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For over a century, the surgical treatment is essential component of public health. As an overall increase in life expectancy, its role is growing rapidly (Hendrickson, 2009). Lack of access to a basic problem remains a major surgical care of low-income people. First aid and basic surgical care WHO Global Initiative have been made to improve access to Central procedure. Parallel measures to improve surgical safety requirements and reliability are widely recognised (Haynes, 2009).

Improving the safety of surgical second reference remained serious problem. Efforts to reduce maternal and neonatal mortality in childbirth and routine monitoring of maternity care are critically dependent on the system. The success and failure can be monitored and verified. Similar monitoring is generally lacking in curriculum of surgery (Gettman, 2009, 1289-1296). According to Goodell (2006) surgical pause is the creation of a menopausal state by surgical removal of the ovaries. It can be wrong site surgery, wrong patient surgery etc.

The patient safety program of the World Health Organisation found that surgical volume data are derived from some of the Member States (Gardezi, 2009). These are not standardised, and record the type of program diversity. Even countries in surgery regularly encountered large gaps in the data. Reports are usually outpatient surgery. Some do not include professional programs, such as gynaecological and orthopaedic surgery, and most of them do not include private hospitals (Charlton, 2004, 1121-1122). Most of the data in low and middle income forecasts from regional data, or other purposes have been published. Few countries have a low hospital mortality prognosis or other reliable information (Clarke, 2007, 395-405).

In use underlying third potential problem is that the existing methods of security do not seem to be credible in all countries. The lack of resources is major issue in low-income countries, but not necessarily the most important (Haynes, 2009). Surgical infection, for example, surgical complications is one of the most common causes. There is no evidence that effective measures such as prophylactic antibiotics are effective disinfection in equipment immediately before cutting and confirmation and then combining. This is not because of the cost, but because of poor systematic way (Hendrickson, 2009). Antibiotics, for example, the rich and poor pre-operative, but they often start too early, too late or irregular.

Fourth point is to improve surgical safety has the difficulty of implementation as fundamental problem. Even in the simplest way, with the participation of several key steps for failure and potential risk to patients, this correctly identified the patient and the surgical site to ensure proper disinfection of equipment. Other contains a number of measurements to be made in any anaesthesia safety planning surgery (Holtgrewe, 2001). The team of the most critical management is a team management itself, anaesthesiologists, nurses and others (Hendrickson, 2009). The team was able to avoid surgical patient's representatives of their knowledge and

ability to work effectively many life-threatening complications. However, there are no guidelines or structure operating room employees in order to promote effective teamwork, thus minimizing the risk to the safety of operations (Haynes, 2009).

Gettman (2009) argued that an old woman had a subarachnoid block for her left total hip replacement. She had previously and recently experienced her right left total hip replacement under subarachnoid block. She received no sedation for operation. She was fascinated by the operation theatre which she claimed she did not bring to mind from the preceding surgical treatment. Due to her query when the surgical pause commenced, it was elucidated that this had been introduced as her past surgical treatment, its intention being to ensure that we had the correct patient for the correct surgical treatment. The patient at this point stated in a loud, clear voice, *'I'm XX, and I'm here to have my left total hip replacement'*. After that, she asked if she had been audible to everybody in the operation room. Points raised by this are the need to notify the patient of the surgical pause earlier. It should the awake patient partake in the surgical pause. The first point probably only applies to the wakeful patient but what about those receiving sedation? Different anaesthetists use differing levels of sedation. As to the second point, the temptation is to say 'We do it'. As anaesthetists, they take ownership and enjoy responsibility for the case. With safety being the ultimate goal, should the patient's ownership of their body be acknowledged or would their participation contribute to dangerous distraction? The patient is aware of this communication and is supportive of it.

According to Goodell (2006) more dynamic nature of these policies makes compliance at times inconsistent within our specialty. In the implementation process of policies, the impact of this latitude promoted by national organizations is unidentified and was beyond the scope of the survey instrument. This measure about the quality improvement shows that policies that are designed to be unequivocal have resulted in significant practice variations by society members. Hard works should be made to align development, implementation, and continued observation of pre-operative methods to make sure they are being applied as planned to make sure the patient's safety and well-being. According to Backster (2007) considerable variations are there in hospice policy that is not described completely by the requirements of regulatory entities, an issue which needs more studies and researches to be accurately addressed.

