ASPAN
American Society of PeriAnesthesia Nurses

# Message from the President

## Vision In Action: Safety Begins With Us

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Everyday we strive to excel in what we do at work. None of us plan to go to work to make a mistake. We use our knowledge, experience, skills, and critical judgment in everything we do. Our nursing actions have been shown to be directly related to better patient outcomes. Each day we intercept health care errors before they can adversely affect our patients. If we are doing so well, why do we need to address safety in our work environment?

In its report, *To err is human: Building a safer health system*, the Institute of Medicine (IOM) estimated that as many as 98,000 hospitalized Americans die each year, not as a result of their illness or disease, but as a result of errors in their care.[2] This is an alarming number that got the attention of federal and state policy makers, health care organizations, health care practitioners and experts. A Committee on the Work Environment for Nurses and Patient Safety identified threats to patient safety arising from every level and component of health care delivery, including work processes, workload, work hours, and workspaces of nursing staff. As we face a nursing staffing shortage, the committee believes it is even more imperative that nurses' work and work environments be designed to facilitate the safe delivery of nursing care.

What is our role? As perianesthesia nurses, we have a critical role in patients' safety. We are patients' advocates and work at the bedside preparing our patients for surgery. We assure that all required information obtained in patients' records, as well as through the interview process, meet the patients' readiness for surgery and other procedures. We assess and monitor patients postoperatively to critically evaluate and implement the appropriate interventions and treatment. We also function as a coordinator, educator, and directors. In our position, we all address work environment factors that foster safety culture. We are vigilant in preventing errors. A study of medication errors in two hospitals over a six-month period found that nurses were responsible in intercepting 86% of all medication errors made by physicians, pharmacists, and others involved in the patient care.[3] This validates that we are an inseparable link to patient safety.

What is error? Errors are failures of planned actions to be completed as intended, or the use of wrong plans to achieve what is intended. Adverse events are injuries caused by medical intervention, as opposed to the health condition of a patient. For example, a medication error may lead to no detectable adverse event and other errors can temporarily or permanently harm a patient.

Why do health care errors occur? There are two different views that focus on individuals versus systems. As individuals, we are primarily responsible for any error or unsafe action. These unsafe acts arise from individual's faulty mental processes or weakness of character, such as forgetfulness, inattention, poor motivation, carelessness, negligence, and recklessness. The contrasting systems view of errors and error prevention is based on the interrelated human and nonhuman systems. A fundamental principle of the systems approach to error reduction is the recognition that all humans make mistakes and that errors can occur even in the best organizations. As a result, errors can occur through active human failure and actions implicated in all organizational accidents. The experts recommend that we need to strive for fair and just systems of safety that acknowledge both individual and system contributions to successful, as well as adverse events, while emphasizing the system approach to error reduction.[4] For example, a nurse makes a medication error as a result of picking a similar looking vial and giving the wrong medication.

The nurse's contribution in preventing errors is the implementation of the Five Rs (right patient, right order, right medication, right dose, and right route). The system contribution is the elimination of similar vials with different medications and implementation of other methods to prevent errors, i.e., package and label medications differently, location of drugs in different places rather than side by side. Reporting such incidents should not be based on a punitive approach, but rather as a lesson learned to make things better and safer.

What are the risk factors that perianesthesia nurses are facing that may contribute to errors? Patients are more acutely ill and there is high patient volume within a fast-paced environment. In addition, perianesthesia nurses care for a variety of patients from pediatric to aging population, from ambulatory to critically ill patients, different socio-economic backgrounds, etc. Patients' information is coming from different sources and may not be available when we need it. Inadequate education, training, and lack of competency among nurses contribute to the problem. Cost pressures affecting work redesign and declining numbers of nursing staff are also important factors to examine. Perianesthesia nurses are often working long work hours due to the unpredictable nature of our patient flow and increased on-call hours. Being in an open room with higher noise level can increase interruptions. Increased demands on nurses' time, including long documentation and paperwork to meet clinical requirements, regulatory and institutional needs, are additional risk factors.

So how do we create and sustain a culture of safety in the perianesthesia setting? The Committee on the Work Environment for Nurses and Patient Safety identified necessary patient safeguards in the workplace environment of nurses:

- Ensure the link between practice and patient safety. Attention to safety should have the same extent if not more than finance and productivity.
- Provide ongoing vigilance in balancing efficiency and patient safety. Engage staff in decision making and continue to educate.
- Promote effective nursing leadership by participating in executive decision-making representing the different levels of staff.
- Provide adequate staffing which is consistent with best available evidence on safe staffing threshold.
- Provide organizational support for ongoing learning and decision support. Promote the use of preceptor, mentor, and training for new technology.
- Collaborate with other disciplines to solve issues and/or exchange ideas.
- Focus on unsafe and inefficient work design.
- Build the organizational culture that continuously strengthens patient safety by reporting, analyzing and giving feedback. Rewards and incentives may be used.

Commitment of leadership to safety is critical. Although organizations can influence values, norms and institute incentives and awards, it is imperative that both leaders and employees move in the same direction. Words alone are not effective and, therefore, we must be able to "walk our talk" at all levels. Communication must meet multiple goals and commitment can ensure patient safety and culture of safety. Education and training are key elements in identifying error detection, analysis, and reduction. Reporting errors and near misses are critical steps in analyzing issues and developing actions to resolve problems. However, this should follow the direct feedback to the appropriate employee(s) to influence change in practice.

Institutions and specialty organizations like ASPAN provide numerous educational opportunities, including standards and competency modules, but knowledge is not enough unless we apply it. We must make a commitment to be a part of the solution because safety begins with us.

**REFERENCES**


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