Local Safety Standards for Invasive Procedures based on NatSSIPs

THE HEADLINES


Barts Health LocSSIPS:
Standardise
Harmonise
Educate
Safer systems – safer culture

The National Safety Standards for Invasive Procedures (NatSSIPs)

This document sets out the Headlines of the Barts Health Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs. There are occasional, specialty-specific caveats to these Headlines which can be found in the full versions of the LocSSIPs.

These standards are a **minimum**, based on national best practice, to improve safety. They apply to **all staff and all services** that perform invasive procedures, and are the standards we expect here at Barts Health NHS Trust.

Alistair Chesser
Chief Medical Officer

Caroline Alexander
Chief Nurse

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Sequential Steps
‘The NatSSIPs Eight’

1. Procedural verification and site marking

'Correct procedures on the correct sites and sides'

1. The procedure and any laterality must be written without abbreviation on the consent form.

2. If the consent form has laterality, the patient must be marked:

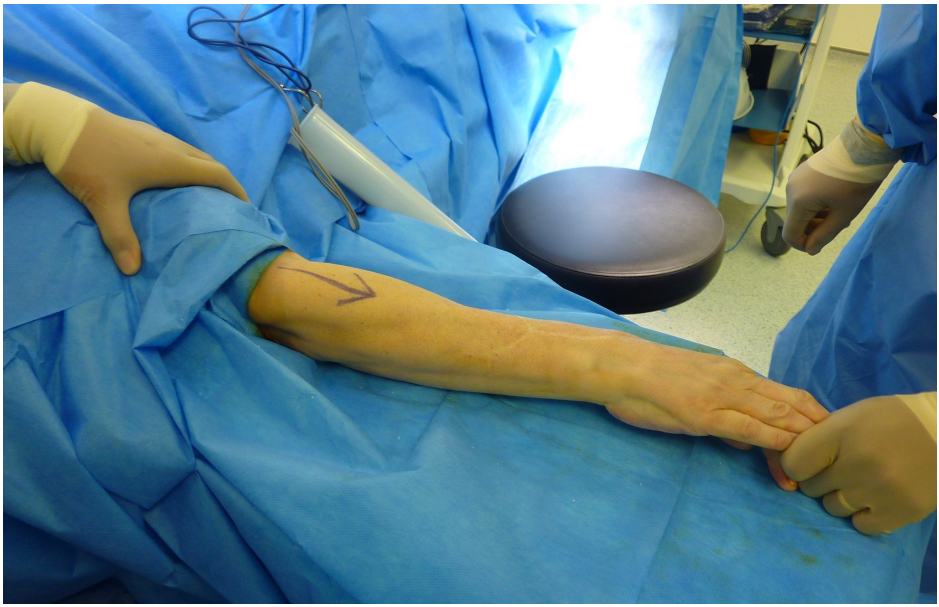
- **All superficial and limb procedures must be marked:** even if the site is obvious. The only exception is procedures on single midline structures where there is no laterality.

- **For procedures on internal structures, the skin must be marked when the target organ or lesion has laterality**: this applies whether the entry points are generic (such as laparotomy, laparoscopy or endovascular procedures), lateralised (such as craniotomy or nephrostomy) or through a natural orifice (such as the mouth): this mark should be on the correct side of the body and within the operative field *wherever possible*. If there is no laterality or laterality is unclear preoperatively, the patient should not be marked. Left and right hemicolectomy are not included as they are part of the same organ.

- **Palmer notation and a whiteboard must be used for dental procedures:** this must be clearly documented on the consent form, checklist and whiteboard. Skin marking can be used but is not mandatory.

- **Spinal procedures must be marked with the spinal level in words in the operative field:** the exact level must then be confirmed with image guidance intraoperatively.

3. If procedure site cannot be determined until on-table imaging has been performed (such as vascular access procedures), site marking is not necessary.



4. **The operator must mark the patient themselves on the ward**: the procedure site must be marked shortly before the procedure (but not in the anaesthetic room or the procedure room), by the operator or a nominated deputy who will be present during the procedure.

5. **An indelible marker must be used.**

6. **Wherever possible the mark should be an arrow that will remain visible in the operative field:** after preparation of the patient and application of drapes. If marking within the operative field could cause harm to the patient, a mark for laterality or the spinal level outside the field is acceptable.

