By Rachel Fields
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Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, CEO and executive director of the Association of periOperative Registered Nurses (AORN), discusses the top 10 patient safety issues facilities should tackle in 2011.

1. Sharps. According to Ms. Groah, patient safety issues involving sharps fall into four main categories:

• **Knife blades.** Ms. Groah says patient safety experts recommend nurses and surgeons implement a "safe zone," or an area where the nurse places the knife blade for the surgeon to pick up. This practice is an alternative to directly handing the knife blade to the surgeon, which can result in cuts. "Many surgeons are very reluctant to implement a safe zone," Ms. Groah says. She credits the reluctance to surgeons' disbelief that an adverse event could happen to them, as well as a feeling that the "safe zone" wastes time and is unnecessary for patient safety.

• **Blunt suture needles.** According to Ms. Groah, blunt suture needles are proven to be safe and effective and have been on the market for a number of years. Despite this, she says surgeons hesitate to embrace the use of blunt needles, opting for sharp needles instead and thus increasing the likelihood of being punctured.

• **Double-gloving.** Double-gloving, or wearing two pairs of surgical gloves, is another practice that can help prevent needle sticks. Unfortunately, some providers are reluctant to double-glove because of the decreased sensitivity.

2. Medication safety. Medication safety covers several topics, including the reuse of needles, syringes and multiple-dose vials, proper labeling of medication and communication with patients about drug interactions. Ms. Groah says the reuse of needles, syringes and multiple-dose vials is a major issue, one that has caused several serious disease outbreaks in the United States. "If providers are using a multiple-dose vial, they need to make sure it's dated and not used beyond expiration and that a new syringe goes into that vial every time," she says. "Best of all is to get rid of multiple-use vials [and purchase single-use vials instead]."

She says providers should also make sure that medications on the back table in the OR are properly labeled. "You can't assume that you know what's in the container and that you're not going to forget," she says. "Every single medication on the back table must be labeled to prevent patient injury."

Communication with patients pre-operatively and before discharge is extremely important to avoid adverse medication interactions, Ms. Groah says. "When a patient comes in for surgery, they need to bring a list of the medications they're on so there is no interaction with the [anesthetic]," she says.

If the provider does not explain that every single medication needs to be listed, the patient may think that some medications — such as non-prescription herbs — are not worth mentioning. "Indeed, some of the things we take that are not prescription medications have a potential for interactions," she says. She says while there is no single "best practice" for medication

reconciliation, some facilities ask geriatric patients to bring all their medications in a bag. That way, the provider knows that no medications have been missed, and they can look at every drug to record the correct name and dosage.

Communication is also important prior to discharge, she says. Particularly in ambulatory care settings, providers need to review medication practices with patients to make sure they know when it's safe to start taking medications again. "Patients need to be told when they're discharged that they can start taking the medications they have routinely been taking," she says. "People think, 'I was told to stop taking that [prior to surgery]' and nobody told me to start taking them again so they don't."

3. Hand hygiene. "If we did appropriate hand-washing after every patient and every contact, we could really cut down on surgical site infections," Ms. Groah says. She calls hand-washing the "number one" priority for providers: You can distribute as many antibiotics as you want, but if providers are not washing their hands, patient safety will be significantly endangered. She says providers should encourage patients to ask caregivers whether they have washed their hands. "Give patients permission to ask that question," she says. "Patients put the healthcare team on a pedestal and they won't ask things like that."

AORN has recommended various techniques to help providers wash their hands appropriately. Ms. Groah also recommends providers partner with the hospital's infection preventionist to build a hand hygiene program that truly permeates the institution. "Partnering with other caregivers on something that is so universal is really important for success." she says.

4. Accurate documentation and use of EMR. Accurate documentation is essential before, during and after surgery, Ms. Groah says. Before surgery, providers should give instructions to the patient over the phone and in writing, so they have the opportunity to absorb the information. "The physician's office can start with pre-op instructions that the patient takes home to read," she says. "Patients don't remember everything, and some remember very little, so that documentation pre-op is very important."

During the surgical procedure, she says facilities must work to make EMR easy for nurses to use. If the nurse has to spend extra time on the computer, he or she will most likely compromise patient care. "The guideline there is to put the computer so the nurse is facing the patient or OR table, so they don't have their back to the OR table and the surgical field," she says. She says electronic documentation should use pull-down menus and multiple choice, rather than a lot of free-texting. When facilities first implement EMR, they should account for a steep learning curve and provide an extra nurse for every nurse learning to use the system.

Post-operative instructions should be reviewed for clarity and multi-cultural considerations, Ms. Groah says. Instructions should be written at a reading level no higher than sixth grade to account for differences in reading ability, and some areas of the country will need instructions written in Spanish, Chinese or other languages, depending on the dominant population. To make sure patients understand post-op instructions, she says providers should ask patients to repeat information back to them. Often, a patient who doesn't understand will be hesitant to speak up, so the provider must ask questions to determine whether the information is

understood.

