

## **Surgical technology and operating-room safety failures: a systematic review of quantitative studies.**

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Weerakkody RA, Cheshire NJ, Riga C, et al. Surgical technology and operating-room safety failures: a systematic review of quantitative studies. *BMJ Qual Saf.* 2013;22(9):710-8. doi:10.1136/bmjqs-2012-001778.

<https://psnet.ahrq.gov/issue/surgical-technology-and-operating-room-safety-failures-systematic-review-quantitative-studies>

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Surgical equipment failures have been [implicated](#) as a significant contributor to errors and delays in the operating room. This systematic review found that equipment problems account for a large proportion of operating room errors, although the exact number could not be determined due to differences in study methodology. As the majority of equipment problems were due to potentially preventable issues (such as equipment being unavailable or improperly configured), the authors argue that equipment checks should be incorporated into surgical safety [checklists](#). Preoperative [time outs](#) are also an effective means of prospectively identifying potential equipment issues. A postoperative complication caused in part by equipment unavailability during surgery is discussed in an AHRQ WebM&M [commentary](#).