2. Team Brief

'Opening communication channels to plan safer care'

1. **All planned procedure sessions must start with a Team Brief:** for elective sessions, this team must involve the operator(s). For emergency sessions (such as the emergency theatre), where the identity of potential operators during the course of a session is unknown, Team Brief should be conducted by the emergency anaesthetic and scrub team alone. A case-by-case brief should then occur with the respective operating teams when their patient arrives. For planned minor procedure sessions, the team members and format necessary for Team Brief should be decided locally. Team Brief is not required for one-off procedures in minor areas.

2. **Set time:** the briefing should occur at an agreed time and on time. Time for Team Brief should be included in staff job plans.

3. **All team members should be present and introduce themselves:** the whole team should be present and confirm their names and roles. For elective sessions, Team Brief should not start without the lead operator and the lead anaesthetist (if applicable) present. This will usually mean the job-planned consultant(s) for elective lists. In the exceptional circumstance where this responsibility needs to be delegated, their colleague must be able to perform the procedure independently and must be able to convey the lead's requirements and plan to the procedural team. For emergency sessions and unplanned procedures, this should be modified locally as necessary.

4. **An open culture:** briefings encourage an environment of openness, flattened hierarchy and mutual respect.

5. **Any team member can lead:** they should ensure that the whole team is listening and participating and that interruptions are avoided.

6. **Discuss every patient and keep a record:** each patient should be discussed in list order from the perspective of the operator, operator's assistant and the anaesthetist. A record of this should be visible during the procedure session.

- Planned procedure and laterality
- Allergy status
- Stent, prosthesis or implant availability
- Equipment requirements
- Relevant comorbidities
- Patient positioning and associated risks
- Postoperative destination
- Infection risks

7. **Report any issues identified:** any issues raised at Team Brief that may have relevance for the care given to other patients should be reported via the incident reporting system.

3. Sign In

'The final safety check before anaesthesia'

1. All patients must undergo sign in using a checklist: all patients under general, regional or local anaesthesia, or under sedation, must undergo Sign In. Specialty-specific checklists and checklists for minor procedures are available and should be used where appropriate. In minor procedure areas, and others where appropriate, Sign In and Time Out may be merged for speed and ease of use.

2. Two-person check: for procedures performed under sedation or general / regional anaesthesia, this should be the anaesthetist and anaesthetic assistant. For procedures not involving an anaesthetist, the operator and an assistant should perform Sign In.

3. Provision must be made for those who cannot speak English or have other communication difficulties: trust-registered interpreters should come into the anaesthetic room or procedure area, or an adult family member if this is not possible. Otherwise, the consenter should be present to confirm prior comprehension via the interpreter.

4. Safety checks must include the following in major *and* minor procedure areas:

- Patient name, date of birth and medical record number check with the patient and the consent form. In major procedure areas, it must also be checked against the printed identity band, Care Plan and operating list. Identity bands are recommended wherever possible in minor procedure areas.
- Consent form checks to confirm the absence of abbreviations, understanding of patient and date of consent.
- Site marking, if applicable, to be cross-checked with patient, consent and operating list.
- Allergy status.

5. Safety checks should also include the following where appropriate:

- Pregnancy status.
- Infection risk to staff .
- Starvation time.
- VTE stockings.
- Anaesthetic and emergency equipment checks.
- Arrangements in case of blood loss.
- Regional ‘Stop Before You Block’ checks.
- Availability of essential instrumentation.
- Availability of stents, prostheses and implants.
- Any existing metalwork.
- Availability of additional staff.
- Others to be decided locally as appropriate.

