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No. 286-Surgical Safety Checklist in Obstetrics and Gynaecology

This clinical practice guideline has been reviewed by the Clinical Practice Gynaecology Committee and reviewed and approved by the Executive and Council of The Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Patient safety, surgical safety checklist, obstetrics, gynaecology, emergency care

Abstract

Objective: To provide guidance on the implementation of a surgical safety checklist in the practice of obstetrics and gynaecology.

Outcomes: Outcomes evaluated include the impact of the surgical safety checklist on surgical morbidity and mortality.

Evidence: Medline databases were searched for articles on subjects related to "surgical safety checklist" published in English from January 2001 to January 2011. Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. Searches were updated on a regular basis and incorporated in the guideline to January 2012.

Values: The quality of evidence was rated with use of the criteria described by the Canadian Task Force on Preventive Health Care. Recommendations for practice were ranked according to the method described by the Task Force (Table).

Benefits, harms, and costs: Implementation of the guideline recommendations will improve the health and well-being of women undergoing obstetrical or gynaecologic surgery.

Summary Statements:

1. Surgery may account for up to 40% of all hospital adverse events (II-2).
2. Good communication is essential for safer surgical care, as communication failure is common in the operating room (III).
3. The concept of a surgical safety checklist has been studied globally, and there have been decreases in complications and mortality when the checklist has been implemented (II-1).
4. Emergency cases such as a "crash" Caesarean section will require a modified approach that is centre- and situation- dependent (III).
5. The SOGC endorses the adoption of the surgical safety checklist in obstetrics and gynaecology (III).

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Table. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment[a]	Classification of recommendations[b]
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

Taken from: Woolf SH, et al.; and the Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

[a]The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

[b]Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Recommendations:

1. The surgical safety checklist should be adopted by all surgical care providers and their respective institutions to improve patient safety (II-1A).
2. Surgeons should be familiar with, advocate for the use of, and participate in all 3 parts of the surgical safety checklist (II-1A).
3. The surgical safety checklist may be modified and adapted for use in surgical obstetrics cases (II-2A).