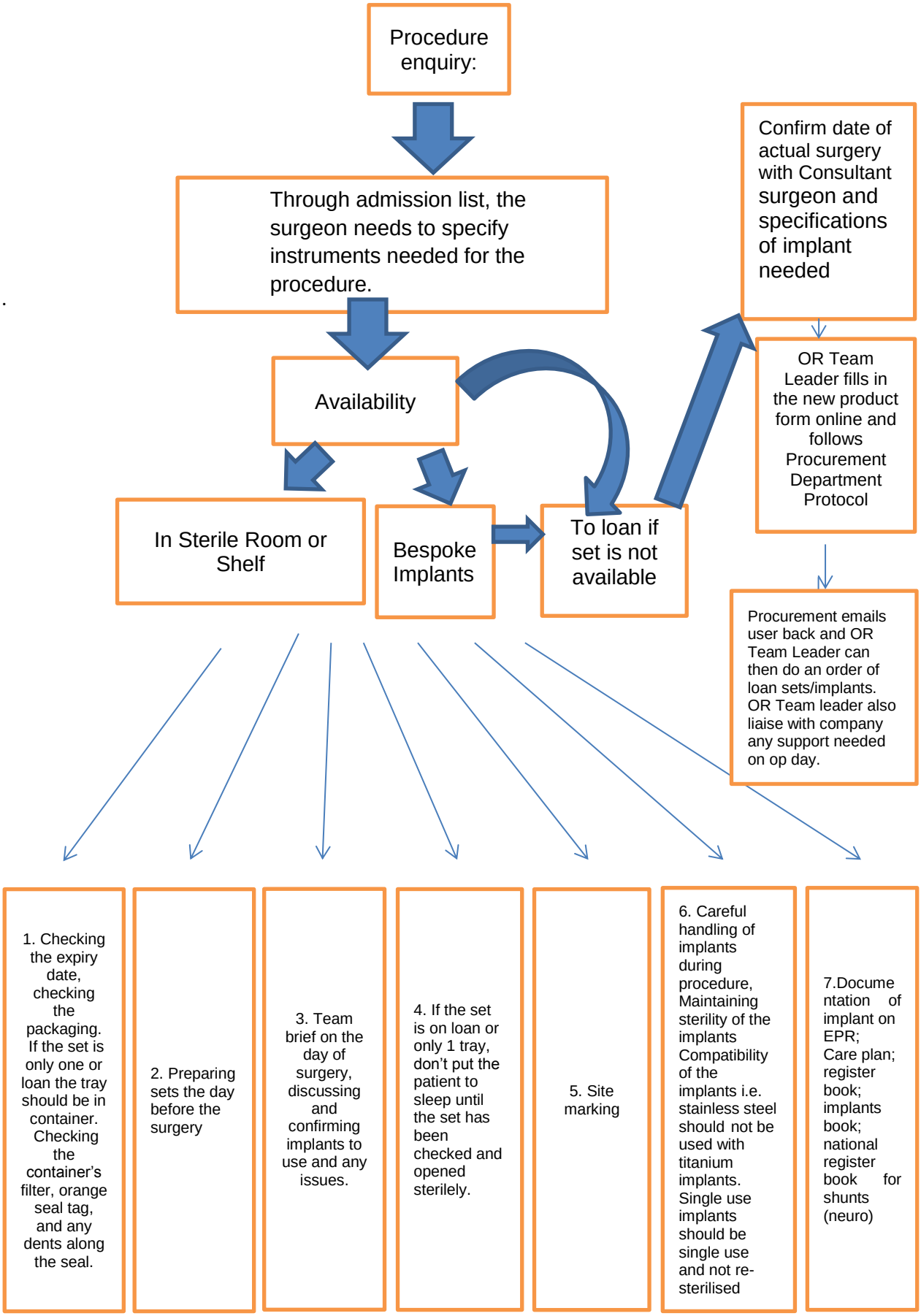


Appendix 5 – Surgical Safety Checklist 1

SAMPLE

Surgical safety checklist

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Team brief

Led by the surgeon, nurse or anaesthetist
Before starting the list

1. **Introductions.**
2. **Review each case the list**
   - **Concerns**
   - **Anticipated blood loss**
     - Where is the blood?
   - **Any special equipment, or one off sets?**
   - **Imaging?**
   - **Surgical Site Infection Bundle**
     - Antibiotics?
     - Warming?
   - **Infection Status?**
   - **Thrombo-prophylaxis?**
   - **Pregnancy testing?**
   - **Can we give a drink?**
   - **Throat pack?**
   - **Consent for Research Study if applicable?**
3. **Who is scrubbing/operating?**
4. **Any staffing/time issues?**
5. **Any outside issues?**
6. **Confirm list order**
7. **Who will be sending?**

Sign in

Led by the anaesthetist
Before induction of anaesthesia

1. **Identity of child against ID Band, list & consent**
2. **Surgical site marking**
3. **Ward pre-operative checklist**
4. **Anaesthetic machine & CGO switch checked**
5. **Allergy status**
6. **Paracetamol/Antibiotics given?**
7. **PEG/NG aspirated?**
8. **Procedure specific checks**
   - **Stop** before you **Block**!
   - One-off surgical set checked?
   - If Blood is needed, is it available?

