

Pneumatic Tourniquets

4.10 Pneumatic Tourniquets, Application and Use

Pneumatic Tourniquets may be used to occlude blood flow in an extremity to establish a “bloodless” field for surgery, or to confine anesthetic agents to an extremity for intravenous regional anaesthesia such as Bier Block. (AORN, 2010)

The Perioperative Registered Nurse shall:

<u>PRACTICE</u>	<u>RATIONALE</u>
4.10.1 Verify the purpose of the tourniquet application preoperatively.	Single tourniquets may be used to establish a bloodless field. Double tourniquets are required to establish a Bier Block.
4.10.2 Verify the surgical site prior to the application of the pneumatic tourniquet	Reduces the potential for error related to wrong site surgery.
4.10.3 Follow manufacturer’s instructions for the application and safe use of pneumatic tourniquet(s).	Staff require access to this information as different manufacturers of pneumatic tourniquets have different requirements for use of the device.
4.10.4 Inspect and test the entire tourniquet system before each use. This includes but is not limited to: <ul style="list-style-type: none">- calibration of the system (units may be self calibrating on start up);- checking the pressure gauge according to manufacturer’s instructions.- testing the tourniquet for integrity and function;- inspecting the cuff and tubing for cracks, tears and leaks;- inspecting adapter connections for security;- check to ensure alarms are functioning;- ensuring if a gas source is used it is compatible with the equipment and design.- malfunctioning equipment and accessories shall be removed for repair and/or discarded and replaced.	Accuracy of calibrations of pressure gauges is critical. Nerve injury and palsy can result from excessive or insufficient pressure. To detect malfunctioning equipment prior to patient use Reusable tourniquets are subject to wear and deterioration. Unintentional pressure loss may result from cuff and/or tubing leaks or insecure connections. “Connection of incorrect gas for inflation creates a fire hazard” (AORN, 2010, p. 177). To prevent patient injury related to unsafe equipment
4.10.5 In collaboration with the surgeon or Anesthesiologist, select an appropriately sized cuff, or cuffs, if two single cuffs are being used. The tourniquet cuff should overlap at least 3 inches (7.5cm) but not more than 6 inches (15cm), or as specified by the cuff manufacturer. Select a cuff that is wider than half the limb’s diameter.	Correct sizing of tourniquet cuffs allow for even pressure and skin/nerve/muscle protection. Not enough overlap compromises effective tourniquet function and may result in unexpected release, and inadequate constriction. Too much overlap causes increased pressure and potential wrinkling of soft tissue. Wider cuffs disperse pressure over a larger surface area thus minimizing the risk of injury to underlying tissue.

PRACTICE

RATIONALE

- | | |
|--|---|
| 4.10.6 Ensure the condition of the skin under and distal to the cuff site is not broken or discoloured prior to cuff application. | Sets a baseline for post procedure assessment when the cuff is removed. |
| 4.10.7 Ensure the cuff is snug at both proximal and distal edges. Position the tourniquet cuff at the point of maximum circumference of the extremity. For tapered limbs (i.e. bariatric patients), use a contoured tourniquet cuff. | Clinical trials show that wider and contoured cuffs occlude blood flow at a lower pressure than narrow or straight tourniquet cuffs of equal width. |
| 4.10.8 Do not rotate cuffs or reposition them after application. | Rotation creates shearing forces that may cause skin tears and/or micro-vascular damage. |
| 4.10.9 Follow manufacturer's instructions regarding placing padding around the extremity beneath the cuff. Do not use cotton cast padding, sheet padding, "Webril", or any material that may shed fibers. (McEwan, 2011). | Soft, wrinkle-free padding provides extra protection to the limb. Improperly applied padding may cause injury by pinching soft tissue and skin.

