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ASF Health Standards Version 11

Standard 7: Surgical and Procedural Safety

Core standard · applicability by facility type shown for each criterion

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APPROVAL

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Date: 1 November 2026

Complete on its own, without internet access. References are listed in section 12. The current version is at france-asf.fr.

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1 Introduction

This document is Standard 7 of ASF Health Standards. It sets out how a facility makes surgical and procedural care safe: the surgical safety checklist, safe anaesthesia, prevention of surgical site infection, procedures performed within granted privileges, safe recovery after the operation, and complete instrument, swab and sharps counts.

A standard is a set of numbered criteria. Each criterion says what must be in place (the criterion statement), how it is rated for each setting, what the assessor will check and what evidence the facility must show. The guidance in this document explains what each criterion means in practice, so that a reader who has only this paper can understand and meet it.

Purpose of this document. Standard 7 makes sure that every operation and invasive procedure is planned, checked, performed and recovered from in a way that prevents avoidable harm to the patient.

Who should read it. Surgeons, anaesthetists, theatre and procedure-room nurses, theatre managers, infection prevention staff, the clinical governance lead, the chief executive, and the assessors who verify the facility. Each criterion names the positions responsible for it (section 8.2).

The standard is a tool to improve care, not a list of paperwork. Templates and forms named in this document are reference drafts. You may adapt them, replace them with your own, or upload your own documents, provided they meet the same criterion.

2 About ASF and this standard

Accréditation Sans Frontières (ASF) is a non-governmental, non-profit accreditation body. It was legally established in Paris in 2020. ASF develops health standards that are practical, affordable and open to all facilities, including those working with limited resources, in crisis, or in transition.

ASF believes accreditation should be accessible in every sense: geographically, so that facilities in remote areas can take part; financially, so that cost is not a barrier; and in language and format, so that staff can read and use the standard in their own working environment.

Each standard is an independent document. Standard 7 has been written so that it can be read and used on its own. It repeats the definitions, abbreviations and references it needs. A reader who has only this document can understand every criterion in it.

3 How to use this standard

If you are a line manager or a member of the human resources team, read section 4 to confirm which criteria apply to your facility type, then section 5 to find the rating for your setting. Read each criterion from 7.1 to 7.6, paying attention to the rating, the guidance and the evidence. Prepare the evidence named in each criterion, covering the period stated.

If you are an assessor, use the sample and the checks in each criterion. The pass rule and the immediate-fail rule decide each criterion. A criterion is met only when all its checks are passed and no immediate-fail event is found.

Reading a criterion. Each criterion has: the criterion statement; the three ratings (humanitarian, transition and fragile, standard); the rating rule; the guidance; what good looks like; common mistakes; why it matters; the sample; the checks, with method, evidence and pass condition; the immediate-fail event; the documents with who writes, approves and checks them; the positions responsible; and the references.

Document codes. Each document has a code made of a topic prefix, a type and a number, for example ENV-SOP-001 (environment, procedure, 001). The type is one of FRM (form, a record kept as evidence), REG (register), PLN (plan),

POL (policy), SOP (standard operating procedure) or GDL (guide). The codes identify documents only. The full list is in section 12.

4 Scope

Standard 7 covers the surgical safety checklist, anaesthesia, surgical site infection prevention, surgeon privileges and site marking, post-operative monitoring and recovery, and instrument, swab and sharps counts. The applicability is shown in section 4.

The standard applies in three settings. The rating for each criterion is given for each setting, and the facility uses the rating for its own setting: **humanitarian settings** (emergency or crisis, very limited resources), **transition and fragile settings** (a health system in change or under strain), and **standard settings** (full resources).

WHERE STANDARD 7 APPLIES

Standard 7 applies to the facility types shown below. Every criterion has the same applicability. The applicability of all 70 standards is in **Annex 1: Applicability of ASF Health Standards by facility type** (ASF-HS11-ANX01), published on france-asf.fr.

Criterion	Applies to
7.1 The Surgical Safety Checklist Is Used	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.
7.2 Anaesthesia Is Delivered Safely	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.
7.3 Surgical Site Infection Is Actively Prevented	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.
7.4 Procedures Are Performed Within Granted Privileges and Marked Correctly	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.
7.5 Post-Operative Monitoring and Recovery Are Safe	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.
7.6 Instrument, Swab and Sharps Counts Are Completed	3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic.

5 Ratings and colours

Rating	Colour	Meaning
Must		Required in every setting. Criteria that can directly affect a patient's life are always Must, and no setting lowers them.
Medium		Required, adapted to what a transition setting can realistically do.

Rating	Colour	Meaning
Minimum		The lowest acceptable level in a humanitarian setting, where resources are very limited.

In standard settings every criterion is Must.

TRAINING LEVELS

Level	Colour	Meaning
Essential		Must be completed by the people named in the role table.
Recommended		Good practice. Not checked as a requirement.
Optional		May be used for development.

