

## AORN Position Statement on Patient Safety

### Preamble

The safety of patients undergoing operative or other invasive procedures is a primary responsibility of the perioperative registered nurse.<sup>1</sup> Registered nurses form a professional bond with patients, who place their physical and emotional well-being in the hands of registered nurses and their surgical colleagues and who believe that the care provided will be safe and effective. The patient/caregiver bond is founded on the patient's trust in the registered nurse and the surgical team. Protecting the patient and promoting an optimal surgical outcome further strengthens that bond.

Perioperative registered nurses have created a significant literary legacy<sup>2,3</sup> and a strong clinical tradition of protecting patients from harm, avoiding error, and promoting safe operative practices.<sup>4</sup> AORN introduced its Patient Safety First initiative in 2002 to recommit the Association and its members to improving the safety of patients in surgery.<sup>5</sup> This initiative expands on an already substantial array of tools to assist the perioperative registered nurse in advocating for patients. AORN's *Standards, Recommended Practices, and Guidelines* reflect the perioperative registered nurse's scope of responsibility.<sup>4</sup> The Perioperative Nursing Data Set (PNDS) creates a common language that enables registered nurses to articulate their value, document competencies, and evaluate nursing care.<sup>6</sup> AORN's publications and educational offerings provide, among other things, continuing education, health policy updates, and networking opportunities. Both nursing and medical codes of ethics further promote the theme of safety and protection from error; "First, do no harm" is the universally recognized dictum of medicine's Hippocratic oath. AORN, the Association of periOperative Registered Nurses, long a proponent of patient safety, has rededicated itself to reducing error, educating registered nurses and patients about safe practices, and creating innovative and collaborative strategies to strengthen the culture of safety.

### Background

Whether the traditional operating room (OR), the ambulatory surgery center, the interventional suite, or the physician's office, the surgical setting is one of the most potentially hazardous of all the clinical environments. Infection, hemorrhage, and wrong patient/surgery/site are among the most serious potential complications. Potential hazards also include a variety of energy sources (eg, electrical, thermal, laser, radiological), chemicals (eg, medications, antiseptics, cements, intravascular dyes, irrigating solutions), biologicals (eg, bloodborne pathogens, drug resistant organisms), equipment and devices (eg, powered instruments and equipment, defibrillators, tourniquets, electrosurgical units, positioning devices), and the multiple supplies and instruments that comprise the surgical armamentarium. In addition to these technical sources of potential risk, there are human factors (eg, communication patterns, institutional culture, staffing patterns) that are increasingly recognized as a vital component in the creation of a safe, team-based OR environment. Communication between and among team members is one of the most critical according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A breakdown in communication was the most common reason cited by JCAHO for contributing to wrong site surgery.<sup>7</sup>

### Contributing factors

Surgical error results from multiple factors.<sup>8</sup> Latent conditions created by flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors.

Among contributing factors are

- inadequate communication among team members,
- incomplete review of patient health records and diagnostic studies,
- traditional hierarchical and autocratic cultures,
- patient-related decisions made only by physicians,
- rapidly and frequently changing technology,
- intimidating management styles,
- absent or inconsistently applied policies and procedures,
- fatigue,
- multitasking,
- time pressures and constraints,
- emergency surgery,
- cultural differences between patients and staff members and among staff members,
- staffing shortages,

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- a blaming culture,
- confusing packaging of medications and supplies,
- unclear instructions,
- insufficient orientation and training,
- patient characteristics requiring unusual setup or requirements, and
- failure to include the patient and family members in assessment and decision making.<sup>9</sup>

### **Error-reduction strategies**

Error reduction requires the commitment of all members of the surgical team. In addition to correcting the contributing factors identified above, individual and institutional strategies can also include the following actions.

- Reduce reliance on memory by using checklists, protocols, and computerized decision aids.
- Improve information access of patient records.
- Support contracts for new equipment and supplies that include clauses providing staff member education on the use of the equipment and supplies.
- Standardize processes as much as possible for back table/Mayo tray setups, medication doses, pre-operative procedures, and other activities.
- Establish mechanisms to update procedure/preference cards.
- Participate in quality and process improvement initiatives.
- Develop policies and procedures that address unsafe practices.
- Focus on the safety aspects of products during the selection and evaluation process.
- Promote safety-related clinical competency.<sup>10</sup>
- Include the patient and family members (when possible) in confirming the correct patient identity, the correct surgical procedure, and the correct surgical site.
- Educate employees about the potential for errors and how to avoid them.<sup>11</sup>
- Encourage patients and their significant others to actively participate by partnering with the RN in the planning and implementation of the surgical experience and to question patient care activities.
- Develop a “near miss” reporting mechanism that will track trends of patient care activities that can be studied and analyzed for further error reduction.