4. Time Out

'The final safety check before the procedure'

1. **All patients must undergo Time Out using a checklist:** all patients under general, regional or local anaesthesia, or under sedation, must undergo Time Out. Specialty-specific, emergency and minor procedure checklists are available, and should be used where appropriate. In minor procedure areas, and others where appropriate, Sign In and Time Out may be merged for speed and ease of use.
2. **All team members should be present and introduce themselves:** this should occur for the first patient on the list- if staff change after Team Brief, and if team members subsequently change.
3. **Any team member can lead, but the operator carries responsibility:** they should ensure the whole team is listening and participating.
4. **Immediately before the procedure:** Time Out must occur prior to the procedure and before skin preparation and draping, but prior urinary catheterisation is allowed.
5. **Encourage the patient / parent to be involved:** if appropriate.
6. **Safety checks must include the following in major *and* minor procedure areas:**

- Reconfirmation of patient identity, procedure, consent and site marking as per the Sign In LocSSIP.
- Allergy, pregnancy and infection status, if appropriate.
- Any critical or unexpected procedural steps. Any specific equipment requirements or special investigations. Relevant imaging / tests / implants available.
- Confirmation of sterility of instruments and equipment. Any equipment issues or concerns.

7. Safety checks should also include the following where appropriate:

- Anticipated blood loss.
- Confirmation of any existing intentional foreign objects *in situ*, e.g. packs.
- Any anaesthetic concerns; monitoring equipment and other specific support, e.g. blood availability; mortality risk,
- Procedural site infection prevention: antibiotic prophylaxis; patient warming; glycaemic control; hair removal if required.
- Venous thromboembolism prophylaxis.
- Others to be decided locally as appropriate, e.g. perfusion checks

8. A new Time Out should be performed during the case if doing separate, sequential procedures on the same patient with different operating systems.

5. Stent, prosthesis and implant (SPI) verification

'Correct prosthesis, correct process, every time'

1. Stents, prostheses and implants (SPI): these are defined as permanent internal or external medical devices for the artificial replacement of absent or impaired structures.

2. Pre-operative communication of requirements by the operating team is essential: this allows accurate planning. The specialist nurse for each procedural area is responsible for efficient management and ordering of stocks.

3. Stents, prostheses and implants must undergo separate checks (if type-critical) to reduce the risk of a wrong prosthesis

SPI availability must occur as part of Sign In, prior to anaesthesia or sedation. Ideally this should be at the time of Team Brief in order to prevent patients being sent for unnecessarily, but it can be incorporated into the main Sign In checks when the patient arrives in the procedure area. The chosen size and type should be written on the theatre whiteboard (if in theatres).

SPI verification must occur for type-critical stents, prosthesis or stents and requires a two person visual and verbal check that must occur between the scrub practitioner and the operator. The following should be verbally confirmed by both:

- Type, design, style or material
- Size
- Side (if applicable)
- Expiry date
- Sterility
- Compatibility of multi-component device (if applicable)
- Any other required characteristics

SPI confirmation must form part of Sign Out checks when an SPI has been implanted. Confirmation that a two person check was performed must be documented on the checklist. The product label must be confirmed to match the procedural site and side and the product details added to the operation record, Care Plan, theatre record and specialty-specific registers, if applicable.

6. Prevention of retained foreign objects

'Nothing unintended left behind'

1. **Prevention of retained foreign objects is everyone's responsibility**
2. **Items included in the count should be understood by the teams using them:** the integrity of all items must be checked before and after use.
3. **Full count procedures are used for all procedures in operating theatres; labour ward rooms, and at any other time when swabs, sharps and instruments are used and there is a cavity large enough to retain them. The full trust policy on accounting for items must be followed.** This also applies in other areas when 'surgical' procedures are occasionally performed, such as the interventional radiology and emergency departments.

- Two trained staff must perform the count
- The count must be performed:
    1. At baseline (and include any existing intentional foreign objects *in situ* and anaesthetic packs).
    2. Before intentionally packing a cavity.
    3. Before closure of a cavity, major organ or joint
    4. At the end of the procedure.
    5. Any time a discrepancy is suspected.
- The trust count board must be used, with standard notation and documentation.
- Staff must be allowed to count without distraction.
- Any item that enters the surgical field must be accounted for including swabs, instruments, sharps, disposable items and packs. All swabs entering the operative field must contain radio-opaque markers and be uncut. This includes throat packs.
- Staff handovers should be avoided unless absolutely essential.
- In the event of failed reconciliation the operator must be informed, the count repeated and the theatre and operating site searched. If unsuccessful, x-ray should be used at the discretion of the operator and a risk-benefit decision made as to the item's retrieval.