6 Abbreviations

Abbreviation	Meaning
ASF	Accréditation Sans Frontières (Accreditation Without Borders), a non-governmental, non-profit accreditation body
FRM	Form. A record that is filled in and kept as evidence
GDL	Guide. Reference guidance for staff
ISCO-08	International Standard Classification of Occupations, 2008 edition (International Labour Organization)
POL	Policy. A written statement of what the facility will do and why
PPE	Personal protective equipment
REG	Register. A running record of entries, such as training, absence or working time
SOP	Standard operating procedure. A step-by-step description of how a task is done
OR	Operating room (theatre)
SSI	Surgical site infection
WHO	World Health Organization

DOCUMENT CODE PREFIXES

Prefix	Topic
SRG	Surgery and theatre documents
AES	Anaesthesia
DAY	Day surgery and recovery

Prefix	Topic
SSC	Surgical staff and credentialing
WST	Waste
HH	Hand hygiene
IPC	Infection prevention and control

7 Terms and definitions

Term	Definition
Time-out	The pause before skin incision in which the team confirms patient, site, procedure and risks aloud.
Sign-out	The final pause before the patient leaves the operating room, in which instruments, swabs, sharps and the plan are confirmed.
Surgical site infection (SSI)	An infection of the operation site that develops after a procedure.
Privileges	The procedures a named clinician is formally allowed to perform, granted by the facility.
Retained item	A surgical instrument, swab or sharp left inside the patient after a procedure.
Setting	The context in which a facility works: humanitarian, transition and fragile, or standard. Each criterion is rated for each setting.
Must, Medium, Minimum	The three ratings of a criterion. See section 5.
Immediate fail	One event that means a criterion is not met, whatever else is in place.

8 Standard 7 at a glance

Standard 7: Surgical and Procedural Safety is a core standard of ASF Health Standards. It covers how surgical and procedural care is planned, performed, monitored and recovered from safely, for the facility types listed in section 4.

The standard has six criteria. Each is shown below and explained on its own page in section 9.

8.1 CRITERIA AND RATINGS

No.	Criterion	Humanitarian	Transition	Standard
7.1	The Surgical Safety Checklist Is Used	Must	Must	Must
7.2	Anaesthesia Is Delivered Safely	Must	Must	Must
7.3	Surgical Site Infection Is Actively Prevented	Medium	Medium	Must
7.4	Procedures Are Performed Within Granted Privileges and Marked Correctly	Medium	Must	Must
7.5	Post-Operative Monitoring and Recovery Are Safe	Medium	Must	Must
7.6	Instrument, Swab and Sharps Counts Are Completed	Must	Must	Must

8.2 RESPONSIBILITIES

Each criterion names the positions responsible for it. Each position should have written terms of reference. ISCO-08 codes are shown for each role and are recorded in the staff register.

No.	Criterion	Positions responsible or involved
7.1	The Surgical Safety Checklist Is Used	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)
7.2	Anaesthesia Is Delivered Safely	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)
7.3	Surgical Site Infection Is Actively Prevented	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)
7.4	Procedures Are Performed Within Granted Privileges and Marked Correctly	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)
7.5	Post-Operative Monitoring and Recovery Are Safe	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)
7.6	Instrument, Swab and Sharps Counts Are Completed	Surgeon or designated team leader (ISCO 2212) · Anaesthetist (ISCO 2212) · Theatre nurse (ISCO 2221)

Reporting lines. The reporting line and supervision of each role are taken from the ASF terms of reference for that role, published on france-asf.fr. A facility with a different structure records its own reporting lines in its organogram.

Role	Reports to	Supervises
Surgeon or designated team leader (ISCO 2212)	The head of surgery.	No direct reports.
Anaesthetist (ISCO 2212)	The head of anaesthesia.	No direct reports.
Theatre nurse (ISCO 2221)	The theatre manager.	No direct reports.

8.3 E-LEARNING

The e-learning courses for this standard, who must take each one, who is recommended to take it, and the criteria it supports, are listed in section 11.

8.4 RELATED COURSES IN THE GMJ ACADEMY

These courses cover the same subjects in more depth or for a specific type of facility. They are optional. They are not required by the criteria.

Course	Subject	Criteria	GMJ Academy course page
Safe Surgery: Correct Site, Procedure, Patient (PS-04)	Correct site, procedure and patient checks	7.1, 7.4	English · Georgian
Safe Anaesthesia and Sedation (PS-13)	Safe anaesthesia and sedation	7.2, 7.5	English · Georgian
Surgical Site Infection Prevention (PS-15)	Surgical site infection prevention	7.3	English · Georgian
WHO Surgical Safety Checklist for Field Teams (FLD-03)	WHO surgical safety checklist in practice	7.1	English · Georgian

7.1 The Surgical Safety Checklist Is Used

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The WHO Surgical Safety Checklist is completed out loud, as a team, at three pauses: before induction of anaesthesia, before skin incision, and before the patient leaves the operating room.

Rating rule. Must in every setting: the WHO Surgical Safety Checklist is completed out loud at all three pauses, with the whole team taking part.

GUIDANCE

The WHO Surgical Safety Checklist is completed out loud, as a team, at three pauses: before induction of anaesthesia, before skin incision, and before the patient leaves the operating room.

The checklist works only when the team says it out loud at each pause. A checklist completed after the operation protects no one.

> **Good practice.** The checklist is spoken out loud at all three pauses, with the whole team taking part.

> **Partial because.** The three pauses are held, but not every team member takes part, or a pause is sometimes missed, or some records are not signed at all three pauses.

WHAT GOOD LOOKS LIKE

- The checklist is spoken out loud at all three pauses, with the whole team taking part.

COMMON MISTAKES

- The checklist is signed after the operation with no pause during the procedure.
- The team does not all join, or the checklist is completed after the procedure.

> **Why it matters.** The checklist works only when the team says it out loud at each pause. A checklist completed after the operation protects no one.

WHAT THE ASSESSOR CHECKS

Sample. Observation of 10 procedures across two weeks, and the completed checklist records for the last 3 months.

1 Three pauses done out loud

Method. Observe 10 procedures and note each pause.