Appendix 6 – Surgical Safety Checklist 2

SAMPLE

Surgical safety checklist

Great Ormond Street Hospital for Children NHS Foundation Trust

Time out

Led by a member of the theatre team. Before start of surgery.

1. **Introduce any new team members**
2. **Surgeon, Anaesthetist and Scrub Practitioner verbally confirm:**
   - Child's identity
   - Procedure, site, and position
   - Imaging
3. **Ensure anaesthetist confirms:**
   - ASA
   - Allergies
   - Antibiotics
   - Local anaesthetic dose
   - Any new concerns since induction
4. **Ensure Scrub team confirms:**
   - All relevant equipment available
   - TEDs and FLOWTRONs applied
   - Warming
   - Pressure areas checked
5. **Procedure-specific checks**
6. **Infection Status**

Sign out

Led by the circulating nurse. Before any team member leaves the OR.

1. **What have we done?**
2. **Have we checked against the consent?**
3. **Are all counts complete?** (instrument, swab, throat pack, sharps, guide wires)
4. **Are specimens labelled and how are we sending them?**
5. **Have there been any equipment problems?**
6. **What are the post-operative plans?**
7. **Procedure specific checks?**
8. **Infection Alerts/Status?**

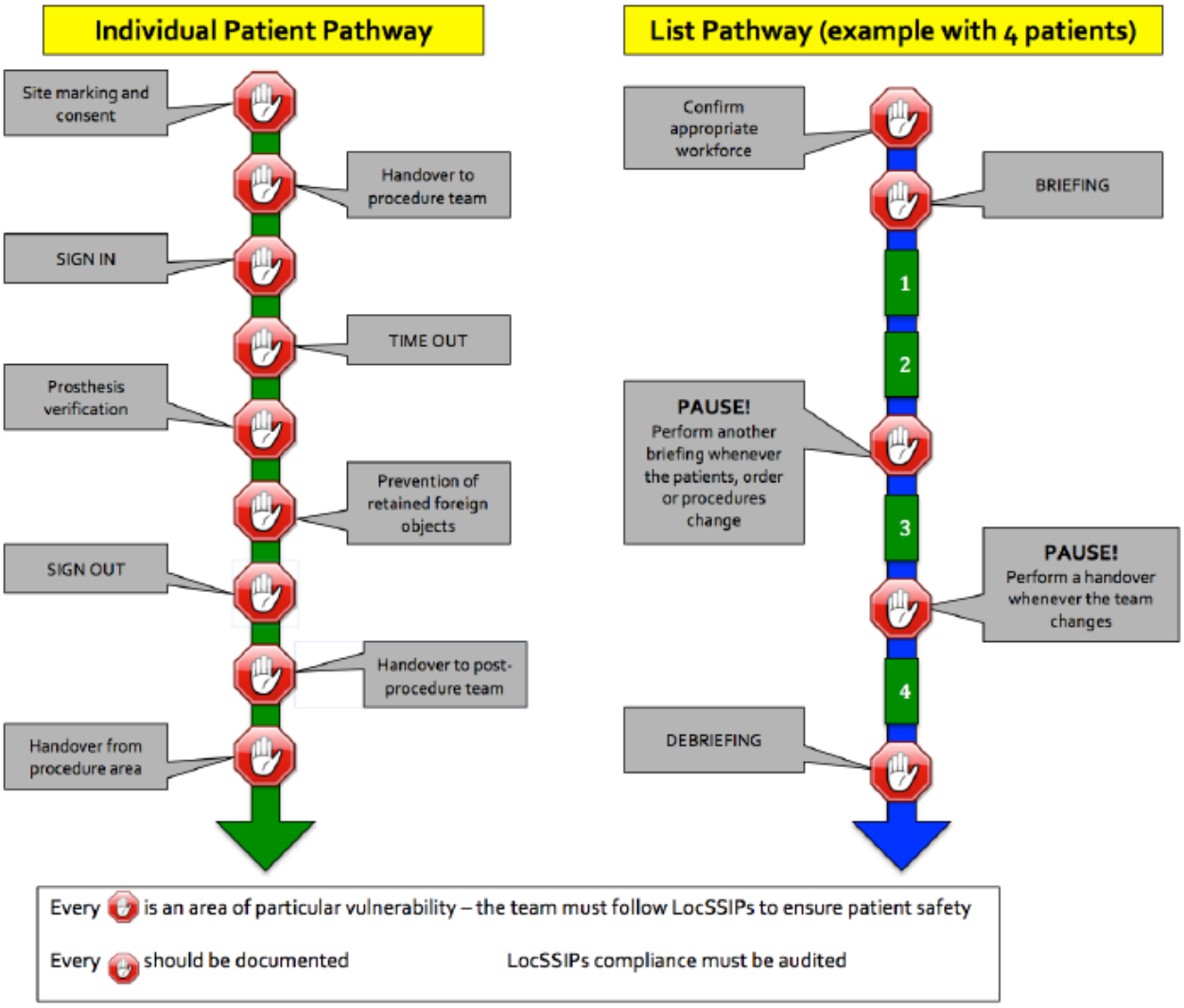
Team debrief

Led by the surgeon, nurse or anaesthetist. At the end of the list.

Review the printed list:

1. **How well was the Surgical Safety Checklist done today?**
2. **What worked well today? If relevant complete a praise form.**
3. **Were there any staffing, equipment or prosthesis issues?**
4. **What could improve for next time?**
5. **Were there any avoidable delays?**
6. **Did any incidents occur which require a Datix? If yes who will complete the Datix form?**

Appendix 7 – LocSSIP Process



Appendix 8 – LocSSIP template – Guidance for completion

SAMPLE

LocSSIP Template – Guidance for completion

Local Safety Standards for Invasive procedures *LocSSIPS are locally adapted safety standards for invasive procedures are based on the national standards including specialty specific procedures or group of procedures. These standards follow the patient through the procedural pathway, from referral, the initial decision to treat through, procedure and then to discharge.