"Lint from these materials can become embedded in the hook and loop cuff fasteners and reduce their effectiveness, possibly leading to an unexpected release of the cuff during the procedure" (McEwan, 2011). |
| 4.10.10 Protect the patient's skin under the cuff from pooling of fluids or solution. Impervious drapes or tourniquet coverings should be used around the tourniquet. | Prep solution pooled under the tourniquet cuff may cause chemical burns to the skin, and if alcohol based, may be an ignition source for fire. |
| 4.10.11 Exsanguinate the extremity after prepping and draping, but before cuff inflation. Limb exsanguination may be achieved by elevating the limb or wrapping it distally to proximally with an elastic esmarch bandage before tourniquet cuff inflation (Phillips, 2007). | Compresses superficial blood vessels, forcing blood out of the extremity. |
| 4.10.12 Never exsanguinate using an esmarch bandage following a traumatic injury or after the removal of a cast. | "Thrombi in blood vessels may become dislodged, resulting in emboli." (AORN, 2010, p. 179). |
| 4.10.13 Inflate the cuff immediately after exsanguination. | Prevents refilling of the limb. |
| 4.10.14 Inflate the tourniquet cuffs rapidly. | "Rapid tourniquet cuff inflation occludes arteries and veins almost simultaneously, preventing filling of superficial veins before occlusion of arterial blood flow" (AORN, 2010, p. 180). |

PRACTICE

4.10.15 Ensure the cuff pressure settings are based on:

- the manufacturer's recommendations;
- the surgeon's and/or anaesthesiologist's instructions which are determined according to the patient's age, limb size, systolic blood pressure, width of the cuff to be used, and taking into consideration patients with atherosclerotic vascular disease.
- Pressure settings should be based on limb occlusion pressure (LOP). Some pneumatic tourniquet systems have been designed to determine LOP automatically and add a safety margin to allow for fluctuations in blood pressure intraoperatively.
- If this is not an option a standard cuff can be used to determine LOP:
 - when the blood pressure is approximately stabilized to the level expected during surgery (depending on the anesthetic technique this may occur before or after induction of anesthetic);
 - locate the arterial pulse distal to the cuff using a doppler stethoscope;
 - slowly increase the cuff pressure until the arterial pulse stops and remains stopped for several heartbeats (the pressure at this time is LOP)
 - deflate the cuff, and confirm the distal pulse has resumed.
 - Set the pneumatic tourniquet pressure to the LOP plus a predetermined safety margin
 - LOP less than 130 mm Hg, add 40 mm Hg
 - LOP between 131 – 190 mm Hg add 60 mm Hg;
 - LOP greater than 190 mm Hg add 80 mm Hg;
 - The recommendations for pediatric patients is to add 50 mm Hg.
 - Confirm the LOP and pressure setting with the surgeon prior to inflation (AORN, 2009).

RATIONALE

Adequate blood supply may already be compromised.

To minimize the risk of injury, the tourniquet pressure should not be any higher than necessary. "Research studies have shown that occlusion can be achieved using a lower pressure when using a LOP method in conjunction with a wide tourniquet cuff in adult patients. The same was found when studying children" (AORN, 2010, p. 179).

To allow for fluctuations in blood pressure throughout the procedure.

PRACTICE

- 4.10.16 Monitor safety parameters during pneumatic tourniquet use including:
- Fluctuations in patient's blood pressure
 - cuff pressure display;
 - observation of excessive fluctuations;
 - the duration of inflation and,
 - notify the surgeon when the cuff has been inflated for 1 hour and every 15 minute interval thereafter.

- 4.10.16 At time of deflation of the tourniquet cuff, immediately remove the cuff and padding and check circulation in the limb. Address any signs of tissue damage with the surgeon and document.

- 4.10.18 After cleaning of a reusable pneumatic tourniquet system, inspect it. The inspection should include but not be limited to assessing:
- for thorough cleanliness;
 - any obvious discoloration remaining due to blood or residue remaining from previous use that could be a potential source of contamination;
 - any physical damage to the cuff, for example, any rips, tears, holes, unevenness or rippling along the length of the cuff when laid flat;
 - the positive-locking hose connector(s) on the valve stem for intactness;
 - the black "O-ring" on each connector for cracks, damage or completeness.
 - the colored ribbon for tears or broken stitching;
 - the hook and loop (Velcro) material for tears, frays or broken stitching; and
 - if more than 25% of the (Velcro) contact closure material is embedded with fibers that cannot be removed for leaks in the cuff or connectors. (McEwan, 2011)

- 4.10.19 Discard disposable cuffs as per manufacturer's recommendations.