Evidence to show. Completed checklist record (SRG-FRM-001) and an observation record.

Pass when. All three pauses are completed out loud in at least 9 of the 10 observed procedures.

2 Team takes part

Method. Observe who responds at each pause.

Evidence to show. Observation record.

Pass when. At least the surgeon, anaesthetist and nurse respond at each pause.

3 Records are complete

Method. Check the last 3 months of checklist records.

Evidence to show. Completed SRG-FRM-001 records.

Pass when. Every record is signed by the team leader at all three pauses.

Pass. The criterion is met when every check above is passed.

Immediate fail. The checklist is signed after the operation with no pause during the procedure. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
SRG-FRM-001	Surgical safety checklist record	Theatre team	Clinical lead	Quality lead
SRG-POL-001	Surgical safety checklist and team pause	Quality lead	Chief executive	Quality lead
SRG-SOP-001	Surgical safety checklist procedure	Clinical lead	Medical director	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings

REFERENCES FOR THIS CRITERION

- World Health Organization (2009). Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives. https://news.gmj.ge/guideline/guidelines-for-safe-surgery-2009-safe-surgery-saves-lives/

7.2 Anaesthesia Is Delivered Safely

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Anaesthesia follows a written safety protocol, with monitoring throughout the procedure matched to the level of anaesthesia and the patient's risk.

Rating rule. Must in every setting: anaesthesia follows a written safety protocol, with monitoring throughout and an escalation route for complications.

GUIDANCE

Anaesthesia follows a written safety protocol, with monitoring throughout the procedure matched to the level of anaesthesia and the patient's risk.

Anaesthesia is the highest-risk part of many procedures. Continuous monitoring through the whole procedure finds problems early, while there is still time to act.

> **Good practice.** Monitoring recorded at least every 5 minutes, with the equipment checked before each list.

> **Partial because.** Monitoring is recorded at irregular intervals, or the equipment is checked but the log is not completed.

WHAT GOOD LOOKS LIKE

- Monitoring recorded at least every 5 minutes, with the equipment checked before each list.

COMMON MISTAKES

- A ventilated or sedated patient is monitored with alarms switched off or with no monitoring recorded.
- Monitoring is recorded at irregular intervals, or the equipment is checked but the log is not completed.

> **Why it matters.** Anaesthesia is the highest-risk part of many procedures. Continuous monitoring through the whole procedure finds problems early, while there is still time to act.

WHAT THE ASSESSOR CHECKS

Sample. Ten anaesthesia records from the last 3 months, and the anaesthesia machine check log for the same days.

1 Monitoring is recorded throughout

Method. Check each record for monitoring entries at induction, during the procedure and at emergence.

Evidence to show. Anaesthesia record and monitoring chart (SRG-FRM-002).

Pass when. Monitoring is recorded at least every 5 minutes in all sampled records.

2 Equipment is checked before each list

Method. Check the machine check log for each sampled day.

Evidence to show. Anaesthesia machine and equipment check (SRG-FRM-003).

Pass when. A completed check is recorded before the first case of each sampled day.

3 Escalation is known

Method. Ask an anaesthetist and a nurse to explain the steps for a sudden fall in oxygen saturation.

Evidence to show. Anaesthesia safety and monitoring policy (SRG-POL-002).

Pass when. Both describe the same steps, and the steps match the policy.

Pass. The criterion is met when every check above is passed.

Immediate fail. A ventilated or sedated patient is monitored with alarms switched off or with no monitoring recorded. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
SRG-FRM-002	Anaesthesia record and monitoring chart	Theatre team	Clinical lead	Quality lead
SRG-FRM-003	Anaesthesia machine and equipment check	Theatre team	Clinical lead	Quality lead
SRG-POL-002	Anaesthesia safety and monitoring	Quality lead	Chief executive	Quality lead
AES-SOP-003	Sedation and anaesthesia safety	Clinical lead	Medical director	Quality lead
DAY-SOP-002	Sedation and anaesthesia level, and response to complications	Clinical lead	Medical director	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Safe Anaesthesia and Sedation Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Safe Anaesthesia and Sedation Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Safe Anaesthesia and Sedation Essential in all settings

REFERENCES FOR THIS CRITERION

- World Health Organization (2009). Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives. https://news.gmj.ge/guideline/guidelines-for-safe-surgery-2009-safe-surgery-saves-lives/
- World Health Organization. Anaesthesia at the district hospital, second edition. https://news.gmj.ge/guideline/anaesthesia-at-the-district-hospital/

7.3 Surgical Site Infection Is Actively Prevented

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Medium	Medium	Must

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The surgical site infection (SSI) prevention bundle is applied to every procedure: antibiotic prophylaxis given at the right time, skin preparation with an approved antiseptic, hair removed only when it would interfere with surgery, normal body temperature and blood glucose control.

Rating rule. Medium in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: surgical site infection is prevented through a bundle applied to every procedure, with compliance recorded.

GUIDANCE

The surgical site infection (SSI) prevention bundle is applied to every procedure: antibiotic prophylaxis given at the right time, skin preparation with an approved antiseptic, hair removed only when it would interfere with surgery, normal body temperature and blood glucose control.

Surgical site infection is one of the most common complications of surgery. Most cases can be prevented with a short set of measures applied every time.

> **Good practice.** The bundle is recorded, antibiotic timing is checked, and infections are reviewed every quarter.

> **Partial because.** The bundle is used but not recorded, antibiotic timing is not checked, or surveillance is done only once a year.

