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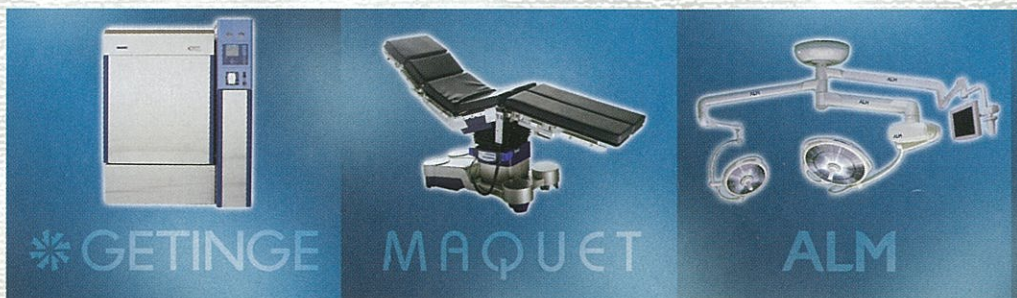
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President's Message

By Mary Knight, RN, BScN, MN, CPN(C)

The theme chosen for the 2002 Perioperative Nurses' Week "Perioperative Registered Nurses: Ensuring Patient Safety" was chosen because since the beginning of surgery as we know it, nursing activities within the perioperative setting have promoted safety for the surgical patient. Through verification of our patient's identity and surgical site, surgical asepsis, infection control practices, environmental safety, surgical counts, documentation, etc., we have integrated the core value of patient safety into our everyday practice in a high-tech and incredibly complex environment. Patient safety has always been, and will continue to be, our primary *raison d'être*.

In the broader healthcare context, it has been recognized that patient safety concerns are real; that systems are prone to error and failure, and that measures must be taken to reduce risk. The publication of "To Err is Human" (1999) by the Institute of Medicine in the U.S. placed the issue of adverse occurrences and errors squarely in the public domain, and created an impetus to action in North America. Reports in both Australia and the United Kingdom led to national efforts in both jurisdictions to promote systemic improvements in the safety and quality of health care, with a focus on minimizing adverse occurrences.

In Canada, the recent publication of the report of the National Steering Committee on Patient Safety: "Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care" (September, 2002) is an attempt to advocate for a national approach to patient safety. Assumptions such as: safety is a fundamental aspect of quality health care; human error is inevitable; and, that underlying systematic factors contribute to most near misses, adverse occurrences and critical incidents underpin the recommendations of the Committee. Other assumptions include: collaboration across all sectors of the Canadian Health Care System must occur to ensure a coordinated and effective strategy for improving patient safety; the health care system must facilitate comprehensive identification of hazards; the health care system must develop an atmosphere of trust, in which openness and frankness in identifying and reporting problems is encouraged and rewarded (no "blame"); partnerships must be encouraged between all consumers and providers of health care; and, appropriate disclosure to all partners must be promoted.

Nineteen recommendations provide many interesting thoughts on how our patchwork quilt of provincial and territorial health systems could be connected to ensure a safer health care system for all Canadians. One of the greatest tragedies is not just that a critical incident occurs, but that we have not always had the opportunity to learn from our own mistakes, nor from the mistakes of our colleagues.

Whether or not the full scope of the Committee's recommendations is adopted, health care systems in Canada and around the world are already beginning to change. Traditional reporting systems are being re-structured to include reporting of "near misses" and steps are being taken to change the culture of blame related to reporting occurrences.

Recognition of the increasing complexity of the health care system, including its processes and rapidity of change has contributed to the emphasis on patient safety. It is also clear that our traditional processes to ensure safety are not sufficient to control adverse outcomes (2002). Patient safety, long the focus of the perioperative nurse, is moving to its rightful place front and center stage!

References:

Kohn, L.T. Corrigan, J.M. & Donaldson, M. (eds.) (1999). *To Error is Human: Building a Safer Health System*. Washington: National Academy Press.

National Steering Committee on Patient Safety (September 2002). *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*. *

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