AORN Position Statement on Patient Safety

POSITION STATEMENT

AORN believes:

- Severe, preventable injury and harm should never occur in the perioperative practice setting.
- Every patient has the right to receive the highest quality perioperative care in every practice setting where operative and other invasive procedures are performed.
- Every patient experiencing an operative or other invasive procedure deserves to have, at a minimum, one perioperative registered nurse (RN) circulator during the intraoperative phase of care.[1]
- Health care providers must collaborate on interdisciplinary teams to establish and sustain an organizational **culture of patient safety** by
    - developing initiatives aimed at reducing errors,
    - engaging patients to participate in their own care,[2,3] and
    - creating an environment that is safe for patients.[4]
- Advancing evidence-based perioperative knowledge through scholarly inquiry bolsters **patient safety** and the profession by promoting excellence in perioperative nursing practice.[4]

RATIONALE

Perioperative patients are vulnerable to injury due to diminished or absent sensations of pain, the inability to act on those sensations, and the inability to communicate or make decisions while receiving anesthesia. These vulnerabilities increase the potential for patient harm and require that health care providers prioritize patient safety first and foremost. Patients should be engaged in their own care and empowered to ask questions and speak up about concerns regarding their safety.[2,3,5]

The perioperative setting is a high-risk environment that presents unique challenges in the delivery of patient care (eg, concurrent tasks, distractions, noise). **Adverse events** that affect perioperative patient outcomes can include infection, hemorrhage, medication errors, specimen errors, positioning or pressure injuries, burns, unintentionally retained surgical items, **wrong-site surgery**, and death. A variety of factors can contribute to adverse events.[6,7]

Vital components of a safe perioperative environment include, but are not limited to,

- organizational commitment to a safe and **just culture**;
- patient centeredness[2,5];
- teamwork[8];
- effective communication[9-11];
- a safe **environment of care**[12-15];

- prevention of
    - infections,[10,16-18]
    - wrong-site surgery,[19]
    - positioning injuries,[20]
    - pressure injuries,[20]
    - medication errors,[21]
    - specimen errors,[22]
    - patient falls,[20,23]
    - surgical fires,[12,14,24]
    - exposure to surgical smoke,[25]
    - sharps injuries,[26] and
    - unintended retained surgical items[27];
- effective cleaning and care of instruments[28];
- safe patient handling and movement[20,23];
- onboarding practices that effectively prepare perioperative teams to deliver safe patient care[29];
- education and competency verification of perioperative personnel; and
- safe staffing and on-call practices.[30]

Perioperative nurse leaders at all levels, including executives, should collaborate with the organizational executive leadership team to establish and sustain a culture of safety within the organization. When adverse events and **near misses** occur, these should be viewed as opportunities for learning and improvement instead of grounds for punishment,[2,23,31] although this does not eliminate the need for accountability.[2] Elements of a perioperative patient safety culture include

- effective leadership,[2]
- accountability (ie, taking responsibility for one's actions),[2]
- transparency (ie, openly sharing information),[2]
- psychological safety (ie, an environment in which people feel comfortable speaking up),[2]
- teamwork and communication (eg, respect),[2,32]
- reliability (ie, using the best evidence and minimizing variation to eliminate error [developing a **high-reliability team**]),[2]
- improvement and measurement (ie, developing and testing system improvements and measuring effects and outcomes over time),[2]
- continuous learning (eg, conducting root cause analyses, examining collected data to identify what is working or failing),[2,32,33]
- advocacy (ie, advocacy for patients and to address social determinants of health),[34] and
- an effective event reporting policy and procedure that includes reporting near miss safety events.[2,31,35]

The perioperative RN recognizes the contributions of all health care professionals and collaborates to achieve safe, quality patient care. The primary responsibility of the perioperative RN is to promote the health, welfare, and safety of the patient. AORN's Guidelines for Perioperative Practice describe evidence-based best practices for the delivery of safe perioperative care.

GLOSSARY

Adverse event: An event that produces an unintended effect or patient harm.

Culture of patient safety: A culture in which each member of the perioperative team values safety and commits to personal responsibility for patient safety. Also known as a patient safety culture.

Environment of care: The setting in which care is provided, including the physical environment, equipment, and potentially hazardous materials used in that area.

High-reliability team: A team that is organized to consistently anticipate and detect defects, maintain stable operations, and expeditiously respond to abnormalities.

Just culture: A culture that balances personal accountability and system improvement.

Near miss: An error that is discovered and rectified before it results in harm. Identification of the error may be due to chance or to interception of the error before harm occurs. Also known as a "close call" or "good catch."

Patient safety: Prevention or reduction of harm or injury to patients caused by medical care.

Wrong-site surgery: An operative or other invasive procedure performed on the wrong patient; on the wrong body part, side of the body, or level of an anatomic site; or using the wrong implantable device. This also includes performing the wrong procedure on a patient.

