Check, check and check again

NatSSIPs standards play a vital role in reducing misdiagnosis, says **Annie Hunningher**

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When you look back, it seems strange that in the past many of us will have worked in an operating theatre without a checklist. It is like getting into a car without a seat belt. The world has changed, as has our understanding of risk and human fallibility. We are not perfect, and we need tools to help us.

In 2007, WHO Patient Safety launched the second Global Patient Safety Challenge: 'Safe Surgery Saves Lives.' They brought together an international group of experts and a surgical team to devise the WHO Surgical Safety Checklist.

As we learned to understand the human factor, we understood the increasing need to build safety into a complex system and reduce avoidable harm, morbidity and mortality. Checklists help us to do this through standardisation of key aspects of care and by building situational awareness, communication, safety culture and teamwork.

How the checklist is implemented is important, as is the checklist being deployed in the way it was intended. We have all seen checklists used and implemented in the wrong way, where compliance trumps meaningful engagement.

In 2015, NHS England published NatSSIPs 1 (the National Safety Standards for Invasive Procedures) to help NHS organisations reduce patient safety incidents related to invasive procedures, with a focus on surgical 'never events', which in surgery include the big three: wrong site surgery, retained foreign object and wrong implant. NatSSIPs 1 provided a set of national standards of operating department practice that were developed to support all providers of NHS-funded care to develop and maintain more detailed standardised local procedures, which included use of checklists but also went further into the sequential steps needed. It included the aim of standardisation, harmonisation and education across specialties, including surgical but also invasive specialties such as interventional radiology.

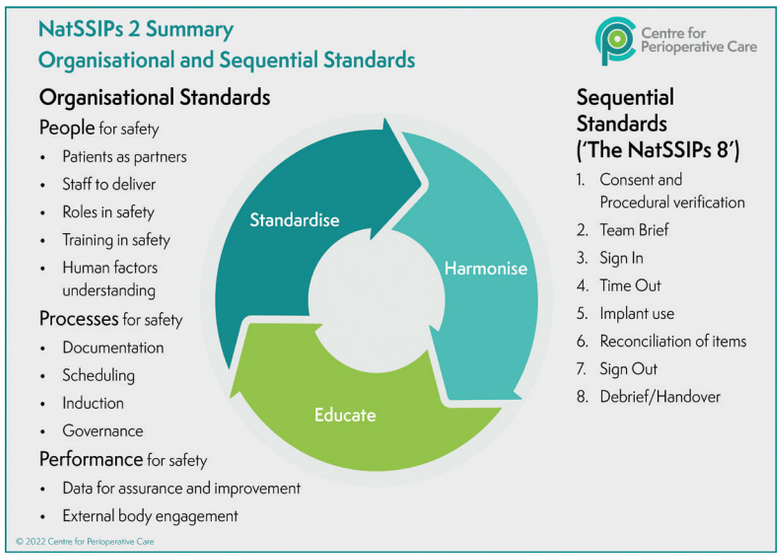
In 2023, NatSSIPs was revised with the Centre for Perioperative Care (CPOC) and with wider involvement including patients, clinicians and stakeholders. The key aim of the update was to be proportionate in the application of standards to risk and to recognise that, unless a team sees value in a check or stop moment, they will not do it. This allowed consideration of safety science, including psychological safety, safety culture and systems thinking.

The central focus of the patient and their role in the checks was reinforced, with a need not only for teams to follow the sequential steps but also the organisational standards. NatSSIPs 2 categorised procedures into major or minor, each requiring different checks proportionate to the risk of harm. NatSSIPs 2 goes beyond surgical areas into any invasive procedure, which might include outpatient, maternity, interventional and cardiology procedures. It updated the WHO five steps to safer surgery to include three more steps to make the 'The NatSSIPs Eight' of Sequential Standards (Steps). They form the basis of an 'enhanced local standard' WHO Checklist or specialty-specific checklists in some settings.

As part of the NatSSIPs work, we have been doing qualitative visits into theatres. An example on a recent safety visit was a biopsy specimen from a patient that was not labelled with the patient details, and at Sign Out the team confirmed the sample was labelled when it was not. The patient left the theatre for recovery leaving an unlabelled sample on the trolley. On further discussion, it was an issue with the printer and the access, which meant that only the surgeon could print the label when he was de-scrubbed.

Compliance data would not have picked up this risk and only by seeing 'Work as Done' can we work with teams to improve safety and the system. NatSSIPs can help with misdiagnosis by improving team communication and situational awareness through better teamwork. Using safety tools such as the SEIPS (Systems Engineering Initiative for Patient Safety) model can help us understand the system, not just the human/person elements.

Successful, sustained benefit from NatSSIPs will occur only in the context of full engagement with both the Organisational and Sequential Standards and a recognition that safety improvement and reducing misdiagnosis needs to be intentional. It doesn't happen by luck!



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