RATIONALE

Prolonged inflation time leads to serious patient injury, including extremity paralysis. "There is a general agreement that inflation time should not exceed 60 minutes for an upper extremity and 90 minutes for a lower extremity. In pediatric patients, inflation times of less than 75 minutes for lower extremities have been recommended. When prolonged tourniquet time is desired, the tourniquet should be released for reperfusion of the limb every hour. The reperfusion time should be 15 minutes, after which the tourniquet may be reinflated for another full period as above" (AORN, 2010, p. 180).

"Even the slight impedance of venous return by the padding or deflated cuff may lead to congestion and pooling of blood at the surgical site" (AORN, 2010, p. 180).

To prevent cross contamination to another patient and check for potential cuff damage.

Improper cleaning places the patient at a risk of infection.

Accumulation of debris on the hook and loop strip (Velcro) closure may reduce contact closure effectiveness.

Some newer tourniquet instruments have advanced leak detection for automatically detecting leaks in cuffs during and after surgical operations.

PRACTICE

- 4.10.20 Document pneumatic tourniquet use. This shall include:
- time of inflation/deflation;
 - pressure setting;
 - location and size of cuff;
 - unit serial number, model, or designated number;
 - equipment check with a pressure gauge (for manual units);
 - surgeon notification of elapsed time;
 - the condition of the skin under the cuff before and after tourniquet usage; and
 - identification of the person applying the cuff.
- 4.10.21 Be aware that additional care shall be taken in procedures involving tourniquet control in two extremities.
- completely deflate and remove the first tourniquet cuff and limb protector to ensure complete deflation has occurred.
- 4.10.22 Place a pulse oximeter on the finger or toe of the affected limb to check for circulation if the cuff can not be removed.

RATIONALE

Accurate documentation of the pneumatic tourniquet application is a medical legal requirement.

Problems with circulation and/or incomplete tourniquet deflation could go unnoticed throughout the second procedure.

REFERENCES

- Association of periOperative Registered Nurses. (2010). *Perioperative Standard and Recommended Practices*. Denver: Author.
- McEwan, J. (2011). *Tourniquet use and care* http://www.tourniquets.org/use_care.html
- Phillips, N.M. (2007). *Berry & Kohn's operating room technique*. (10th ed.). Toronto: Mosby.

BIBLIOGRAPHY

- Association of Surgical Technologists, (April 3, 2007). *Recommended Standards of Practice for Safe Use of Pneumatic Tourniquets*.
http://www.ast.org/pdf/Standards_of_Practice/RSOP_Pneumatic_Tourniquets.pdf
- McEwen, James. A., PhD., P. Eng; Inkpen, Kevin, MASc; (2002). Tourniquet safety: preventing skin injuries. *The Surgical Technologist*, 24 (8).
- McEwen, J.A. Kelly, D.L, Jardanowski, T, Inkpen, K, (2002). Tourniquet Safety in Lower Leg Applications. *Orthopaedic Nursing*, 21(5), 55-62.
- McEwen, James A., PhD,PEng; Inkpen, Kevin, MASc; Younger, Alastair, MB,ChB,FRCSC. (2002) Thigh tourniquet safety. *The Surgical Technologist*, 24(7) 8-19.
- Walsh, Eric F, et al, (2006). Microbial Colonization of Tourniquets used in Orthopedic Surgery. *Orthopedics*, 29(8), 709-713. accessed April 15, 2009 from www.ORTHOSuperSite.com

Smoke Evacuators

4.11 *Smoke Evacuators*

“4.3.1 General

Procedures shall be in place to protect patients and clients from exposure to plume. These procedures shall include, but not be limited to, the following:

(a) During a medical or surgical procedure performed in or near respiratory passages, adequate plume removal shall be provided for patient or client protection.