4. **Abbreviated count procedures are used when procedures are performed outside of theatres via incisions too small to retain objects, via needle punctures or via natural orifices without the insertion of swabs. An abbreviated count to confirm the presence of intact equipment and the removal of any wire is sufficient:** this will apply to the majority of radiology, cardiology, endoscopy and minor procedures.

- Two members of staff (the operator and their assistant) must perform the check verbally.
- This check should be modified or augmented by individual areas as necessary to mitigate their particular risks for retained objects.

5. **Intentionally retained objects:** the standard *Pink for Packs* procedure should be followed, including a pink wristband, pink sticker, clear documentation and a patient leaflet.

7. Sign Out

'Count and procedural confirmation with planning for postoperative care'

1. **All patients must undergo Sign Out using a checklist:** all patients who have had procedures under general, regional or local anaesthesia, or under sedation, must undergo Sign Out. Specialty-specific and minor procedure checklists are available and should be used where appropriate.

2. **All team members should still be present:** as a minimum, this must include the operator, the operator's assistant and the anaesthetist (if applicable).

3. **Any team member can lead, but the operator carries responsibility:** they should ensure the whole team is listening and participating.

4. **It must be completed before the patient leaves the procedure room:** Sign Out must only occur once wound dressings are in place and the count is complete, but before the patient leaves the room.

5. **Safety checks must include the following in major *and* minor procedure areas:**

- Confirmation of the exact name of the procedure, site and side; this may have been altered or expanded.
- Estimated blood loss.
- Any specimens must be labelled correctly and in the correct container.
- Confirmation of a correct count including instruments, swabs, throat packs and sharps. All items must be confirmed to be intact.
- Confirmation of any intentionally retained items (if appropriate) and the presence of pink wristbands and stickers as per the *Pink for Packs* procedure.
- Stent, prosthesis and implant check if applicable.
- Key surgical and anaesthetic plans for recovery and postoperative management including level of care.
- VTE risk assessment is completed.
- IV lines are flushed and unnecessary extensions removed.
- The patient is still wearing electronic wrist bands.

6. Sign Out must also include the following where appropriate:

- Drain and clamp instructions.
- VTE prophylaxis prescription.
- Responsibility assigned for talking to the patient and or family.
- Others to be decided locally as appropriate.

7. Sign Out must not end until all steps to prevent retained foreign objects are complete: if *Pink for Packs* wristbands and stickers are not in place or a throat pack has not yet been removed, Sign Out must stop and wait until these have been done.

8. Notes should be completed as soon as feasible: the procedure notes and Care Plan (in major areas) should be completed by the operator and scrub practitioner or operator's assistant as soon as possible. Take-home medication should be prescribed for day-case patients.

8. Debrief

'What went well and how can we improve?'

1. All elective major procedure sessions should end with a debrief: although sometimes logistically difficult to arrange, Debrief allows the team to provide feedback on the session before facts are forgotten. This feedback can be used to improve future work and should thus be prioritised.

2. Debrief also applies to minor procedure sessions: local modifications as necessary should be encouraged to make it practical and useful for individual areas.

3. Points of interest should be captured during the session to ensure they are not forgotten at the end: issues should be identified during the list and captured for summary and discussion at the end.

4. Debrief should occur on a case-by-case basis during emergency sessions or one-off minor procedures: a flexible approach is needed when the composition of the team is constantly changing.

5. Dedicated time: job plans, scheduling and working patterns should allow and oblige staff to participate in Debrief.

6. Involve the whole team: every member of the procedural team should be encouraged to take part and offer suggestions for future improvement.

7. Key elements to discuss:

- Things that went well
- Problems identified and plans to address these
- Areas for improvement

8. Maintain a debrief action log:

- Problems identified
- Action taking place to resolve the issue
- Named member of staff leading on the action
- Timeframe for action

9. Share and learn from themes in the debrief: these should be openly available and shared with the wider procedural team. Local governance processes must ensure that any issues identified lead to learning and improvement.