WHAT GOOD LOOKS LIKE

- The bundle is recorded, antibiotic timing is checked, and infections are reviewed every quarter.

COMMON MISTAKES

- No surveillance of surgical site infections is in place.
- The bundle is used but not recorded, antibiotic timing is not checked, or surveillance is done only once a year.

> **Why it matters.** Surgical site infection is one of the most common complications of surgery. Most cases can be prevented with a short set of measures applied every time.

WHAT THE ASSESSOR CHECKS

Sample. Twenty procedures from the last 3 months, with the bundle record and the infection log.

1 Bundle recorded for each procedure

Method. Check the bundle record for each sampled procedure.

Evidence to show. SSI bundle compliance record (SRG-FRM-004).

Pass when. The bundle is recorded for at least 18 of 20 sampled procedures.

2 Antibiotic given on time

Method. Compare the time of the antibiotic dose with the time of incision.

Evidence to show. Anaesthesia record (SRG-FRM-002).

Pass when. Given within the window in SRG-SOP-003 in at least 18 of 20 procedures.

3 Infections are reviewed

Method. Check the infection log and the review minutes for the last 3 months.

Evidence to show. SSI log and review minutes.

Pass when. Every infection is logged and reviewed at least every quarter.

Pass. The criterion is met when every check above is passed.

Immediate fail. No surveillance of surgical site infections is in place. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
SRG-FRM-004	Surgical site infection bundle compliance record	Theatre team	Clinical lead	Quality lead
SRG-FRM-002	Anaesthesia record and monitoring chart	Theatre team	Clinical lead	Quality lead
SRG-POL-003	Surgical site infection prevention	Quality lead	Chief executive	Quality lead
SRG-SOP-003	Surgical site infection prevention bundle	Clinical lead	Medical director	Quality lead
SRG-SOP-002	Surgical site marking and patient identification before every operation	Clinical lead	Medical director	Quality lead
HH-SOP-001	Hand hygiene at the point of care	Clinical lead	Medical director	Quality lead
IPC-POL-001	Infection prevention and control programme	Quality lead	Chief executive	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Surgical Site Infection Prevention Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Surgical Site Infection Prevention Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Surgical Site Infection Prevention Essential in all settings

REFERENCES FOR THIS CRITERION

- World Health Organization (2018). Global guidelines for the prevention of surgical site infection, second edition. https://news.gmj.ge/guideline/global-guidelines-for-the-prevention-of-surgical-site-infection-second-edition/
- World Health Organization. Implementation manual to support the prevention of surgical site infections at the facility level. https://news.gmj.ge/guideline/implementation-manual-to-support-the-prevention-of-surgical-site-infections-at-the-facility-level-turning-recommendations-into-practice/

7.4 Procedures Are Performed Within Granted Privileges and Marked Correctly

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Medium	Must	Must

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Each surgeon operates only within the privileges granted by the facility. The operating list is checked against those privileges before the day starts, and the operative site is marked and verified before every operation.

Rating rule. Medium in humanitarian settings. Must in transition and fragile settings. Must in standard settings: procedures stay within granted privileges, and the site is marked and checked before every operation.

GUIDANCE

Each surgeon operates only within the privileges granted by the facility. The operating list is checked against those privileges before the day starts, and the operative site is marked and verified before every operation.

Wrong-site, wrong-procedure and operations by staff without the right training are among the most serious patient safety events. Clear privileges and site marking prevent them.

> **Good practice.** Privileges are reviewed every year, the list check is signed at the start of the day, and the site is marked and checked out loud.

> **Partial because.** Privileges exist but are not reviewed, or the list is checked verbally but not signed.

WHAT GOOD LOOKS LIKE

- Privileges are reviewed every year, the list check is signed at the start of the day, and the site is marked and checked out loud.

COMMON MISTAKES

- An operation is performed outside the surgeon's granted privileges.
- Privileges exist but are not reviewed, or the list is checked verbally but not signed.

> **Why it matters.** Wrong-site, wrong-procedure and operations by staff without the right training are among the most serious patient safety events. Clear privileges and site marking prevent them.

WHAT THE ASSESSOR CHECKS

Sample. The privilege list for all operating surgeons, the operating lists for 10 days, and site-marking records for 15 procedures.

1 Each surgeon has current privileges

Method. Check the privilege list against each surgeon's file.

Evidence to show. Surgeon privileges and operating list check (SSC-SOP-001).

Pass when. Every operating surgeon has a privilege entry that has not expired.

2 Operating lists are checked

Method. Check each sampled operating list against the privilege list.

Evidence to show. Signed operating list check (SSC-SOP-001).

Pass when. All sampled lists are checked before the first case.

3 Site is marked and verified

Method. Check the records for 15 procedures involving laterality or several levels.

Evidence to show. Surgical site marking record (SRG-SOP-002).

Pass when. The site is marked and verified at the time-out in every sampled procedure.

Pass. The criterion is met when every check above is passed.

Immediate fail. An operation is performed outside the surgeon's granted privileges. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
SSC-SOP-001	Surgeon privileges and operating list check	Clinical lead	Medical director	Quality lead
SRG-SOP-002	Surgical site marking and patient identification before every operation	Clinical lead	Medical director	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Safe Surgery: Correct Site, Procedure, Patient Essential in all settings

REFERENCES FOR THIS CRITERION

- World Health Organization (2009). Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives. https://news.gmj.ge/guideline/guidelines-for-safe-surgery-2009-safe-surgery-saves-lives/
- World Health Organization (2007). WHO Nine Patient Safety Solutions. https://news.gmj.ge/guideline/who-nine-patient-safety-solutions-2007/

7.5 Post-Operative Monitoring and Recovery Are Safe

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Medium	Must	Must

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Patients are monitored after surgery in a recovery area by trained staff, with written discharge criteria. Any deterioration triggers a defined response.