Sexton (2006) argued that during the surgical procedure, there are some examples to improve safety. Over the past five years in the United Kingdom and other industrialised countries, surgical pause introduced a standard part of surgical care (Sexton, 2006). It is a short, less than 1 minute break before the cut, and immediately operational. All members of the team of surgeons participated in the operation; anaesthetists, nurses and other orally confirm the identity of the patient, rather than surgical procedure to perform. This means clear communication between team members and site mandatory and bad bug's patients (Michaels, 2007, 526–32). Makary (2006) discussed that surgical pause process led to new experiences known as extended break. It will take more protective measures and includes confirmation of the identity of the patient and the surgical site, and the key to the operation you want to perform. This is a detailed discussion among group members to communicate openly and to improve promotion of

cooperation (Kwaan, 2006, 353–8). An institution of the study was extended break shown to improve safety, and improve the selection and pre-operative temperature and sugar in the blood and the proper prophylactic antibiotics detention (Makary, 2006).

Haynes (2008) discussed the time to reduce the number of errors. It is a matter related to only a portion of the surgical team. Making a schedule of events is also important to detect errors - especially when it is the appropriate time without induction. It is included oral report and excluded a team leader report or other employees (Haynes, 2009).

Gettman (2009) argued that real question discussed some of the participants turned with repeated empty mundane. This discusses their roles and the way they lose the possibility of suspending the true value. The error rate has crept into some organisations as the technology is not specific (Haynes, 2009) (Goodell, 2006).

Errors in transactions are at wrong place. The time to go back to the source has produced interesting results. In many of these cases, the consent form has the pace and the team still believe they are right (Gettman, 2009, 1289-1296). This misperception remained busy or distracted. It is considering documents and graphic form, including errors in the place. No-brainer is available in cases where the patient did not (Gardezi, 2009).

According to Goodell (2006) consultation may occur wrong if the patient does not follow guidelines. Unfortunately, many examples are abounding. In this he patient awake and asked for general pre-shaved legs. In total, the process of marking a patient before surgery is now considered the key to avoid mistakes (Clarke, 2007, 395–405).

Exceeding the time limit for spiral development includes the model of medical institutions. Patients do not feel a level of security is still needed. Haynes and other Gawande (2009) discussed in the New England Journal of Medicine article, the third approach to significantly reduce the incidence of complications. They were reduced by half (Charlton, 2004, 1121-1122). The World Health Organisation (WHO) procedure is generally accepted. This process preparation divided into three parts, the list of ways to improve communication between staff and patient. A person will find it cleverly overlooked with no detail, resulting in fewer errors. To manage the surgical pause follow each step, and then write a critical path to oblivion, reduce errors and mistakes (Backster, 2007). It also creates a map of the input that can be used to determine what could be the problem in a comprehensive treatment after the incident. This is the body in each case for data collection and research to improve the process (Altpeter, 2007, 527-532).

In addition, Medicare and Medicaid Services (CMS) have published a list of events not service providers will see a variety of errors in surgical pause such as wrong -site surgery, wrong patient and other complications or denied. This hit surgeon tried their portfolios so that it remains to be seen how effective it will be in the future to prevent errors of surgical operation (Sexton, 2006). Makary (2006) discussed that if each facility infrastructure office or outpatient clinic is reducing system errors, it is exceeded a list of timeout. It is for those who choose not legal risk (Michaels, 2007, 526–32). Allegations against professional misconduct of surgeon will lead surgeon to

practice social norms. In other words, you will be in a similar situation, the surgeon made a similar training (Kwaan, 2006, 353–8).

