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POSITION STATEMENT

Creating a Practice Environment of Safety

POSITION STATEMENT
AORN believes a culture of safety includes effective communication, individual accountability, a just culture, and a learning culture. AORN recognizes that significant patient safety accomplishments require the presence of a strong safety culture.

Culture of Safety

- AORN believes that all health care organizations strive to create cultures of safety. Strategies for health care organizations to develop cultures of safety include, but are not limited to, the following:
    - allocating an appropriate amount of resources and providing the necessary incentives or rewards to promote a healthy patient safety culture;
    - adopting a responsible and accountable environment to promote a culture that freely reports errors; and
    - responding to errors with a focus on process improvement and individual accountability.
- A commitment to safety must be articulated at all levels of the organization.
- Safety is valued as a top priority, even at the expense of productivity.
- Each perioperative team member has an ethical obligation to perform his or her role and responsibilities with appropriate competencies and with the highest level of personal integrity.
- Patients and their designated support persons are essential partners, and including them in appropriate aspects of care is necessary to develop a safe perioperative culture.

Culture of Communication

- Disruptive behavior is an impediment to communication.
- AORN promotes a comprehensive, zero-tolerance approach to disruptive and intimidating behavior.
- All members of the team, including perioperative leaders, should immediately confront the disruptive individual and implement strategies to de-escalate the situation and manage behaviors.

Just Culture

- A just culture is an environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken.

- Actual or potential errors must be evaluated by reviewing processes first, followed by evaluating contributing factors. Individual accountability is determined in relation to actions.

Learning Culture

- A learning culture is demonstrated when the leaders of an organization are willing and able to draw the correct conclusion from safety data and to take the responsibility to implement the needed strategies for reform.
- Evidence-based practices and continued safety research contribute to an environment that fosters learning.
- Learning is enhanced by an open interdisciplinary discussion of actual or potential errors.
- Disciplinary policies must balance the benefits of a learning culture with the need to retain personal accountability.
- Tools should be created to assist perioperative leaders in investigating and determining accountability when an error has occurred.

RATIONALE

A culture of safety provides an atmosphere where perioperative team members can openly discuss errors, process improvements, or system issues without fear of reprisal.[1-9] A shared set of beliefs is a key condition for safety in high-risk settings, including health care organizations.[10]

In the past decade, many activities have been implemented to address elements that relate to a culture of patient safety. Activities include, but are not limited to, the following:

- increased federal funding for the Agency for Healthcare Research and Quality, which has established a set of Patient Safety Indicators and performed research on the nurse's role in patient safety;
- establishment and growth of the National Quality Forum, where stakeholders from across the health care industry convene to endorse patient safety and quality performance measures;
- establishment of the Surgical Care Improvement Project (SCIP), a national partnership of organizations seeking to reduce surgical complications through the use of SCIP performance measures;
- continued work from organizations such as the National Patient Safety Foundation and the Institute for Healthcare Improvement, which initiated the 100,000 Lives and 5 Million Lives campaigns;
- federally encouraged reporting initiatives led by the Centers for Medicare & Medicaid Services; and
- growth of industry collaborations, such as the Hospital Quality Alliance, the Ambulatory Care Quality Alliance, and the Ambulatory Surgery Center Quality Collaboration.[11]

In the operating room and other complex service lines, communication, cooperation, and coordination are vital to safe patient outcomes.[12,13] Leaders and front-line staff members are accountable for systems and processes that provide a framework that reduces the potential for doing harm in the clinical environment.[14] Leaders who promote team performance and safety play a pivotal role in achieving multidisciplinary coordination in the patient safety culture.[15]

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RESOURCES

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Original approved by the House of Delegates, Washington, DC, March 2006
Revision; approved by the Board of Directors, February 2011
Sunset review, February 2016