

## Is it possible to reduce surgical error in our hospitals? “Yes, we can!”

Every year more than 2 million people undergo a surgical operating room procedure across Australia and New Zealand<sup>1</sup>. It is now clear that the rate death associated with those operations is around one person in 200 and, in addition, one person in every 10 suffers a preventable event that causes them harm.

This means that every year over 10,000 people die and more than 200,000 people suffer preventable harm as a result of undergoing an operation. To put this in perspective, five times more people die or are seriously injured by surgery than in road traffic accidents. Surgery is the cause of a major health risk to our community.

Events like these can be tragic for the patient, traumatic for health staff and damaging for the reputation (and budget) of a hospital. Despite this, efforts to improve the situation have been patchy and are often resisted by patients and staff who may not see the benefit of changing the way they work. Implementing change in health is difficult, slow and sometimes expensive. Naturally enough leaders, managers and clinicians look for some evidence before embarking on significant change.

New information from a number of hospitals, including the Auckland City Hospital, has become available, demonstrating that the use of a simple [Surgical Safety Checklist](#) can significantly reduce both death and complications from surgery by up to 40%<sup>2</sup>. Developed originally by the WHO, the checklist can be completed in minutes at three critical points

1. before the anaesthetic is administered,
2. before skin incision and
3. before the patient leaves the operating theatre.

This simple checklist has the potential to save hundreds of lives and prevent tens of thousands of surgical complications.

In the UK, this initiative is seen as so important that the checklist has now been mandated for all NHS hospitals and is being progressively rolled out over the next 12 months. The use of this checklist should be a core part of safety and quality improvements of all hospitals in Australia and New Zealand.

For further information on this or other safety and quality initiatives and their implementation, contact Dr Michael Smith at [ss.associates@bigpond.com](mailto:ss.associates@bigpond.com) (Tel +61 2 4702 6952)

SpencerSmith and Associates Pty Ltd is an independent consulting firm specialising on safety and quality policy, planning and implementation in healthcare; executive health services planning and management and clinical and non-clinical organisational review and investigation.

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<sup>1</sup> Weiser TG, Regenbogen SE, Thompson KD, et al. *An estimation of the global volume of surgery: a modelling strategy based on available data*. Lancet 2008;372:139-44.

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<sup>2</sup> Haynes AB, Weiser TG, Berry RW et al. *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population*. NEJM 2009 Jan 29;360(5):491-9. Epub 2009 Jan 14 at <http://content.nejm.org/cgi/content/full/NEJMsa0810119>