There are actually three different studies and projects to improve site quality assessment mark, including two different methods to make the right website. They find all challenges to ensure that every surgery has significant correct site in a surgical pause, exposing patients may encounter wrong side surgery (WSS) (Gettman, 2009, 1289-1296). Checking a small surgeon in practice site was founded, marking the national guidelines. The study found a different approach does not wear mark each type of surgery the patient has a certain relationship (Clarke, 2007, 395–405). Diqiaowani and his colleagues tried to solve the site marker perspective; it is the patient's responsibility. The surgeon has not accountability for overall responsibility for the patient to commemorate the site shortly after receiving a set of instructions (Backster, 2007). They found that when the patient (rather than someone from the surgical team) required preoperative marking "no" on the wrong foot or ankle during a surgical pause, 60% of patients have incorrectly labelled parts (Gardezi, 2009).

Sexton (2006) argued that latest research and evaluation projects improve the quality of a sign. This will cause other errors due to persistence of ink. It will discourage marking the sites. Study found that surgical site marked with a marker pen did not affect fertility, or place a patient at higher risk of infection (Backster, 2007). Quality improvement project found that the staff did not mark the right upset because breast cancer is indelible ink in preterm children and the policy does not solve the lateral position (Gardezi, 2009).

Two studies showed that most of the time component can be prevented WSS, but not all. Another study found that two minutes before surgery, a standardised presentation, surgeons, anaesthetists and nurses were trained; there are specific improvements in surgical site and surgical side communication (Charlton, 2004, 1121-1122).

Not all of these factors can be addressed in the context of the operation of the device. Economic and physical resources of the national health care system are limited by many factors, including economic development (Haynes, 2009). Safe Surgery Saves Live challenge is an initiative of two years and at an early stage of the investigation. The project team decided that it would not be able to meet time and project budget and deficits infrastructure. Similarly, although human resources are essential medical services and security, improving education, infrastructure and training, success is unlikely in the near future, if you need a lot of investments (Hendrickson, 2009).

Holtgrewe (2001) discussed that the lack of power fills indispensable especially in the context of limited resources. Many health workers have an important job to be kept to a minimum. It requires suitable training, there is no consensus on how much training is not enough, how to measure the power (Holtgrewe, 2001). Without this basic information, this makes it extremely difficult to establish training standards and certification, and finally left the government and professional associations to determine the best way to deal with these problems, due to their resources and needs.

Given the infrastructure and the Working Group of Experts on Human Resources concluded that the most effective measure would create initial general safety, the existing operational team, working in the operating room. These standards are applicable inventory and surgical services in the context of, standardised basic steps (Hendrickson, 2009). General characteristics, strategies and models of pre-operative workflow are critical, vulnerable, and suitable for simple upgrades (Haynes, 2009).

According to Backster (2007) purpose of the working group is to identify possible legislation in four areas: improving the safety of surgical teams, and facilitate communication between members of the team. It will ensure completion of the preparatory stages of development timely and appropriate and teamwork. This will lead to patient safety through proper monitoring of anaesthesia and prepare to detect in advance potentially lethal anaesthesia or recovery problems (Gettman, 2009, 1289-1296). They can cause irreversible damage, prevent infection of surgical at all levels of health and the fight against pollution infection development of public health. They can provide basic indicators of surgical outcome antiseptic surgical services (Gardezi, 2009) (Holtgrewe, 2001).

According to Goodell (2006) Safe Surgery Saves challenge of life, and then it includes three principles. The first is simple. A full list can create a package to improve the standards and guidelines for patient safety, but it would be difficult to implement. They provide comprehensive and can meet strong resistance. In this configuration, a single call cannot be overstated. Simple measures are the easiest of the Institute and various parameters can have serious consequences (Gardezi, 2009).

The second use of is a broad principle. Focus on resources and the environment shares at a low level will reduce the number of people affecting is the goal of all communities and backgrounds with rich resources, poor resources, so that all Member States participate (Backster, 2007). In addition, frequent defects in each set and the environment, taking into account the typical solutions. Third, be a witness in court (Goodell, 2006). Measuring the impact is a key portion of the second call. Relevant indicators should be identified; even if they are only substitution process must be reasonable and quantitative doctors in all contexts. If you follow three simple rules, wide range of applications and concrete goals for success is possible (Kao, 2008) (Makary, 2006).