One of the most effective team strategies is to create and nurture a culture of safety. Such a culture is founded on a sense of trust among team members and a feeling of safety when the need for change or improvement must be addressed. Establishing a culture of safety and trust is a process of changing a culture from one of blaming individuals for errors to one in which errors are treated not as personal failures but as opportunities to improve the system and prevent harm.<sup>12</sup> Success in the creation of a safety culture depends on the commitment of all team members to report, address, and correct system failures. Four elements are required to create such an environment:<sup>13</sup>

- a sense of trust among team members;
- disseminating and verifying receipt of information to all levels of staff and management;
- developing and supporting a proactive approach rather than a reactive, blaming approach; and
- making a sincere commitment to affirming safety as the first priority.

### **AORN's position**

AORN is committed to promoting patient safety by advancing the profession through scholarly inquiry to identify, verify, and expand the body of perioperative nursing knowledge. The Association supports the establishment of an accountable, trusting, safety culture that reflects individual and collective values, beliefs, behaviors, and skills with a desire and commitment to patient safety.

AORN also is actively collaborating with the American College of Surgeons, the American Society of Anesthesiologists, JCAHO, the Center for Medicare and Medicaid Services, and other professional organizations and accrediting and regulatory agencies to foster systems and procedures that minimize surgical risk.

AORN recognizes the diverse cultural influences and human factors that can contribute to errors and unsafe work practices. The Association strives to develop programs and services that assist perioperative registered nurses in clinical, education, research, and leadership roles to create cul-

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tures of safety in their practice environments and to reduce harm to patients in all perioperative practice settings.

### AORN patient safety resources

- AORN's Patient Safety First web site (<http://www.patientsafetyfirst.org>) provides access to numerous patient safety resources. It also is available through AORN's web site (<http://www.aorn.org>).
- AORN's Patient Safety First e-mail address ([patientsafetyfirst@aorn.org](mailto:patientsafetyfirst@aorn.org)) can be used to report safety concerns and obtain advice or referrals on safety issues.
- AORN's Patient Safety First toll-free patient safety hotline, (866) 285-5209, can be used to report safety concerns and obtain advice or referrals on safety issues.
- Safety Net, Patient Safety First's voluntary and confidential near-miss database and reporting system can be accessed at [http://www.patientsafetyfirst.org/psf\\_report.htm](http://www.patientsafetyfirst.org/psf_report.htm).
- Safety-related articles and Home Studies are published in the *AORN Journal* and *AORN Connections*.
- AORN Position Statement on Correct Site Surgery
- Guideline to Eliminate Wrong Site Surgery: supported by both AORN and the American College of Surgeons
- Joint Commission on Accreditation of Healthcare Organizations, "Universal protocol for preventing wrong site, wrong procedure, wrong person surgery." Endorsed by AORN, the American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American Dental Association, and American Association of Orthopaedic Surgeons.
- *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2003). Includes competency statements and the American Nurses Association *Code of Ethics with Explications for Perioperative Nursing*.
- S C Beyea, ed, *Perioperative Nursing Data Set*, second ed (Denver: AORN, Inc, 2002). Includes registered nurse-sensitive patient outcomes and interventions.

1. "AORN explications for perioperative nursing," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2003) 53-83.
2. A A Smith, *The Operating Room: A Primer for Pupil Nurses* (Philadelphia: WB Saunders, 1916) 80.
3. E L Alexander, *Operating Room Technique* (St Louis: The CV Mosby Company, 1943) 7. Currently in its 12th edition as *Alexander's Care of the Patient in Surgery*, J C Rothrock, ed (St Louis: Mosby, 2003).
4. *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2003).
5. "Safety initiative in full swing," *AORN Member News* 1 (January 2002) 8.
6. S C Beyea, ed, *Perioperative Nursing Data Set, second ed* (Denver: AORN, Inc, 2002).
7. *Joint Commission on Accreditation of Healthcare Organizations, "Sentinel event alert: A follow-up review of wrong site surgery,"* *Joint Commission Perspectives* (January 2002) 10-11.
8. *Institute of Medicine, To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 1999).
9. M Leonard, C A Tarrant, "Culture, systems, and human factors—Two tales of patient safety: The KP Colorado region's experience," *The Permanente Journal* 5 (Summer 2001) 46-49.
10. J M Reeder, *Patient Safety, Competency Assessment Module* (Denver: Certification Boards, Inc, 2002).
11. S C Beyea, "Accident prevention in surgical settings—keeping patients safe," *AORN Journal* 75 (February 2002) 361-363.
12. *Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001) 83.
13. S C Beyea, "Creating a culture of safety," *AORN Journal* 76 (July 2002) 163-166.

### Additional resources

J Reason, *Managing the Risks of Organizational Accidents* (Burlington, Vt: Ashgate Publishing, 1997).  
J B Cooper et al. "National Patient Safety Foundation agenda for research and development in patient safety," *Medscape General Medicine, Patient Safety* 2, <http://www.medscape.com/MedGenMed/PatientSafety>.

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