Rating rule. Medium in humanitarian settings. Must in transition and fragile settings. Must in standard settings: post-operative monitoring and recovery follow written discharge criteria, with escort and advice given.

GUIDANCE

Patients are monitored after surgery in a recovery area by trained staff, with written discharge criteria. Any deterioration triggers a defined response.

Many post-operative complications, such as bleeding, respiratory depression and sepsis, appear after the patient has left the operating room. A defined recovery and discharge standard catches them in time.

> **Good practice.** Observations at the defined intervals, and a discharge checklist signed for every patient.

> **Partial because.** Recovery is observed but not recorded, or advice is given verbally only.

WHAT GOOD LOOKS LIKE

- Observations at the defined intervals, and a discharge checklist signed for every patient.

COMMON MISTAKES

- A patient is discharged with no recovery monitoring at all.
- Recovery is observed but not recorded, or advice is given verbally only.

> **Why it matters.** Many post-operative complications, such as bleeding, respiratory depression and sepsis, appear after the patient has left the operating room. A defined recovery and discharge standard catches them in time.

WHAT THE ASSESSOR CHECKS

Sample. Fifteen recovery records and fifteen discharge records from the last 3 months.

1 Recovery monitoring is recorded

Method. Check the observations in each recovery record.

Evidence to show. Recovery monitoring and discharge criteria record (DAY-SOP-001).

Pass when. Observations are recorded at the intervals in DAY-SOP-001 in all sampled records.

2 Discharge criteria are met

Method. Check each discharge record against the criteria.

Evidence to show. Recovery monitoring and discharge criteria (DAY-SOP-001).

Pass when. All sampled discharges meet the criteria, or have a documented senior review.

3 Written advice is given

Method. Check the advice record for each sampled patient.

Evidence to show. Escort and written discharge advice (DAY-POL-002).

Pass when. Written advice is given to every sampled patient or escort.

Pass. The criterion is met when every check above is passed.

Immediate fail. A patient is discharged with no recovery monitoring at all. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
DAY-SOP-001	Recovery monitoring and discharge criteria	Clinical lead	Medical director	Quality lead
DAY-POL-002	Escort and written discharge advice	Quality lead	Chief executive	Quality lead
DAY-SOP-004	Pre-procedure checks for day surgery	Clinical lead	Medical director	Quality lead
DAY-SOP-002	Sedation and anaesthesia level, and response to complications	Clinical lead	Medical director	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Recognising and Responding to the Deteriorating Patient Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Recognising and Responding to the Deteriorating Patient Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Recognising and Responding to the Deteriorating Patient Essential in all settings

REFERENCES FOR THIS CRITERION

- Association of Anaesthetists of Great Britain and Ireland (2013). Immediate Post-anaesthesia Recovery 2013. https://news.gmj.ge/guideline/immediate-post-anaesthesia-recovery-2013/
- Association of Anaesthetists and British Association of Day Surgery (2019). Guidelines for Day-Case Surgery. https://news.gmj.ge/guideline/aoa-bads-guidelines-for-day-case-surgery-2019/

7.6 Instrument, Swab and Sharps Counts Are Completed

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Dental clinic. **Not applicable to:** Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Instruments, swabs and sharps are counted before the procedure starts, before the wound is closed and before the patient leaves the operating room. Any mismatch is investigated before the team moves on.

Rating rule. Must in every setting: instrument, swab and sharps counts are recorded at three points, and any mismatch is resolved before the patient leaves.

GUIDANCE

Instruments, swabs and sharps are counted before the procedure starts, before the wound is closed and before the patient leaves the operating room. Any mismatch is investigated before the team moves on.

Retained surgical items are a serious and preventable harm. A count that is not done, or is done but not recorded, gives no protection.

> **Good practice.** Counts recorded at all three points, with any mismatch resolved before closure.

> **Partial because.** Counts are done but not recorded.

WHAT GOOD LOOKS LIKE

- Counts recorded at all three points, with any mismatch resolved before closure.

COMMON MISTAKES

- A patient leaves the operating room with a count that has not been reconciled.
- Counts are done but not recorded.

> **Why it matters.** Retained surgical items are a serious and preventable harm. A count that is not done, or is done but not recorded, gives no protection.

WHAT THE ASSESSOR CHECKS

Sample. Count records for 20 procedures from the last 3 months, and the incident log for count mismatches.

1 Counts are recorded at each point

Method. Check the count record for each sampled procedure.

Evidence to show. Instrument, swab and sharps count record (SRG-FRM-005).

Pass when. All three counts are recorded in at least 19 of the 20 sampled procedures.

2 Mismatches are investigated

Method. Check the incident log for any count mismatch.

Evidence to show. Incident log entries and their resolution.

Pass when. Every mismatch is recorded and resolved before the patient leaves the operating room.

3 Sharps are disposed of safely

Method. Observe the disposal of sharps in 5 procedures.

Evidence to show. Sharps and clinical waste management (WST-SOP-001).

Pass when. Sharps are placed straight into puncture-proof containers.

Pass. The criterion is met when every check above is passed.

