

# AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, and Wrong-Procedure Events

## POSITION STATEMENT

AORN believes:

- All health care professionals should be dedicated to safe, optimal outcomes for all patients undergoing operative and other invasive procedures.
- There is a need to implement standardized processes developed by safety, regulatory, or accrediting organizations or agencies for the prevention of wrong-patient, wrong-site, and wrong-procedure events.
- Interdisciplinary teams that include perioperative RNs, surgeons, anesthesia professionals, risk managers, and other health care professionals should collaboratively develop procedures and protocols to prevent wrong-patient, wrong-site, and wrong-procedure events.
- Perioperative team members should complete a preoperative checklist that includes, but is not limited to, preprocedure verification, site marking, and time-out procedures.

## RATIONALE

Wrong-patient, wrong-site, and wrong-procedure events can and must be prevented. Implementing evidence-based, risk-prevention strategies for the identification and verification of the correct patient, surgical site, and procedure will reduce the risk of error.<sup>1-7</sup>

A comprehensive approach is needed in each health care organization to prevent wrong-patient, wrong-site, and wrong-procedure events. Perioperative RNs are key participants in interdisciplinary teams during the development of procedures and protocols for correct site surgery. As patient advocates, perioperative RNs communicate with all members of the surgical team and other nursing personnel to verify that all components of the standardized process are completed correctly, including but not limited to, preprocedure verification, site marking, and time-out procedures.

## REFERENCES

1. Hempel S, Maggard-Gibbons M, Nguyen DK, et al. Wrong-site surgery, retained surgical items, and surgical fires: a systematic review of surgical never events. *JAMA Surg.* 2015;150(8):796-805.
2. Papadakis M, Meiwandi A, Grzybowski A. The WHO safer surgery checklist time out procedure revisited: strategies to optimise compliance and safety. *Int J Surg.* 2019;69:19-22.
3. Röhsig V, Maestri RN, Parrini Mutlaq MF, et al. Quality improvement strategy to enhance compliance with the World Health Organization Surgical Safety Checklist in a large hospital: quality improvement study. *Ann Med Surg (Lond).* 2020;55:19-23.

4. Panda N, Haynes AB. Effective implementation and utilization of checklists in surgical patient safety. *Surg Clin North Am*. 2021;101(1):37-48. Epub November 2, 2020. doi:10.1016/j.suc.2020.08.010.
5. Solsky I, Berry W, Edmondson L, et al. World Health Organization Surgical Safety Checklist modification: do changes emphasize communication and teamwork? *J Surg Res*. 2020;246:614-622.
6. Makary MA, Mukherjee A, Sexton JB, et al. Operating room briefings and wrong-site surgery. *J Am Coll Surg*. 2007;204(2):236-243.
7. Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med*. 2009;360(5):491-499.

## **ADDITIONAL RESOURCES**

Ariadne Labs. Surgery: WHO Safe Surgery Checklist. <https://www.ariadnelabs.org/areas-of-work/safe-surgery-checklist/>. Accessed December 2, 2020.

Correct Site Surgery Tool Kit. AORN, Inc. <https://www.aorn.org/guidelines/clinical-resources/tool-kits>. [Member login required]. Accessed December 2, 2020.

Guideline for team communication. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2021:1065-1096.

The Joint Commission. National Patient Safety Goals.

<https://www.jointcommission.org/standards/national-patient-safety-goals/>. Accessed December 2, 2020.

The Joint Commission. The essential role of leadership in developing a safety culture. *Sentinel Event Alert*. 2017;57. [https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea\\_57\\_safety\\_culture\\_leadership\\_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9](https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea_57_safety_culture_leadership_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9). Accessed December 2, 2020.

[https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea\\_57\\_safety\\_culture\\_leadership\\_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9](https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea_57_safety_culture_leadership_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9). Accessed December 2, 2020.

Joint Commission Center for Transforming Healthcare. Safe Surgery.

<https://www.centerfortransforminghealthcare.org/improvement-topics/safe-surgery/>. Accessed December 2, 2020.

World Health Organization. WHO surgical safety checklist and implementation manual.

[https://www.who.int/patientsafety/safesurgery/ss\\_checklist/en/](https://www.who.int/patientsafety/safesurgery/ss_checklist/en/). Accessed December 2, 2020.

## **PUBLICATION HISTORY**

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