ASPAN
American Society of PeriAnesthesia Nurses

Message from the President

Journey to Perianesthesia Excellence: Creating Best Practices and a Safety Culture

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Have you ever made a mistake? Have you had a near miss or a close call? Let's face it, we all make mistakes. Mistakes happen whether you're driving, cooking, or typing. Mistakes happen in hospitals, surgery centers, outpatient clinics, and physicians' offices. We, as clinicians, must acknowledge that mistakes happen. Our challenge as healthcare professionals is to avoid mistakes, and when they do occur find ways to prevent such mistakes from causing harm to patients.

Errors are commonly attributed to inappropriate labeling, dosing, routing, preparation, and apparent incompetence.[1] Errors are not unique to healthcare. The aviation and automotive industries realized that system faults lead to errors, necessitating vital system design changes to minimize errors. It has been approximately seven years since the publication of the first Institute of Medicine (IOM) report, To Err is Human: Building a Safer Health System[2], and five years since the follow-up report, Crossing the Quality Chasm: A New Health System for the 21st Century.[3] The volume of implemented and proposed changes resulting from these reports serves as a startling reminder that an improved culture of patient safety must emerge.

Safety in Numbers
As many as 98,000 patients die yearly in hospitals due to preventable errors. Nationwide estimates for collateral expenses related to lost income and household productivity, disability, and necessary additional care for patients experiencing preventable medical errors ranges from $17-$29 billion per year, while the risks associated with hospital stays continue to rise.[2] The IOM reports appalled consumers and eroded trust. As healthcare professionals we have a responsibility to help restore patients' and families' trust in our system.

The third phase of the IOM quality initiative, "Health Professions Education: A Bridge to Quality",[4] asserts that education reform for healthcare professionals can enhance the quality of care and improve collaboration across the professions, which will subsequently facilitate system design solutions. How are we doing seven years after the first report? Awareness of safety concerns is certainly greater, but safety issues don't resolve just because staff members have good intentions.

Safety initiatives are extensively woven into today's healthcare agenda. The Institute for Healthcare Improvement (IHI) is one driving force for healthcare safety. The IHI developed the "100,000 Lives Campaign" to engage U.S. hospitals in making a commitment to implement system changes to improve patient care and prevent avoidable deaths.[5] This campaign marked the first national effort to promote saving a targeted number of lives. Other organizations and stakeholders also stress the importance of re-examining healthcare delivery processes while implementing guidelines and protocols to improve quality outcomes.

Important aspects for improvement in healthcare safety include:

- Improved communication through development of communication systems that assist in error prevention
- Effective decision-making, required to facilitate change and improve the workplace environment

- Enhanced interdepartmental collaboration that involves nurses in system design ideas and decision-making processes

"You must be the change you wish to see in the world." – Mohandas Karamchand Gandhi

Perianesthesia Safety Initiative
ASPAN's mission is to generate a safer perianesthesia care setting and provide guidelines for best practices. It is not acceptable to provide care based solely on personal or organizational opinions. Standards, protocols, and healthcare delivery systems can be accepted when their validity and outcomes are proven to be positive. Nurses occupy a critical role in patient safety and share responsibility to ensure client hospitalizations are as accident and error free as possible. As nurses, we must continually push for better standards and promote best practices while mentoring colleagues to uphold patient safety systems in the workplace.

Two years ago, the Safety Strategic Work Team (SWT) assessed safety culture among perianesthesia nurses. The information gathering, based on the 2004 JCAHO safety goals, focused on patient, nursing, staffing and environmental issues. The survey used included three major elements: patient safety, staff safety, and environmental safety. Each element contained specific questions pertaining to each perianesthesia area of care. A nationwide survey, begun during the 2005 ASPAN National Conference in Chicago, yielded more than 600 responses from perianesthesia colleagues and provided insight regarding how nurses manage safety. Dina Krenzischek, MAS, RN, CPAN, ASPAN Safety Committee Chair, completed the safety survey data entry and with the assistance of Linda Wilson, PhD, RN, CPAN, CAPA, BC, analyzed the data. More information regarding ASPAN's strategic safety initiatives is found in the article on page 16.

Safe Staffing
An increasing number of reports and research findings support that quality of healthcare is proportional to the number of RNs providing patient care. The nursing profession is aggressively searching for a solution to produce staffing levels that are safe and effective for patient care, while maintaining affordability. Because nursing influence impacts regulatory and policy recommendations aimed at improving the quality of healthcare, ASPAN will ensure there is a strong perianesthesia presence in the decision-making process.

Myrna Mamaril, MS, RN, CPAN, CAPA, and Ellen Sullivan, BSN, RN, CPAN, serve as Co-Coordinators of ASPAN's Staffing SWT. This team is in the process of investigating opportunities and strategies for safe staffing in the perianesthesia arena. Please see the article on page 4 for more information on the SWT's work in progress. ASPAN, as the voice for perianesthesia nursing, will remain at the forefront to find the right solution and make a difference in perianesthesia care staffing paradigms.

ASPAN is committed to providing recommendations for a better and safer work environment; therefore, we must remain proactive regarding safety initiatives. As is evident from the committee work described in this *Breathline* edition, your ASPAN leaders are committed to a perianesthesia safety journey to excellence, and the protection of our patients and your professional practice. As perianesthesia nurses, we are the experts who can minimize or eliminate errors in our setting. WE will make this journey together!

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