Immediate fail. A patient leaves the operating room with a count that has not been reconciled. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
SRG-FRM-005	Instrument, swab and sharps count record	Theatre team	Clinical lead	Quality lead
WST-SOP-001	Sharps and clinical waste management	Clinical lead	Medical director	Quality lead
SRG-SOP-001	Surgical safety checklist procedure	Clinical lead	Medical director	Quality lead
SRG-SOP-004	Instrument, swab and sharps count procedure	Clinical lead	Medical director	Quality lead

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Surgeon or designated team leader (ISCO 2212)	Leads the procedure, pauses the team and decides on any count mismatch.	Ophthalmology & Day Surgery Safety; Sharps and Clinical Waste Handling Essential in all settings
Anaesthetist (ISCO 2212)	Takes part in the pauses and in the anaesthesia and count decisions.	Ophthalmology & Day Surgery Safety; Sharps and Clinical Waste Handling Essential in all settings
Theatre nurse (ISCO 2221)	Counts, records and checks the equipment and the record for each case.	Ophthalmology & Day Surgery Safety; Sharps and Clinical Waste Handling Essential in all settings

REFERENCES FOR THIS CRITERION

- World Health Organization (2009). Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives. https://news.gmj.ge/guideline/guidelines-for-safe-surgery-2009-safe-surgery-saves-lives/

10 Questions and answers

Who does Standard 7 apply to?
Facilities that perform surgical or other invasive procedures. The table in section 4 shows each criterion by facility type: all six criteria apply to hospitals, ambulatory clinics and dental clinics, and are marked N/A for the other six facility types. Each criterion has its own pass rule and its own immediate-fail rule, so each one must be met on its own.

What is an immediate fail?
An immediate fail is one event or finding that means a criterion is not met, even if everything else in that criterion is in place. For example, if a patient leaves the operating room with a count that has not been reconciled, criterion 7.6 fails outright, however complete the other records are. Each criterion in this document lists its own immediate fail under "Immediate fail". Facilities should read these before the survey, because they are the points on which the outcome is decided most quickly.

Which documents do I submit?
The documents are the policies, procedures and forms listed under each criterion in the "Evidence and documents" table. Forms, such as the Surgical safety checklist record (SRG-FRM-001) or the Instrument, swab and sharps count record (SRG-FRM-005), are completed for each procedure and kept as evidence. Policies and procedures are signed documents that show the version, date, owner and approver. Have the records ready for the period stated in each criterion, which is the last 3 months for most checks. You may use your own document if it meets the same check, as long as it is clearly the same record.

Are the ratings the same in every setting?
No. Three criteria are Must in every setting, including humanitarian settings, because they protect life directly: the surgical safety checklist (7.1), safe anaesthesia (7.2) and the counts (7.6). Privileges and site marking (7.4) and recovery (7.5) are Medium in humanitarian settings and Must in transition and fragile and in standard settings. Prevention of surgical site infection (7.3) is Medium in humanitarian and in transition and fragile settings, and Must in standard settings.

Must every operation have a completed surgical safety checklist?
Yes, and it must be completed out loud by the team at three pauses: before induction of anaesthesia, before skin incision, and before the patient leaves the operating room. The surveyor observes 10 procedures across two weeks and expects all three pauses to be spoken in at least 9 of them, with at least the surgeon, the anaesthetist and the nurse responding at each pause. The surveyor also checks the last 3 months of completed checklist records (SRG-FRM-001), each signed by the team leader at all three pauses. A checklist signed after the operation, with no pause during the procedure, is an immediate fail.

Must a patient be monitored throughout anaesthesia?
Yes. Monitoring must be recorded from induction, through the procedure, to emergence, at least every 5 minutes, on the Anaesthesia record and monitoring chart (SRG-FRM-002). The anaesthetic machine and equipment must be checked before the first case of each day, and the check recorded (SRG-FRM-003). The surveyor reviews ten anaesthesia records from the last 3 months and asks an anaesthetist and a nurse to explain the steps for a sudden fall in oxygen saturation; both should describe the same steps, and the steps should match the policy (SRG-POL-002). A ventilated or sedated patient with alarms switched off, or with no monitoring recorded, is an immediate fail.

What is the surgical site infection bundle, and how is it checked?
It is a short set of measures applied to every procedure: antibiotic prophylaxis given at the right time, skin preparation with an approved antiseptic, hair removed only when it would interfere with surgery, and normal body temperature and blood glucose control. The surveyor takes twenty procedures from the last 3 months and expects the bundle to be recorded for at least 18 of them (SRG-FRM-004), with the antibiotic given within the window set in the bundle procedure (SRG-SOP-003) in at least 18. Every infection must be logged and reviewed at least every quarter. A facility with no surveillance of surgical site infections fails the criterion immediately.

How are privileges and site marking checked?
Each surgeon may operate only within the privileges the facility has granted. The surveyor checks that every operating surgeon has a privilege entry that has not expired, that the operating lists for 10 days were checked against the privileges before the first case (SSC-SOP-001), and that the site was marked and verified at the time-out in 15 procedures involving a side of the body or several levels (SRG-SOP-002). An operation performed outside the surgeon's granted privileges is an immediate fail.

Must a discharged patient have written advice?
Yes. After surgery the patient is monitored in a recovery area by trained staff, with observations at the intervals set in the recovery procedure (DAY-SOP-001). Discharge follows written criteria, or a documented senior review where the criteria are not fully met. Every patient or escort receives written advice (DAY-POL-002), because spoken advice alone is easy to forget. The surveyor reviews fifteen recovery records and fifteen discharge records from the last 3 months. Discharging a patient with no recovery monitoring at all is an immediate fail.