When jet ventilation is applied during laser treatment in the upper respiratory tract, the surgical team shall take precautions to ensure that the ventilation flow does not transport plume particles and gases into the patient’s respiratory system.

(b) During enclosed procedures (e.g., laparoscopy and endoscopy), the surgical team shall ensure that there is appropriate plume removal from the surgical site.

(c) Adequate room ventilation shall be provided.” (CSA Standard Z305.13-09 p.4)

PRACTICE

4.11.1 A smoke evacuation system shall be used whenever tissue is vaporized. Smoke evacuation shall comply with CSA Z305.13-09: Plume scavenging in surgical, diagnostic, therapeutic, and anesthetic settings.

RATIONALE

“One gram of tissue was lasered with a carbon dioxide laser, and an identical gram of tissue was vaporized with electro-surgical current. A comparison of the emitted chemical byproducts to those present in average tobacco smoke demonstrated that the laser smoke generated from a gram of tissue was equivalent to smoking three unfiltered cigarettes, while the electro-surgical smoke was equivalent to smoking six unfiltered cigarettes” (McCormick, P. Bulletin: 2008, Volume 17, Issue 1).

“Associated risk from inhalation of these particles include airway inflammation, coughing, headaches, nausea, hepatitis, asthma, chronic bronchitis, carcinoma, emphysema, and HIV” (Walker, B. 2005)

“This plume has been found to contain toxic gases and vapors (eg benzene, hydrogen cyanide, formaldehyde) that produce an offensive odor; bio-aerosols, including blood fragments; and viruses” (AORN, 2010, p. 230).

“When analyzed, smoke from electro-surgical units, commonly known as Bovie smoke, is shown to be quite similar to that of other potentially pathogenic smoke, behaving as a carcinogen, a mutagen and an infectious vector. In addition, particulate matter in smoke is known to have health risks related to inducing inflammatory and allergic responses in susceptible people”. (McCormick, P. 2008)

<u>PRACTICE</u>	<u>RATIONALE</u>
4.11.2 Manufacturer's recommendations shall be followed regarding proper use, care and cleaning of the smoke evacuators.	Improperly used and/or poorly cleaned equipment places staff and patients at risk.
4.11.3 Smoke evacuation system filters shall be changed according to the manufacturer's recommendations.	To ensure optimum filter functionality
4.11.4 Smoke evacuator systems shall have ultra low penetration air filtration (ULPA filter at 0.1 MICRON filtration) and an efficiency rating of not less than 99.9%.	Due to the micron size of particulate and bacterial matter present in smoke plume.
4.11.5 Inspect the smoke evacuation system for electrical safety and filter patency before each use.	To ensure the device is in working order, safe and effective.
4.11.6 The smoke evacuator system shall be used for surgical plume only, not for evacuation of body secretions.	Wet filters are rendered ineffective.
4.11.7 The collection device for evacuating plume should be positioned as close as possible to the point of plume evolution without compromising visualization.	Local exhaust ventilation is used to capture airborne contaminants as near as possible to the point of evolution without altering surgical effectiveness to produce an effective removal rate.
4.11.8 Special laparoscopic attachments shall be used to evacuate the plume from the abdomen during laparoscopic procedures.	“ When surgical smoke is not evacuated during laparoscopic procedures, an increase in MetHb and COHb occurs while oxygenation of tissue decreases. MetHb levels may remain above normal in the blood stream for up to 6 h after a procedure, and these changes make pulse oximetry inaccurate.” (Barrett, 2003, pg. 983). Evacuation of plume also keeps the peritoneal cavity clear of smoke allowing for better visualization.
4.11.9 Smoke evacuation filters shall be disposed of as biohazardous waste as per local/provincial /federal regulations.	Used filters are considered biohazardous waste as DNA and viruses have been captured on the filter.

REFERENCES

- Barrett, W.L., Garber, S.M., (2003) Surgical smoke-a review of the literature, Is this just a lot of hot air?
Surgical Endoscopy 17:979-987
- Canadian Standards Association (2009). CSAZ305.13-09 *Plume scavenging in surgical, diagnostic, therapeutic, and aesthetic settings*. Toronto: Author.

