AORN Position Statement on
Creating A Patient Safety Culture

PREAMBLE
Since the Institute of Medicine (IOM) report was released in 1999, the vast majority of patient safety initiatives have focused on micro issues, such as medication errors and wrong-site surgery, with little emphasis on the macro issue of culture. A culture change is necessary to ensure that safety innovations, procedural checklists, and other measures have an opportunity to improve patient safety. Lucian Leape, adjunct professor of health policy, Harvard School of Public Health, Harvard University, Boston, has stated that the single greatest impediment to error prevention is that "we punish people for making mistakes." Medical errors are grossly unreported across the country; only 2% to 3% of major errors are reported, and when reported, they do not create stories or generate action. Analytical methods such as root cause analysis (RCA) and failure mode and effects analysis (FMEA) will not work in detecting the causes of errors if health care workers

- are bound by a "code of silence,"
- fear retribution, or
- feel uncomfortable revealing imperfection in a process for which they are responsible.

POSITION STATEMENT
AORN believes that all health care organizations must strive to create a culture of safety. Such a culture will provide an atmosphere where perioperative team members can openly discuss errors, process improvements, or system issues without fear of reprisal. AORN further believes in the following precepts.

- A commitment to safety must be articulated at all levels of the organization.
- Most patient safety initiatives will fail in the absence of a viable safety culture.
- Safety should be valued as the top priority, even at the expense of productivity.
- Health care organizations should allocate an appropriate amount of resources and provide the necessary incentives or rewards to promote a healthy patient safety culture.
- Health care organizations must adopt a responsible and accountable environment to promote a culture that freely reports errors.
- Health care organizations should value learning and respond to a medical error with a focus on process improvement rather than individual blame.
- Errors and mistakes must be evaluated in a manner such that contributing factors are reviewed first, and then accountability is determined in relation to actions.
- 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.
- A just culture is an environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken. It is not a blame-free environment.
- A learning culture is demonstrated by the organization's willingness and ability to draw the correct conclusion from safety data and 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 untoward events by all members of the perioperative team.
- Patients and their family members are essential partners, and including them in appropriate aspects of care is necessary to develop a safe perioperative culture.
- Disciplinary policies must balance the benefits of a learning culture with the need to retain personal accountability and discipline. Tools should be created to assist perioperative leaders in investigating and determining accountability when an error has occurred. James Reason, professor of psychology at the University of Manchester, United Kingdom, has proposed a model of culpability that provides one example of a tool that can be used to determine when disciplinary actions should be taken.
- Disruptive behavior is an impediment to communication and cannot be tolerated in any member of the perioperative team. All members of the team, including perioperative leaders, should immediately confront the individual and implement strategies to de-escalate the situation and manage behaviors.
This position statement articulates AORN's position regarding creating a patient safety culture based upon available research. AORN supports further research that is directed toward creating and maintaining a patient safety culture. It is the responsibility of each facility to establish its own safety culture and policies of accountability.

References

Resources
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