Major invasive procedure | ADULT

NatSSIPs

NHS Barts Health NHS Trust

1 Patient's name 2 DOB DD MM YYYY 3 MRN

Date DD MM YYYY Procedure

SIGN IN BEFORE ANAESTHESIA

Two-person check – anaesthetist and ODP

Patient's details

Patient confirmed name, DOB, procedure and site? Yes ☐ N/A ☐

Information, including MRN, matches wristbands, consent form, operating list and notes? Yes ☐

Consent form within date (48 hrs) and no abbreviations? Yes ☐

Procedure site correctly marked? (indelible arrow in field) Yes ☐ N/A ☐

Allergy present? No ☐ Yes ☐ Check red bands in place

Allergy:

Care plan

Care plan complete and signed? Yes ☐

Have you checked:

Pregnancy status? Yes ☐ N/A ☐

Infection risk? (to staff) Yes ☐

Starvation time? Yes ☐

VTE stockings? Yes ☐ N/A ☐

Procedural checks

Difficult airway or aspiration risk? No ☐ Yes ☐ Check equipment and assistance

Risk of blood loss more than 500ml? No ☐ Yes ☐ Check adequate IV access, valid G & S, blood available

Regional anaesthetic block planned? No ☐ Yes ☐ ***Stop before you block*** checks required

SPI

If stent, prosthesis or implant (SPI) planned, is it available? Yes ☐ N/A ☐

Reg practitioner completing SIGN IN

Name (PRINT) Signature

TIME OUT BEFORE PROCEDURE

All team members present and focused

Team checks

Team members introduced by name and role? Yes ☐

Patient's name, DOB, MRN and consent confirmed? Yes ☐

Marking and positioning agrees with consent form? Yes ☐

Allergy status and infection risk confirmed? Yes ☐

Surgeons/operators

Critical steps/events? Discussed ☐

Anticipated blood loss? Discussed ☐

Specific equipment requirements/ investigations? Discussed ☐

Anaesthetists

Patient-specific concerns? Discussed ☐

Specific monitoring/support (eg blood)? Discussed ☐

Mortality risk: Under 5% ☐ Calculated ..... %

Nurses/ODPs

Any existing packs, including throat packs, in situ? No ☐ Yes ☐ Check added to count

Sterility of instruments confirmed? Yes ☐

Equipment issues/concerns? Discussed ☐

Last checks

Surgical site infection bundle undertaken? (antibiotics, warming, hair removal, glycaemic control) Yes ☐

Calf compressors if procedure over 30 mins? N/A ☐ Yes ☐

Imaging displayed? N/A ☐ Yes ☐

Reg practitioner completing TIME OUT

Name (PRINT) Signature

SIGN OUT BEFORE LEAVING THEATRE

All team members present and focused

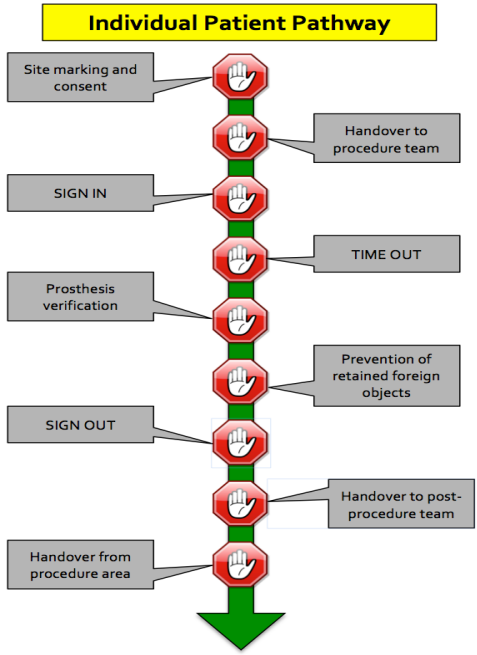
Registered practitioner and surgeon/operator to confirm with team:		
Exact procedure performed?		Yes ☐
Estimated blood loss		ml .....
Specimens correctly labelled?	N/A ☐	Yes ☐
Throat pack removed?	N/A ☐	Yes ☐
Are all counts correct?	No ☐ Follow Trust policy	Yes ☐
Any intentionally retained swabs or packs?	No ☐	Yes ☐ Check confirmed with pink wristband/sticker
SPI If type-critical stent, prosthesis or implant used, was a two-person check performed before insertion?	N/A ☐	Yes ☐