- McCormick, P. (2008) . Bovie Smoke: A Perilous Plum. *AANS Neurosurgeon*. 17(1).
<http://www.aans.org/library/Article.aspx?ArticleId=51343>
- National Institute for Occupational Safety and Health - NIOSH Alert (1996). Control of smoke from laser/electric surgical procedures. *NIOSH Publication No. 96*. p. 128.
- Walker, B. (2005). *The ultimate filtration technology*, Walker Filtration Limited 2005
<http://www.walkerfiltration.co.uk/doclib/smoke%20Plume%20Walker%20FILT%20LTD.pdf>

BIBLIOGRAPHY

- Association of periOperative Registered Nurses. (2010). *Perioperative Standards and Recommended Practices*. Denver: Author.
- AMT Electrosurgery. Nuses Advocating Smoke –free Theatres Immediately.
<http://www.becomenasti.com/resources.htm>
- Australian College of Operating Room Nurses Ltd. (2004) ESU equipment in the perioperative setting. *Standards, Guidelines & Policy Statements*. Reference A5 pp. 1-3.
- Bigony, L. (2007). Risks associated with exposure to surgical smoke plume: a review of the literature. *AORN Journal*
- CDC Workplace Safety and Health (October 2006) *NOISH health hazard evaluation report*,
<http://www.cdc.gov/niosh/hhe/reports/pdfs/2001-0066-3019.pdf>
- Cosmescu, I. & Ulmer, B. (2008). Surgical Smoke Evacuation. *AORN Journal*
http://www.findarticles.com/p/articles/mi_m0FSL/is_6_87/ai_n27498626
- Phippen, Mark L, Wells., M.P. (2000) *Patient Care during Operative and Invasive Procedures*. Toronto: W.B. Saunders Company
- Taylor, S. (2009, March). The OR: smoking in a designated non-smoking area. *Canadian Operating Room Nursing Journal*, 27, (1), 6-8,12, 13, 21,22.
- Ulmer, B. (1998). Occupational safety and health administration acts on guidelines for electrosurgical smoke *AORN Journal*. 67(5).

Adverse/Sentinel Events

4.12 Adverse Events/Sentinel Events/Near Misses

Research into adverse events (AEs) has highlighted the need to improve patient safety. AEs are unintended injuries or complications resulting in death, disability or prolonged hospital stay that arise from health care management.

The overall incidence rate of AEs of 7.5% (in our study) suggests that, of the almost 2.5 million annual hospital admissions in Canada similar to the type studied, about 185,000 are associated with an AE and close to 70,000 of these are potentially preventable. (Baker, 2004).

An adverse event is defined as “an event that results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition (CPSI, 2008). A sentinel event, which is also considered an adverse event, is “an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Such events are sentinel as they “signal the need for immediate investigation and response from all levels of the health care team” (Doucette, 2010).

PRACTICE

4.12.1 A process for reporting adverse events and near misses should be in place in all Surgical suites.

4.12.2 Policies and procedures for adverse events and error reduction and reporting should be available to front line staff. The following principles are essential to success of any risk reduction strategy:

- support from everyone in the organization;
- dissemination of information across all levels of the organization;
- making the focus proactive rather than reactive and
- a commitment to support the process of root cause analysis

RATIONALE

The continuous changes in technology increase the potential for error in the surgical suite.