* *What is considered an invasive procedure? An invasive procedure is any procedure being performed where a hole is made or a body cavity is entered for diagnostic purposes or biopsy. If the answer is unclear, ask the question: Does the procedure have the potential to lead to a Never Event? If the answer to this is yes, this would bring the procedure under the remit of a LocSSIP.* *How to write a LocSSIP? The minimum requirements for developing a LocSSIP are listed under the main headings at the side of the template. Some steps will not be necessary, some can be combined and other details may need adapting to fit the local circumstances. Local processes need to be taken in account if they do not include every step.* *What should be done to get started? Review current SOPs to make sure they are compliant with the Trust Safety Standards for Invasive Procedures policy and the national guidelines. Some SOPs may need modification to make them LocSSIP compatible. Others may need to be fully developed to become compliant.* *Additional information:* • *All writing that is in italics should be used as guidance and be removed in the final document.* • *Appendices may be used to attach additional information.*

Definition of Invasive Procedures	All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, and other procedural areas within the organisation.

LocSSIP Template

Procedure Name or Group of Procedures:	
Specialty specific details	
Organisational steps	
Governance and Audit	• *What* • *When* • *How often* • *Attach proposed audit tool* • *Escalation plan for issues*
Education and Training	• *Induction* • *Human Factors, Team work, CRM* • *Frequent, Routine*
Team and environment induction requirements	• *Special requirements outside of the usual induction and competencies for the area*
Documentation	• *Aide memoire: check list localized modification should be reflected here* • *Clarify where the information regarding the procedure and the participants will be documented. For example: PIMS, Perioperative care plan, (Students, visitors?)*
Scheduling and List	• *Identification of equipment, prosthesis/implant, environment, services*