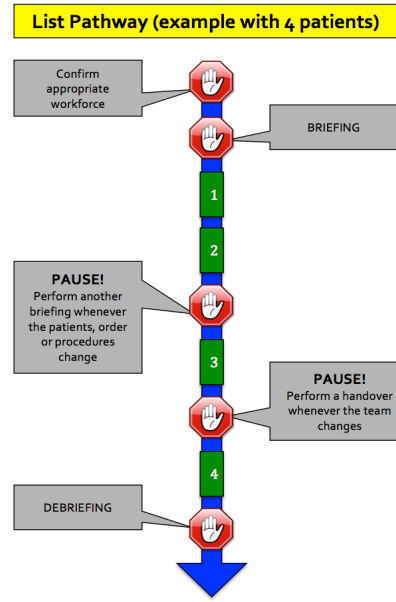
Post-operative handover plans: all team to confirm		
Surgical plan		
Drain instructions discussed and documented?	N/A ☐	Yes ☐
VTE risk assessment signed?		Yes ☐
VTE prophylaxis prescribed?	No ☐	Yes ☐
Specific surgical concerns for recovery discussed and documented?		Yes ☐
Anaesthetic plan		
All IV lines flushed and any unnecessary lines/connectors/giving sets removed?		Yes ☐
Specific anaesthetic concerns for recovery discussed and documented?		Yes ☐ Level of care required .....
Final reminders		
Patient still wearing electronic wristband(s)?		Yes ☐
All information recorded in notes +/- TTAs completed?		Yes ☐
Should anyone talk to the patient +/– family?	No ☐	Yes ☐

Registered practitioner completing SIGN OUT	
Name (PRINT)	Signature

HANDOVER TO RECOVERY

See handover headlines for level 2 HDU patients


Individual Patient Pathway
Site marking and consent
Handover to procedure team
SIGN IN
TIME OUT
Prosthesis verification
Prevention of retained foreign objects
SIGN OUT
Handover to post-procedure team
Handover from procedure area


List Pathway (example with 4 patients)
Confirm appropriate workforce
BRIEFING
1
2
PAUSE!
Perform another briefing whenever the patients, order or procedures change
3
PAUSE!
Perform a handover whenever the team changes
4
DEBRIEFING

Organisational Standards

1. Governance and audit

'A safety culture and system that is proactive, as well as reactive'

1. **There should be a visible clinical governance system with clear leadership** that provides accountability and emphasises proactive improvement as well as reactive responses.

2. **Clinical improvement and governance groups/meetings should be open and include the multidisciplinary team (MDT).** These include mortality & morbidity meetings, ward or service meetings and local governance meetings. They should be minuted, with actions recorded and reviewed.

3. **Management of incidents:** a higher reporting rate equals a safer system. All incidents, including near misses, should be reported via Datix and reporters should expect a response and be involved in solutions. There should be a just culture and no fear of repercussion.

4. **Management of serious incidents**: incidents graded as moderate harm or above should undergo assessment and review by an MDT. Actions should be SMART (Specific, Measurable, Achievable, Relevant, Time-specific).

5. **Management of patient concerns, compliments and complaints** should be seen as a driver for improving service quality. Service lines should work with the site governance team to ensure that they are responded to in a timely fashion, that investigation occurs and that lessons are learnt.

6. **Guidelines, standards, policies and protocols**: there should be a process for the development, review, authorisation and dissemination of locally and nationally produced guidelines, standards, policies, protocols and standard operating procedures.

7. **Risk management** identifies, assesses and grades risks in services. These risks can cover a wide spectrum including business continuity, staffing, equipment, issues with the estate and financial risks.

8. **Induction** (particularly local induction within a service) of new staff must cover our standards and expectations for clinical governance.

9. **Clinical effectiveness** should be monitored and driven through a process of audit and quality improvement projects which incorporates NICE, evidence-based practice, good practice and professional standards.