What happens when a count does not match?
The team stops and searches before the patient leaves the operating room. Instruments, swabs and sharps are counted at three points: before the procedure starts, before the wound is closed, and before the patient leaves. The surveyor checks the count records for 20 procedures (SRG-FRM-005) and expects all three counts in at least 19, and checks the incident log to see that every mismatch was recorded and resolved before the patient left. The surveyor also observes sharps disposal in 5 procedures: sharps go straight into puncture-proof containers (WST-SOP-001).

What do the colours mean?
Red means Must: the criterion is required in every setting, and criteria that protect life are always red. Yellow means Medium: the criterion is required, but adapted to what a transition setting can realistically do. Green means Minimum: the lowest acceptable level in a humanitarian setting, where resources are very limited. In standard settings every criterion is Must. Each criterion shows its rating for each of the three settings, so a facility can see exactly what applies to it. Section 5 shows the colours.

Do we have to use your forms and policies?
No. Every policy, procedure, form and course in this document is a reference draft to help you meet the criterion. You can adapt it to your facility, write your own, or upload your own documents. What the assessor checks is that the standard is met and that you can show how. If you use your own document, make sure it covers the same content as the reference and that it is current, signed and dated, so that the assessor can match it to the criterion without difficulty.

What does essential or recommended training mean for my staff?
In the training tables, red means essential: the course is required for that role in that setting. Green means recommended: the course is advised for that role. Yellow means optional. Each course shows its level for humanitarian, transition and fragile, and standard settings, because the requirement can differ between them. Staff evidence is a verified micro-credential in the GMJ Academy micro-credential portfolio, or a training certificate kept in the staff file.

Do we have to use ISCO-08 codes?
The staff tables give each occupation its ISCO-08 code, so that roles can be compared between facilities and countries. You are not required to change your job titles. What matters is that each role named in the standard can be matched to the person who does that job and to the training they have had. If your titles differ, record the match in your staff file so that the assessor can follow it.

Which training do staff need?
The e-learning table under each criterion shows who must take each course and who is recommended. The theatre team takes the course that matches each criterion: Safe Surgery: Correct Site, Procedure, Patient for the checklist and for site marking, Safe Anaesthesia and Sedation, Surgical Site Infection Prevention, Recognising and Responding to the Deteriorating Patient for recovery, and Sharps and Clinical Waste Handling for the counts, together with Ophthalmology & Day Surgery Safety. Staff can show evidence through a verified micro-credential in the GMJ Academy micro-credential portfolio, or through a training certificate kept in the staff file.

What will the surveyor see on the day?
The surveyor works through the criteria, following the "Sample" and the checks given for each one. Standard 7 is checked both by watching and by reading. The surveyor observes procedures, to see the three checklist pauses and the disposal of sharps, and asks the team questions, for example what happens when a count does not match. The surveyor also reviews records from the last 3 months: checklist records, anaesthesia records and machine checks, bundle records and the infection log, privilege lists and operating lists, recovery and discharge records, and count records.

How does the surveyor choose which records to check?
Each criterion states its own sample, such as "Ten anaesthesia records from the last 3 months, and the anaesthesia machine check log for the same days" or "Count records for 20 procedures from the last 3 months, and the incident log for count mismatches". The surveyor uses the sample given on the criterion rather than choosing records to suit the facility. Preparing for the survey means keeping the records for the whole period stated, organised so that any item in the sample can be produced quickly. A facility that cannot produce the sampled records loses the criterion, whatever else it has in place.

What if we do not have the written protocol yet?
A criterion cannot be met on the basis of an unwritten or informal arrangement, because the assessor needs something to check against. If a protocol does not yet exist, write one before the survey, using the reference draft or your own version, and make sure it is signed, dated and in use. Staff must be able to explain it in practice.

Where can I get the full text?
The full text of each criterion, with its rating, why it matters, the assessor checks, the immediate-fail rule and the documents, is in section 9 of this document. The same criteria are published on france-asf.fr, which holds the controlling copy. The questions and answers in this section summarise the criteria, and if they ever differ, the criterion text is the authority.

Who can I ask about this standard?
For questions about this standard, contact Accréditation Sans Frontières through the contact page of france-asf.fr. Please give the standard number and the criterion (for example 7.3) so that your question can be answered against the right text.

The criterion text is the authority. These answers summarise it.

11 E-learning by standard

These are the GMJ Academy courses named in the criteria of this standard. Each course name opens the course page in the academy. Where a course is published in English and in Georgian, both versions are linked. Evidence of training may be a verified micro-credential in the GMJ Academy micro-credential portfolio, or a training certificate kept in the staff file.

Course	Essential for	Recommended for	Criteria	GMJ Academy course page
Ophthalmology & Day Surgery Safety (AMB-15)	Theatre team	None	7.1, 7.2, 7.3, 7.4, 7.5, 7.6	English · Georgian
WHO Surgical Safety Checklist and team pause, for field teams (FLD-03)	None	Field teams	7.1	English · Georgian
Safe Surgery: Correct Site, Procedure, Patient (PS-04)	Theatre team	None	7.1, 7.4, 7.6	English · Georgian
Safe Anaesthesia and Sedation (PS-13)	Theatre team	None	7.2	English · Georgian
Surgical Site Infection Prevention (PS-15)	Theatre team	None	7.3	English · Georgian
Sterilization, Disinfection and Reprocessing (PS-07)	None	Theatre team	7.3	English · Georgian
Infection Prevention and Control Essentials (BAS-05)	None	Theatre team	7.3	English · Georgian
Credentialing, Competence and the Training Matrix (T-14)	None	Clinical lead, Medical director	7.4	English · Georgian
Recognising and Responding to the Deteriorating Patient (PS-12)	Theatre team	None	7.5	English · Georgian
Sharps and Clinical Waste Handling (BAS-02)	Theatre team	None	7.6	English · Georgian

