MEETING ABSTRACT

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Leak in Surgical Safety Checklist?

Franz J Fellacher¹, Doris Walter², Daniel Aldrian², Franz J Seibert¹, Renate Krassnig^{1*}

From Safety in hospitals: from strategy to implementation Annual Scientific Meeting 2015 Graz, Austria. 29-30 September 2015

Background

Since the dawn of surgery patient safety has been a major issue. In 2008 the WHO Surgical Safety Checklist was developed after extensive consultation, aiming to decrease errors and adverse effects. The WHO Checklist is used originally or based on by a majority of surgical providers around the world - even with us. Nevertheless, mistakes happen.

Material and methods

We report a case that has taken place in our department, supplemented by literature review.

Modified WHO Safety Checklist has been used in our department since a couple of years ago. Although "Team Time Out" was performed standardly following unpleasant situation happened: after an elective arthroscopy, while the surgeon finished documentation, the responsible nurse informed him that the indicator strip for sterility did not show any discoloration.

No one of the operating room personal knew whether the indicator strip was not checked or if it had been overlooked although a modified WHO Surgical Safety Checklist was performed carefully.

Subsequently the question arose, what does it mean to the patient if surgical instruments were not sterilized but only cleaned by Washer-Disinfector.

Results

The patient has not suffered any infection. Review of the literature has shown that the machine washer-disinfector consistently reduces microorganisms [1]. The risk of transmission of infection may be considered negligible [2].

Conclusion

Despite the use of checklists, errors still happen. Everyone on the team is required not only to do their own



¹Department of Trauma Surgery, Medical University of Graz, Graz, Austria Full list of author information is available at the end of the article



Figure 1 Indicator strip for sterility (black=sterility is given; white=sterility not given).

part. Moreover, everyone is required to take care of "the whole big picture".

Competing interests

There are no financial interests to declare.

Authors' details

¹Department of Trauma Surgery, Medical University of Graz, Graz, Austria. ²Department of General Surgery, University Hospital Graz, Graz, Austria.

Published: 30 October 2015

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doi:10.1186/2056-5917-1-S1-A18

Cite this article as: Fellacher *et al.*: **Leak in Surgical Safety Checklist?** *Safety in Health* 2015 1(Suppl 1):A18.