2. Documentation of invasive procedures

'If it's not documented, it didn't happen'

1. **Standardised documents must be used** to ensure recording of essential information throughout the invasive procedure patient pathway.
2. **The design of these documents** should ensure they contribute to safe working practice, allow key safety checks to be performed in sequence and make documentation easy.
3. **The documentation** itself must be complete, legible, contemporaneous, without abbreviation or jargon, and with standardised terminology.
4. **At a minimum, documentation must include:**

- Pre- procedural assessment
- Pre-procedural planning
- Plan for anaesthesia or sedation

Records from the invasive procedure itself:

1. Consent form including risk
2. Perioperative care plan
3. Conduct of anaesthesia
4. Team members present
5. A completed NatSSIPs checklist
6. Operation note
7. Post procedural care and handover

5. **The time and author of any alterations to the documentation must be recorded.**
6. **There must be a standardised process for recording adverse events/near misses/unexpected outcomes.** For example, Datix reporting and in the notes.
7. **Paper and electronic documentation should be aligned** to avoid duplication and inconsistency, with a paperless system as the ultimate goal.

3. Workforce

Safe staffing at all times'

1. **No staff, no start:** a procedure can only begin when the agreed minimum number and skill-mix of staff for that procedure are present.

2. **Day and night:** the same minimum standards apply both inside and outside of normal working hours.

3. **Sufficient time:** job plans and staffing establishments for all groups must ensure that individual staff have sufficient time for participation in the key safety steps before, during and after procedures. This includes the Team Brief at the beginning and Debrief at the end of sessions.

4. **Sufficient staff:** establishments and day-to-day staffing for all professional groups must be adequate to meet the predicted procedural workload.

5. **Allocations** should reflect a risk managed mix of substantive and non substantive staff.

6. **Surge management:** all professional groups must have clear plans for escalation when clinical demand overwhelms resources and a risk management plan for monitoring the frequency of these events.

7. **Regular training:** all staff must receive continuous professional development to keep up to date with changing practice.

8. **Trainees and students** should be supervised.

9. **Escalation process for staffing concerns** raised is in place and these should be documented as a safety issue.

4. Scheduling and list management

'A planned list with clear information enables safer care'

1. **Good scheduling communicates key patient and procedural information to teams.**

2. **Scheduling should take into account workload and the need to follow the 'NatSSIPs Eight'.**

3. **The scheduling team should improve the clinical teams' scheduling through information, feedback, improvement and training.**

4. **There is a scheduling standard operating procedure (SOP)** and, in some specialties, specific scheduling manuals that must be followed.

5. **List information**
   - The operator must select the most precise procedure code available on CRS.
   - The information that accompanies the scheduling of a procedure should include: name, number, date of birth, gender, planned procedure, site and side of procedure, source of patient e.g. ward or admissions lounge.
   - Laterality must always be written in full, i.e. 'left' or 'right'.
   - Further information should be included when relevant: NCEPOD urgency, significant comorbidities, allergies, infection risk, any non-standard equipment requirements or non-stock prostheses, BMI, planned post-procedural care.
   - The use of abbreviations should generally be avoided but, when common abbreviations are used, a list of locally approved abbreviations should be readily available to all staff.
   - If the list information is incorrect, an incident form should be completed and filed.

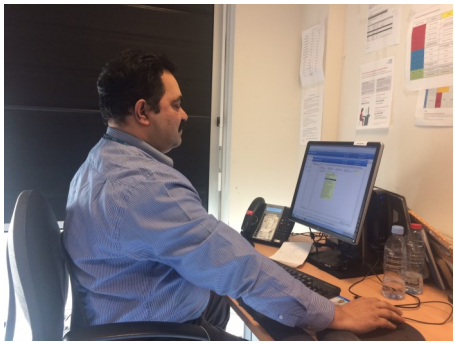
6. List order

7.

- Should be prioritised according to clinical need.
- The order should only change for clinical/safety reasons.
- An order change should be seen as a risk.
- If reordered, the list should be reprinted.
- Any list changes made after the deadline for the publication of a final version of the list must be agreed with the procedure team and should be discussed by all members at the team brief.
- A clear, effective mechanism must exist for removing old lists, when a new version has been published.
- The procedure list should be clearly displayed in the room in which the procedures are performed, and any other areas that are deemed important for the safe care of the patient.

7. **List lockdown**

As a general rule list review should occur at 6, 4 and 2 weeks prior to the list date then locked down at 2 weeks. The list should be reviewed by 3pm the day before the list to identify errors (abbreviations, spelling mistakes, unnecessary information) and any other changes.