The following are the top 10 devices identified as high risk for patient safety:

1. Infusion pumps;
2. Ventilators and anaesthesia systems;
3. Patient monitors;
4. Defibrillators;
5. Electrosurgical and laser units (burns and fires);
6. Heart-lung bypass and circulatory assist devices;
7. IV Catheters and needle devices;
8. Trocars and staplers;
9. Reprocessing of endoscopy instruments; and
10. Magnetic resonance imaging. (OR Manager, 2003, p. 24)

Health care professionals do not intentionally harm patients. Professionals involved in an error often experience physical and emotional reactions to the event. These professionals require collegial support during investigations. The focus of investigations should be prevention of future events and promotion of insight, understanding and professional growth. (vanPelt, 2008, p.249)

<u>PRACTICE</u>	<u>RATIONALE</u>
<p>4.12.3 Health care facilities should have policies and procedures for adverse event reporting that clearly articulate the actions in the following incident type:</p> <ul style="list-style-type: none"> - near misses/close calls; - adverse events; - sentinel events 	<p>The reporting and analysis of adverse events and near misses (and other potential-for-harm and no-harm events) are important opportunities to recognize weaknesses in the system and to put in place safeguards to prevent similar occurrences in the future (CMPA, 2009)</p>
<p>4.12.4 The adverse event reporting system should:</p> <ul style="list-style-type: none"> - describe occurrences that are unexpected, unusual, or out of the ordinary routine, whether or not they cause injury; - provide for a timely and comprehensive investigation; - identify potential corrective or remedial action; - provide raw data to identify trends; and - provide information necessary to defend staff and/or the health care facility (CMPA, 2009) 	<p>Capturing detailed information about these events should assist in the development of preventative strategies prior to an actual event.</p> <p>This data may be used to identify procedural change required and/or education needs.</p>
<p>4.12.4 Health care facilities should consider anonymous reporting systems which may include but are not limited :</p> <ul style="list-style-type: none"> - blame free with a focus on correcting systems and safety issues, - forms that are easy to fill out and submit. 	<p>Increases compliance with completion of forms.</p>
<p>4.12.5 The incident reporting form should include but not be limited to the following information:</p> <ul style="list-style-type: none"> - what happened in detail; - when happened (date and time); - where it happened; - who was involved and who witnessed the event; and - if equipment is involved, document serial number. 	<p>This information is required for analysis. The Canadian Patient Safety Institute recommends a root cause analysis, or other appropriate form of investigation be carried out for all sentinel events (CPSI, 2006)</p>
<p>4.12.6 Health care facilities should work with their insurers to develop expectations around the following issues related to incident investigation:</p> <ul style="list-style-type: none"> - copies of the adverse event report are sent to Risk Management; - copies of the incident report are sent to nursing services; - process related to whether the procedure requires investigation, follow up and reporting follow up to Risk Management; 	<p>These items are considered "evidence" and need to be secured until the investigation is complete. Examination or repair by in-house biomedical staff should not occur until the facility insurer allows. (HIROC, 1992, p. 1)</p> <p>Disposable items may have a manufacturing flaw that contributed to the incident. The outer packaging identifies lot numbers which would assist in a device recall if necessary.</p> <p>This serves to provide the chain of evidence.</p>

PRACTICE

- guidelines for securing (when necessary) records, equipment or supplies in an area "lock-up" for safe keeping until the investigation is complete;
- guidelines that stress the importance of conserving disposable items involved (including outer packaging if possible) until the investigation is complete;
- process for when the procedure requires that printouts/tracings (e.g. ECG tracing) be retained and notations made of the serial number of the machine generating the tracing; and
- process for when the procedure requires that notes made during the event (i.e. notes made to assist with retrospective charting) be retained. (HIROC, 1992, pp. 13-14)

RATIONALE

REFERENCES

- Baker G. R. et al. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Journal*, 170 (11).
- Hoffman, C. et al (2006). Canadian Root Cause Analysis Framework: A tool for identifying and addressing the root causes of critical incidents in healthcare.
- Hospital Insurance Reciprocal of Canada. (1992). Risk Management Assessment: Operating Room Services. H.I.R.O.C.
- Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. Ottawa, ON: Canadian Medical Protective Association; 2009.
- OR Manager. (2003). Technology in surgery: top ten safety issues with medical devices. *OR Manager*. 19 (4).
- vanPelt, F. (2008): Peer support: healthcare professionals supporting each other after adverse medical events. *Quality and Safety in Healthcare*. 17(4).