REFERENCES

1. *AORN position statement on one perioperative registered nurse circulator dedicated to every patient undergoing a surgical or other invasive procedure.* Denver, CO: AORN, Inc.; 2019Position Statements. Personnel & Staffing.
2. Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A framework for safe, reliable, and effective care.* Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.
3. Sharma AE, Rivadeneira NA, Barr-Walker J, Stern RJ, Johnson AK, Sarkar U. Patient engagement in health care safety: An overview of mixed-quality evidence. *Health Aff*. 2018;37(11):1813-1820. https://doi.org/10.1377/hlthaff.2018.0716. doi: 10.1377/hlthaff.2018.0716.
4. Introduction to the guidelines for perioperative practice. In: Kyle E, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
5. Abid MH, Abid MM, Surani S, Ratnani I. Patient engagement and patient safety: Are we missing the patient in the center? *Cureus*. 2020;12(2):e7048-e7048. https://pubmed.ncbi.nlm.nih.gov/32219044; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7086117/. doi: 10.7759/cureus.7048.
6. Kim MJ, Jang SG, Kim IS, Lee W. A study on the status and contributory factors of adverse events due to negligence in nursing care. *J Patient Saf*. 2020. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emexa&NEWS=N&AN=633093937. doi: http://dx.doi.org/10.1097/PTS.0000000000000791.
7. Thiels CA, Lal TM, Nienow JM, et al. Surgical never events and contributing human factors. *Surgery*. 2015;158(2):515-521.
8. Wakeman D, Langham MR,Jr. Creating a safer operating room: Groups, team dynamics and crew resource management principles. *Semin Pediatr Surg*. 2018;27(2):107-113. doi: https://dx.doi.org/10.1053/j.sempedsurg.2018.02.008.
9. Fearon MC, Spruce L, Conner R, Wood A. Guideline for team communication. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
10. National patient safety goals. https://www.jointcommission.org/standards/national-patient-safety-goals/. Accessed 9/10/2021, 2021.

11. Isik I, Gumuskaya O, Sen S, Arslan Ozkan H. The elephant in the room: Nurses' views of communication failure and recommendations for improvement in perioperative care. *AORN J*. 2020;111(1):e1-e15. doi: https://dx.doi.org/10.1002/aorn.12899.
12. Johnstone EM, Burlingame BL, Conner R. Guideline for a safe environment of care. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
13. Burlingame BL. Guideline for design and maintenance of the surgical suite. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
14. Burlingame BL, Kyle E. Guideline for electrosurgical safety. In: Wood A, Kyle E, eds. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
15. Burlingame BL. Guideline for radiation safety. In: Kyle E, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
16. Wood A. Guideline for transmission-based precautions. In: Wood A, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
17. Wood A, Conner R. Guideline for hand hygiene. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
18. Cahn J, Wood A. Guideline for sterile technique. In: Wood A, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
19. *AORN position statement on the prevention of wrong-patient, wrong-site, and wrong-procedure events.* Denver, CO: AORN, Inc.; 2021.
20. Van Wicklin SA. Guideline for positioning the patient. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
21. Burlingame BL. Guideline for medication safety. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
22. Cahn J. Guideline for specimen management. In: Kyle E, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
23. Ogg MJ, Van Wicklin SA. Guideline for safe patient handling and movement. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
24. Burlingame BL. Guideline for laser safety. In: Wood A, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
25. Ogg MJ. Guideline for surgical smoke safety. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
26. Ogg MJ. Guideline for sharps safety. In: Wood A, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
27. Wood A, Conner R. Guideline for prevention of retained surgical items. In: Conner R, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
28. Kyle E, Wood A. Guideline for care and cleaning of surgical instruments. In: Kyle E, ed. *Guidelines for perioperative practice.* Denver, CO: AORN, Inc.; 2021.
29. *AORN position statement on orientation of the registered nurse and surgical technologist to the perioperative setting.* Denver, CO: AORN, Inc.; 2018.
30. *AORN position statement on perioperative safe staffing and on-call practices.* Denver, CO: AORN, Inc.; 2021Position Statements. Personnel & Staffing.
31. Lozito M, Whiteman K, Swanson-Biearman B, Barkhymer M, Stephens K. Good catch campaign: Improving the perioperative culture of safety. *AORN J*. 2018;107(6):705-714. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed19&NEWS=N&AN=628427779. doi: http://dx.doi.org/10.1002/aorn.12148.

32. Toolkit to promote safe surgery. https://www.ahrq.gov/hai/tools/surgery/index.html. Published November 2017. Updated 2017. Accessed 4/30, 2021.
33. Soncrant CM, Warner LJ, Neily J, et al. Root cause analysis of reported patient falls in ORs in the veterans health administration. *AORN J*. 2018;108(4):386-397. doi: https://dx.doi.org/10.1002/aorn.12372.
34. Benze C, Spruce L, Groah L, eds. *Perioperative nursing: Scope and standards of practice.* Denver, CO: AORN, Inc.; 2021.
35. Monahan JJ. Using good catches to promote a just culture and perioperative patient safety. *AORN J*. 2018;108(5):548-552. doi: https://dx.doi.org/10.1002/aorn.12394.

ADDITIONAL RESOURCES

TeamSTEPPS. https://www.ahrq.gov/teamstepps/index.html. Accessed September 10, 2021.

PUBLICATION HISTORY

Original approved by the House of Delegates, San Diego: March 2004
Revision approved by the House of Delegates: March 2007
Revision approved by the Board of Directors: February 2011
Revision approved by the membership: February 2017
Revision approved by Board of Directors and the membership: March 2022
Sunset review: March 2027