12 References

CITED FOR CRITERIA

1. World Health Organization (2009). Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives. https://news.gmj.ge/guideline/guidelines-for-safe-surgery-2009-safe-surgery-saves-lives/ (criterion 7.1, 7.2, 7.4, 7.6)
2. World Health Organization. Anaesthesia at the district hospital, second edition. https://news.gmj.ge/guideline/anaesthesia-at-the-district-hospital/ (criterion 7.2)
3. World Health Organization (2018). Global guidelines for the prevention of surgical site infection, second edition. https://news.gmj.ge/guideline/global-guidelines-for-the-prevention-of-surgical-site-infection-second-edition/ (criterion 7.3)
4. World Health Organization. Implementation manual to support the prevention of surgical site infections at the facility level. https://news.gmj.ge/guideline/implementation-manual-to-support-the-prevention-of-surgical-site-infections-at-the-facility-level-turning-recommendations-into-practice/ (criterion 7.3)
5. World Health Organization (2007). WHO Nine Patient Safety Solutions. https://news.gmj.ge/guideline/who-nine-patient-safety-solutions-2007/ (criterion 7.4)
6. Association of Anaesthetists of Great Britain and Ireland (2013). Immediate Post-anaesthesia Recovery 2013. https://news.gmj.ge/guideline/immediate-post-anaesthesia-recovery-2013/ (criterion 7.5)
7. Association of Anaesthetists and British Association of Day Surgery (2019). Guidelines for Day-Case Surgery. https://news.gmj.ge/guideline/aoa-bads-guidelines-for-day-case-surgery-2019/ (criterion 7.5)

INTERNATIONAL STANDARDS CITED

1. International Labour Organization (2008). International Standard Classification of Occupations, ISCO-08. Geneva: ILO.

13 Document register

Every document code used in Standard 7, with its type and the criteria that use it. The codes identify the documents; a facility may use its own document if it meets the same criterion.

Code	Document	Type	What it is for	Criteria
AES-SOP-003	Sedation and anaesthesia safety	Procedure (SOP)	To keep patients safe during sedation and anaesthesia in an aesthetic setting.	7.2
DAY-POL-002	Escort and written discharge advice	Policy	To make sure no patient goes home after anaesthesia alone, and that they know what to watch for.	7.5
DAY-SOP-001	Recovery monitoring and discharge criteria	Procedure (SOP)	To keep patients safe in the hour after anaesthesia, when risk is highest.	7.5
DAY-SOP-002	Sedation and anaesthesia level, and response to complications	Procedure (SOP)	To match the level of sedation to the staff, the monitoring and the response available.	7.2, 7.5
DAY-SOP-004	Pre-procedure checks for day surgery	Procedure (SOP)	To catch the errors that the pre-procedure checks find before the patient is anaesthetised.	7.5
HH-SOP-001	Hand hygiene at the point of care	Procedure (SOP)		7.3
IPC-POL-001	Infection prevention and control programme	Policy	To prevent healthcare-associated infection to patients, staff and visitors through a written, reviewed and monitored programme (B1.15).	7.3
SRG-FRM-001	Surgical safety checklist record	Form (record)	The WHO surgical safety checklist for one procedure, completed aloud at sign-in, time-out and sign-out.	7.1
SRG-FRM-002	Anaesthesia record and monitoring chart	Form (record)	Records the anaesthesia and the monitoring of the patient from induction to recovery.	7.2, 7.3
SRG-FRM-003	Anaesthesia machine and equipment check	Form (record)	The daily check of the anaesthetic machine, monitors, suction and emergency airway equipment before the first case.	7.2
SRG-FRM-004	Surgical site infection bundle compliance record	Form (record)	Records, for each procedure, whether each part of the bundle was done.	7.3
SRG-FRM-005	Instrument, swab and sharps count record	Form (record)		7.6
SRG-POL-001	Surgical safety checklist and team pause	Policy	To make sure the team confirms the right patient, the right procedure and the right site together, at each pause.	7.1
SRG-POL-002	Anaesthesia safety and monitoring	Policy	To keep the patient safe throughout anaesthesia, with monitoring matched to their risk.	7.2
SRG-POL-003	Surgical site infection prevention	Policy	To prevent surgical site infections with a set of practices that can be checked.	7.3
SRG-SOP-001	Surgical safety checklist procedure	Procedure (SOP)	To run the checklist the same way in every theatre, every time.	7.1, 7.6
SRG-SOP-002	Surgical site marking and patient identification before every operation	Procedure (SOP)	To make sure the correct patient has the correct procedure on the correct site, by marking the site before the patient goes to theatre and by checking the mark and the identity at the sign-in and time-out pauses.	7.3, 7.4
SRG-SOP-003	Surgical site infection prevention bundle	Procedure (SOP)	To apply the bundle the same way for every procedure.	7.3
SRG-SOP-004	Instrument, swab and sharps count procedure	Procedure (SOP)		7.6
SSC-SOP-001	Surgeon privileges and operating list check	Procedure (SOP)	To make sure surgeons operate only within their granted privileges.	7.4
WST-SOP-001	Sharps and clinical waste management	Procedure (SOP)		7.6