1

management considerations	• *Planning of list* • *Scheduling* • *Order* • *Length of Time* • *Unplanned procedures*
Workforce	• *Clearly identify the workforce necessary (minimum number and staff skill mix) needed to deliver care. Note procedures which take place out of working hours. Supervision for students, trainees and visitors.*
Sequential steps	
Site marking and consent	• *By whom?* • *Where completed?* • *Describe information to be used to confirm side and site of procedure.*
Team brief (safety brief) and list planning	• *Where does the brief occur?* • *Who should attend?* • *Who leads the brief?* • *When should it occur/beginning of each session, Procedure?* • *Introduction of the team.* • *Staffing issues/ availability.* • *Order of the list, alterations, reprint list.* • *Patients diagnosis /planned procedures, equipment, implants/prosthesis, instrumentation.* • *Anticipated blood loss and location of blood products if required.* • *Requirement for antibiotics, warming devices, venous thromboembolism prophylaxis.* • *Infectious Alerts?* • *Confirmation of the person who will be Nurse in charge and who is sending for the patients.*
Sign In	• *Where does this occur?* • *Who attends?* • *Who leads?* • *Verify correct patient, site, procedure with consent, list and patient/family/nurse.* • *Who documents?* • *Ward preoperative checklist reviewed.* • *Allergy status, Infectious Alerts* • *Last administration of antibiotics or paracetamol.* • *PEG/NG aspirated if present.* • *Procedure specific checks.*
Time out	• *When does this occur?* • *Where is it held?* • *Who attends?* • *Who leads?* • *Who documents?* • *Verification of patient, procedure, site, side, prior to skin incision.* • *Ward preoperative checklist reviewed.* • *Allergy status, Infectious Alerts* • *ASA* • *Confirmation of sterility of instruments and equipment.* • *Confirmation of the availability of the implant if needed.* • *Any equipment issues or concerns.* • *Requirement for antibiotics, warming devices, venous thromboembolism prophylaxis.*
Sign out	• *Confirmation of the procedure performed.* • *Confirmation of the site and side of the procedure.*

	• *Confirmation that all procedures on the consent form have been performed.* • *Confirmation that instrument, sharps and swab counts are complete and correct.* • *Confirmation that any specimens have been labelled correctly and include the patient's name, site and side where applicable* • *The operator and anaesthetist should discuss any post-procedure patient plans and concerns.* • *Discuss any issues/concerns such as with equipment, instruments, blood etc, Infectious Alerts*
Debrief	• *Where does this occur?* • *Who attends?* • *Who leads?* • *Discuss issues/concerns.* • *Discuss quality of communication (briefs, sign in, time out, sign out).* • *Document –debrief.* • *Discuss how and who to escalate issues identified.*
Prosthesis verification	• *Steps for communication* • *Steps for attaining (as with nonstock)* • *Steps for verification (consent, list, sterility, availability)*
Prevention of retained foreign objects	• *Who and when should verify correct counts?* • *Documentation of the process and who is involved.* • *Escalation process for discrepancies.* • *Process to be followed and documentation for intentionally retained items*
Handover	• *Where does this occur?* • *Who attends?* • *Who leads?* • *Discuss issues/concerns* • *Identification of the patient* • *Past medical history* • *Allergies* • *Special precautions* • *Intraoperative events,* • *Medications* • *Lines in place and fluids attached* • *Post-operative plan* • *Infectious Alert*

Document Approval

Date: .....

Head of Clinical Service .....

Matron.....

Assistant Chief Nurse.....

Safety Standards for Invasive Procedures Group.....

Review Date: .....

Appendix 9 – LocSSIP blank template

SAMPLE

(Procedure Name)

Procedure Name or Group of Procedures:	
Specialty specific details	
Governance and Audit	
Education and Training	
Scheduling and List management considerations	
Documentation	
Workforce	
Site marking and consent	
Team brief (safety brief) and list planning	
Sign In	
Time out	
Sign out	
Handover	
Prosthesis verification	
Prevention of retained foreign objects	
Debrief	

Document Approval

Head of Clinical Service ..... .

Matron .....

Assistant Chief Nurse.....

Safety Standards for Invasive Procedures Lead.....

Review Date: ....

Appendix 10 – Equality Impact Assessment

Title of Document:	Safety Standards for Invasive Procedures
Completed By:	Kathryn Fawkes
Date Completed:	2018
Summary of Stakeholder Feedback:	Feedback received from a range of internal stakeholders with no specific issues raised.

Potential Equality Impacts and Issues Identified		
Protected Group	**Potential Issues Identified**	**Actions to Mitigate / Opportunities to Promote**
Age	This policy is relevant to all patients of all ages.	Age and cognitive abilities should be considered in all aspects of the patient pathway.
Disability (Including Learning Disability)	Potential issue when obtaining consent from a patient with a learning disability.	Disabilities will be considered on an individual basis and policies will be followed. In the case of obtaining procedural consent the Consent Policy will be followed.
Gender Re-Assignment	None	NA
Marriage or Civil Partnership	Potential issue with Parental Responsibility	See Consent Policy
Pregnancy and Maternity	Pregnancy testing is to be performed on all females of child bearing age prior to an invasive procedure. Issues arise when the testing is not performed or there is a positive result.	Follow the pregnancy testing policy for patients having an invasive procedure.
Race	Potential issues with individuals who do not speak English.	Use available interpreters, interpreter services and translations to enable clear communication.
Religion or Belief	Potential issues related to religion or belief.	See Consent Policy
Sex	None	NA
Sexual Orientation	None	NA