5. Use of new technology. New technology is appearing constantly, and Ms. Groah says providers must take steps to make sure new technology is used safely. "It's very cumbersome and very difficult to keep up with all of these changes," she says. "The number one issue is safe use of the technology, which means having the proper in-service education for staff and [implementing] ongoing education. If you in-service a new piece of equipment today and tomorrow you get a new staff member, you need to make sure they're using the equipment properly." She says competency should be measured on an annual basis to make sure providers are still up-to-date on safety information.

6. Caregiver competency. Many providers have been practicing for many years, and if facilities do not continually check on their competencies, they can practice out-of-date processes without knowing it. The Joint Commission has specific criteria and guidelines for assessing competencies, including fire safety and CPR, but Ms. Groah says institutions should go above and beyond these regulations. "Individual institutions should look at low-volume but high-risk procedures and make sure their staff is competent to perform those procedures," she says. She adds that AORN publishes a book of competencies that are organized by job description, so each role relates to specific competencies necessary for his or her specific role.

She says competencies should be done annually at minimum, but institutions that notice a problem with a particular provider should assess competencies right away.

7. DVTs. DVTs, or deep vein thrombosis, are also known as blood clots can affect patients in every single healthcare setting. Ms. Groah says certain medications, such as DVT prophylaxis, can be ordered to decrease the likelihood of DVTs. Facilities can also order elastic stockings to put on patients 24 hours prior to and after surgery. The risk of a blood clot is very serious, she says: "The clot may get dislodged from where it forms in the calf or thigh and travel to the heart and lungs, and it can actually be terminal."

She says facilities should make sure to identify patients at risk for DVTs in the pre-op assessment. Consumers are increasingly aware of their healthcare needs and risks and may speak up, but providers during the preopereative assessment will identify DVT-prone patients and take extra precautions.

8. Surgical site infections. Preventing surgical site infections means returning to the basics of nursing and physician education, Ms. Groah says. Every provider has learned about SSIs, but over time, they may forget or become complacent about adhering to correct policies or techniques. In order to help prevent SSIs, all institutions should encourage OR nurses — the "watchdog" of the OR to be alert to breaks in sterile technique and call them to the attention of the team members immediately. Other areas of concern that impact SSIs are increased traffic in the OR, unnecessary opening and closing of OR doors, incorrect antibiotics given to the patient at the wrong time, inadequate hand hygiene and improper surgical attire. The key is to promote learning (and re-learning) among all OR team members is to make sure all policies and procedures are followed and if errors occur that they are corrected immediately.

9. Surgical attire. Issues with surgical attire include home laundering and clothing preference, Ms. Groah says. Some providers want to wear their scrub clothes home and launder them outside the facility, a practice Ms. Groah says is an absolute no. "They are exposing everybody in their family and everybody they encounter outside the facility to the potential contaminants from the OR," she says. In addition, scrub clothes laundered at home are generally not laundered at the correct temperature or using the correct detergent.

She says because operating rooms are cold places, many providers have become used to wearing fleece jackets. Instead, she says they should be wearing "warm-up jackets" that are made specifically for ORs. The jackets button up at the front and are made of the correct fabric for the OR. Fleece jackets, on the other hand, pose a significant safety risk. "They're full of lint, and the lint can get into the incision and cause an infection or create a granuloma, which may require another surgical procedure," she says. "We have colleagues who have been absolutely hysterical about the fact that they can't wear a fleece jacket in the operating room."

10. Retained surgical items. Ms. Groah says the problem of retained surgical items is so difficult to control because it requires OR providers to work as a team. "It requires that, prior to surgery, all the items on the sterile field are counted, and that includes all the sponges, needles and the instruments according to a list of instruments prepared for the case," she says. "At the end of the case, [all those items] have to be accounted for. If you count 100 sponges going into the case, you need to have 100 coming out."

When a surgical item is retained, the patient will require another surgical procedure, which endangers patient safety and also adds to the expense of surgical care. While it seems simple to count the items and make sure none are left behind, Ms. Groah says provider relationships can sometimes get in the way. "The nurse tells the doctor, 'We're short one sponge,' and he or she says, 'I know it's not in there' and proceeds to close," she says. She indicates that nurses can be hesitant to force the issue with physicians for fear of disrespect or other retaliation.

To handle this problem, Ms. Groah says some facilities have "red rules" or "stop the line" calls that any provider in the OR can use. "When anybody on the team has a concern about patient safety or an issue with a patient, they can say, 'This is a stop the line. I'm going to exercise my right to call attention to an issue that may have a negative impact to the patient," she says. "Institutions that have started and implemented this practice have found it to be very successful."