BIBLIOGRAPHY

- Burkoski, V. (2007) Identifying risk: The limitations of incident reporting. *Canadian Nurse*, March, 12-14.
- Canadian Health Accreditation Report: A Focus on Safety (2009). Retrieved August 2011 from <http://www.accreditation.ca/en/news.aspx>
- Canadian Medical Protective Association, 2009. Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. Ottawa, ON:.

Canadian Patient Safety Institute. www.patientsafetyinstitute.ca

Dattilo, E., Constatino, R. (2006). Root cause analysis and nursing management responsibilities in wrong site surgery. *Dimensions of Critical Care Nursing*, 25(5), 221-225.

Watson, D. (2009). Sentinel Events. *American Operating Room Nursing Journal*, 90(6), 926-929.

4.13 Disclosure of Events to Patients

“Achieving a culture of safety requires open, honest and effective communication between healthcare providers and their patients. Patients are entitled to information about themselves and about their medical condition or illness, including the risks inherent in healthcare delivery. At times this will mean that information will be provided about possible unexpected and undesired results” (CPSI, 2008). When an adverse event occurs, the patient should be informed about what has happened. Disclosure acknowledges and informs the patient, which is critical in maintaining the patient’s trust and confidence in the healthcare system (CPSI, 2008)

Media attention focused on medical error has heightened the public's awareness on this issue. Errors can be made by any member of the Health Care Team. Accreditation Canada has made it a Required Organizational Practice that adverse events are disclosed to the patient (Accreditation Canada, 2011).

<u>PRACTICE</u>	<u>RATIONALE</u>
<p>4.13.1 Health care facilities shall have a policy and procedure in place for disclosure of adverse medical events (AME). The policy should include but not be limited to the following elements:</p> <ul style="list-style-type: none">- clear expectation that an adverse event report be completed- clear delineation of what AME are to be disclosed;- to whom should the disclosure be made;- who should make the disclosure to the patient;- what should be said to the patient;- how should the disclosure be documented- when disclosure should take place.	<p>The appropriate mechanisms and procedures are needed to meet public expectations.</p> <p>Experience demonstrates that when patients who have been harmed by an incident are treated with honesty and respect, they are less likely to litigate. (Accreditation Canada, 2011)</p> <p>Some provincial nursing statutes obligate nurses to report unsafe practice or unethical conduct of a health professional to the employer or to the professional college. Failure to report is professional misconduct. (HPA, BC, 2011)</p>
<p>4.13.2 Surgical suites need to include but not be limited to the following related to disclosure of AME:</p> <ul style="list-style-type: none">- clear policy and procedure;- education for all members of the health care team regarding expectations of each individual;- support from an advisory health care team to review all AME events;- clear criteria of which events are to be disclosed; and- support including debriefing for all	<p>Health care team members involved in an AME are under considerable stress and must be fully supported (CPSI, 2008)</p>

PRACTICE

RATIONALE

team members involved in an AME.

REFERENCES

- Accreditation Canada: Required Organizational Practices, February 2011.
<http://www.accreditation.ca/uploadedFiles/ROP%20Handbook.pdf>
- Canadian Disclosure Guidelines: Canadian Patient Safety Institute, May 2008
- Doucette, E. (2010). Full Disclosure of adverse events to patients and families in the ICU: Wouldn't you want to know? *Canadian Association of Critical Care Nurses*, 21(3), 16-19.
- Government of British Columbia. (2011) *Health Professions Act*. [RSBC 1996] CHAPTER 183 Regulation 16/2.

BIBLIOGRAPHY

- Accreditation Canada: Required Organizational Practices, February 2011.
<http://www.accreditation.ca/uploadedFiles/ROP%20Handbook.pdf>
- Allan, A. & McKillop, D. (2010). The health implications of apologizing after an adverse event. *Quality in Healthcare*, 22(2), 126-131.
- Canadian Nurses Association: Code of Ethics, 2008.
http://www.cna-nurses.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf
- Doucette, E. (2010). Full Disclosure of adverse events to patients and families in the ICU: Wouldn't you want to know? *Canadian Association of Critical Care Nurses*, 21(3), 16-19.