Centre for Perioperative Care

NatSSIPs – why is it so important and what can you do?

A summary for surgeons, anaesthetists, ODPs, theatre nurses, radiologists, students, managers, procurement, safety leads and other staff.

CPOC updated the National Safety Standards for Invasive Procedures (NatSSIPs 2) in 2023. These will improve **patient safety** and **team working**. NatSSIPs includes:

- **organisational standards** that enable the team to deliver safe care (such as safety education for the whole team and local induction) and
- **sequential steps** – the eight steps that should happen where relevant for every patient, every time.

Is this mandatory and does it incorporate the WHO checklist?

Yes and yes. The WHO checklist[1,2] was introduced in the NHS in 2009 with 5 steps or stop points to improve safety for operations. In 2015, the first edition of 'NatSSIPs' was intended to reduce 'never events' such as wrong site surgery in the UK. Unfortunately, multiple checks can be seen as a "tick box exercise" with some staff overwhelmed or not engaged. Never events did not decrease[3] and are a poor measure of safety. CPOC was invited to re-write NatSSIPs.

What did CPOC do to make NatSSIPs 2 excellent and usable?

CPOC's writing group of clinical staff, human factors experts and patients incorporated learning from incidents when care has gone wrong or near-misses, but also learning from excellence. It is clear and easy to use.

NatSSIPs 2 includes systems thinking and human factors – and an understanding of work as done i.e. the difference between what organisations think we do and what we actually do. With rota gaps, high staff turnover and burnout, NatSSIPs 2 gives a standard systematic approach, so that every member of staff knows what should happen and this improves teamwork. The NatSSIPs also encourage more patient participation, involvement and focus.

What is expected for procedures outside operating theatres?

NatSSIPs 2 also applies to procedures OUTSIDE operating theatres – such as within interventional radiology, cardiology, the delivery suite, gynaecology outpatients and the emergency department.

- For minor procedures, for example in outpatient clinic areas, 'Sign In' and 'Time out' can be combined.
- For procedures with access too small to lose a swab (eg a needle entry), only a 'proportionate count' is needed, but all guidewires must be accounted for.

What NatSSIPs 2 is for – 1. Patient safety

We do complex work with patients and teams in a complex system. There are common themes when things go wrong and human fallibility should be recognised. Other safety critical industries use systems and checks to enhance team performance. Surgeons can get hyper-focussed and lose situational awareness. We need the eyes and ears of the entire team to support safety for our patients. We need to work as an expert team not a team of experts.

What NatSSIPs 2 is for – 2. Teamwork

We work in very fluid teams. The 'Team Brief' allows every team member to introduce themself by name and role and the list to be planned, with discussion about each patient and general aspects of the list (such as kit, implants, breaks and potential alternative scenarios). NatSSIPs 2 supports communication, situational awareness, leadership and mutual support with a culture of respect. There have been recent reports about appalling cultures and behaviours in some healthcare settings. Strong teamwork includes valuing every member of the team, everyone having a basic understanding of what each case involves and a minimum standard of behaviour. A good Team Brief is an excellent way to start to improve culture.

How to spread awareness?

We encourage ALL staff to find and use the resources on the CPOC website. We have bite-sized sections, cool infographics, recorded podcasts, videos and slide sets. Why not organise a presentation at your next clinical governance meeting? Why not print out sections as posters in the changing rooms, coffee rooms or scrub areas?

Contents - 1. Organisational standards

This is what each organisation should do to support the team to deliver safer care and use the NatSSIPs. It includes team education, local induction, safety data collection, scheduling and leadership to improve delivery of the standards and care. Errors often occur due to system failures, rather than individual failures. NatSSIPs 2 encourages systems to be designed to reduce errors. It also supports the Safety-II concept of learning from the best teams.[4]

Contents – 2. Sequential standards – for each patient where relevant

Please see infographics and posters on the NatSSIPs website

		Why?	Top Tip
1	Consent Procedural verification Site marking	Correct patient, procedure and side.	Arrow with indelible marker. Clear information on lists to check.
2	Team Brief	Set the scene. Know the team. Open team communication channels.	• Introduce each person by name & role. • Clarify expectations. • Discuss possible issues. • Show mutual support.
3	Sign In	The final safety check before anaesthesia.	Involve the patient. Anaesthetist is present.
4	Time Out	Final check before the procedure.	Make sure the team is present in mind & body.
5	Implant (if relevant)	Implant is correct (and compatible if several implants) every time.	Confirm the implant with checks (type, size, side, expiry etc). Check back. Write down if long gap.
6	Reconciliation (no retained foreign objects)	Nothing unintended left behind.	"Respect the count" - be quiet to allow staff to concentrate. 1st count = closing deep layer. Final count = start of skin closure or before procedure ends.
7	Sign Out	Final check with count confirmation and planning of post op care.	A time to finesse the finish.
8	Debrief/Handover	Learn lessons from the day. Sharing of information amongst staff.	Consider writing up lessons during the list.

References

1. WHO checklist.
2. WHO checklist.
3. HSSIB Never Events.
4. Verhagen MJ, de Vos MS, Sujan M, *et al*. The problem with making Safety-II work in healthcare. *BMJ Quality & Safety* 2022;31:402-408.

A partnership between:

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