5. Handovers and information transfer

'Optimise patient handover, optimise patient care'

1. **All handovers**
   - Should be verbal and written.
   - The participants should be focused on the handover and ensure the participants are actively listening.
   - Read back can be used to confirm understanding.
   - Each team member should be given the opportunity to ask questions and clarify information.

2. **Ward to procedure team handover**

- **Who:** patient, admitting nurse or ward nurse familiar with patient, anaesthetist or theatre staff and surgeon (when a patient's care pathway has deviated from that planned).
- **Where:** anaesthetic or procedure room (or holding bay where applicable).
- **Documents:** peri-operative patient care plan dated and signed, printed wrist bands, drug chart, consent and NatSSIPs checklist.

3. **During procedure if staffing changes**
   - **Who:** outgoing and incoming team.
   - **Where:** in theatre.

4. **Procedure team to post-procedure area**
   - **Who:** patient, anaesthetist, surgeon, scrub nurse and recovery nurse.
   - **Where:** post anaesthetic care unit (PACU)
   - **Documents:** NatSSIPs checklist, recovery handover checklist.

5. **Procedure team or post procedure area to critical care**
   - **Who:** consultant anaesthetist, senior member of surgical team, critical care doctor and nurse responsible for ongoing care of patient.
   - **Where:** critical care or PACU
   - **Documents:** major surgery handover headlines document.

6. Induction (local)

'Dedicated staff, dedicated time, structured and comprehensive'

1. **Mandatory: a local induction is mandatory for all new staff** working in areas where invasive procedures are carried out.

2. **Induction pack: a comprehensive induction pack should be sent to all new staff members before their start date.**

3. **Prioritised:** induction requires dedicated time, staffing and space to enable delivery without any adverse effect on patient care.

4. **Structured and comprehensive: the induction programme should be planned in advance with named speakers.** The programme should be included in the induction pack.

5. **Substantive and non-substantive staff should be included** in local induction.

6. **Agency staff should receive a shortened induction and an appropriate checklist completed.**

7. MDT team development

'A team of experts is not an expert team'

1. **Multidisciplinary team training is a minimum standard.**
2. **It must include all the multi-professional groups.**
3. **It must be planned and delivered on a rolling basis.**
4. **It must include teaching and understanding of the local standards LocSSIPs.**
5. **It must embed safety practice.**
6. **It must include non-technical skills and human factors.**
7. **All MDT team members must receive regular updates and continuous professional development.**

The National Safety Standards for Invasive Procedures (NatSSIPs)

The WHO Surgical Safety Checklist was introduced in 2008. NatSSIPs builds on this intervention and goes beyond the immediate team to make us safer.

The NatSSIPs were published by NHS England in September 2015 and were written by every 'body' involved in healthcare, including the CQC, GMC, AfPP, royal colleges and commissioners with the aim to 'Standardise, Harmonise and Educate'. The NatSSIPs are based on national learning from harm, near misses and never events and provide a strong systemic protective barrier to preventing harm.

Invasive procedures include not only surgery, but any procedure where a hole is made in the patient's body and consent is required. The definition therefore includes procedures carried out in endoscopy, acute medicine, interventional radiology, emergency medicine and cardiology (but excludes cannula or catheter insertion and blood tests).

Based on the NatSSIPs, multidisciplinary team members from across Barts Health have collaborated to develop our own Local Safety Standards for Invasive Procedures (LocSSIPs), divided into sequential and organisational parts. The sequential standards build on the existing WHO Five Steps to Safer Surgery by adding three extra checks: procedural confirmation and site marking; stent, prosthesis and implant verification; and prevention of retained foreign objects to create the 'The NatSSIPs Eight'. The organisational standards go beyond the immediate procedural team to improve the wider system, with a strong focus on human factors, multidisciplinary team training, quality improvement and local induction.

The NatSSIPs are absolutely clear that everyone in an organisation involved in invasive procedures has a responsibility to meet these standards.

NHS
Barts Health
NHS Trust

2018

For information contact:
Annie.Hunningher@bartshealth.nhs.uk
Matthew.Wikner@bartshealth.nhs.uk

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Our vision, values and behaviours