The Qualitative Report 8th Annual Conference

The Meaning of Intraoperative Errors: Perioperative Nurse Perspectives

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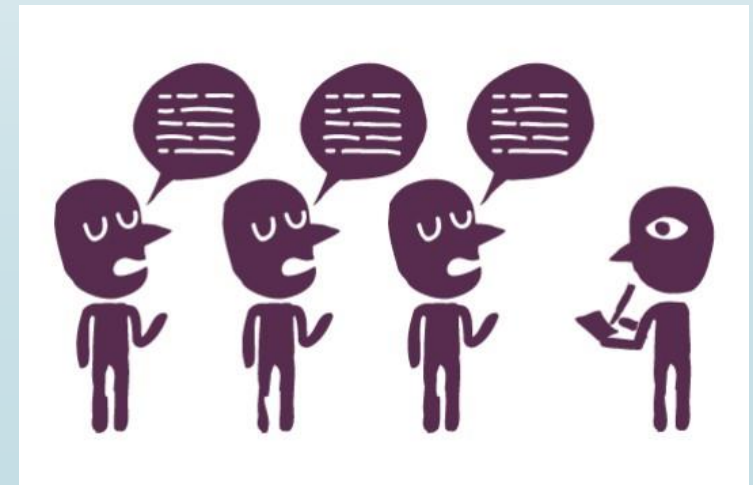Melissa Tovin, PT, MA, PhD

Purpose of the Study

- Describe and interpret the experiences of intraoperative errors from the perspectives of perioperative nurses

Methodology

- Exploratory descriptive design: Hermeneutic phenomenology

- Data Collection

  - Three audio-recorded focus group sessions

- Interview guide

  - Revised and finalized through 2 pilot interviews

- IRB approved

- Participants received a $20 gift card

Participants

- Ten perioperative registered nurses currently practicing in an operating room environment for as least six months

- Demographics

  - Average age-53.4 years

  - Years as a perioperative nurse-23.6

  - Race/ethnicity

    - Caucasian/white: 7

    - Black/African-American: 2

    - Asian: 1

  - Positions

    - Staff-6

    - Clinical Specialist-1

    - CRNA-1

    - RNFA-1; CRNFA-1

Data Analysis and Interpretation

- Audio-recordings were transcribed verbatim by a third party and inserted directly into NVivo-11 for review.
  - Researchers reviewed and compared the audio recordings with the transcribed words for accuracy.
  - NVivo-11 was utilized for data management during analysis.
- Thematic analysis was utilized by the researchers to emerge common categories and themes that represent the essence of the experience of intraoperative errors as described by the participants.
  - 3 Major Themes
- Data saturation

Findings

- Major Themes
  - Environment
  - Being Human
  - Moving Forward

- Major Theme: Environment
  - Errors within the OR are attributed to the surgical environment

"You take a lot of educated people, put them in a room with no windows and fluorescent lighting [laughter], interesting things happen."

- Physical, social, psychological, and cultural factors affected ability to care for the patient
  - *distractions*
  - *intimidation*
  - *generational differences*
  - *being rushed*
  - *communication*

"…the surgeon's yelling and the radio's blaring, and the nurse may be trying to say something or the phone's ringing and nobody hears it, whatever the case may be - a lot of things going on and everyone in the room needs to be sharp, but it doesn't always happen."

"…I see errors occur when people don't feel safe. There's not a culture that encourages people to speak up, encourages people to feel like they're a part of the team, that they feel as like it's just safe in the environment."

"…communication is one, if nothing else, of the biggest reasons [for error], and hurry-ness, rushing".

- Major Theme: Being human
  - Errors were inevitable due *being human*.
    - No intent of doing harm, safety procedures followed, yet errors occurred.
    - Fatigue

"I think errors happen because we're human"

"I think fatigue contributes to it as well."

"Definitely. Short of staff, not getting sufficient breaks, nourishment, hydration, everything that contributes to that, for sure."

- Emotional impact of errors
  - Devastation, horrible, angry, awful, frustrated, embarrassed

"I've seen other people's feelings and I've seen people that feel after an error occurs cry, begin to doubt themselves, begin to doubt that perioperative nursing is for them. I've seen people after errors occur leave."

"I remember telling my husband, I don't know if I can practice anymore."

➡ Major Theme: Moving forward

➡ Different strategies to prevent future errors

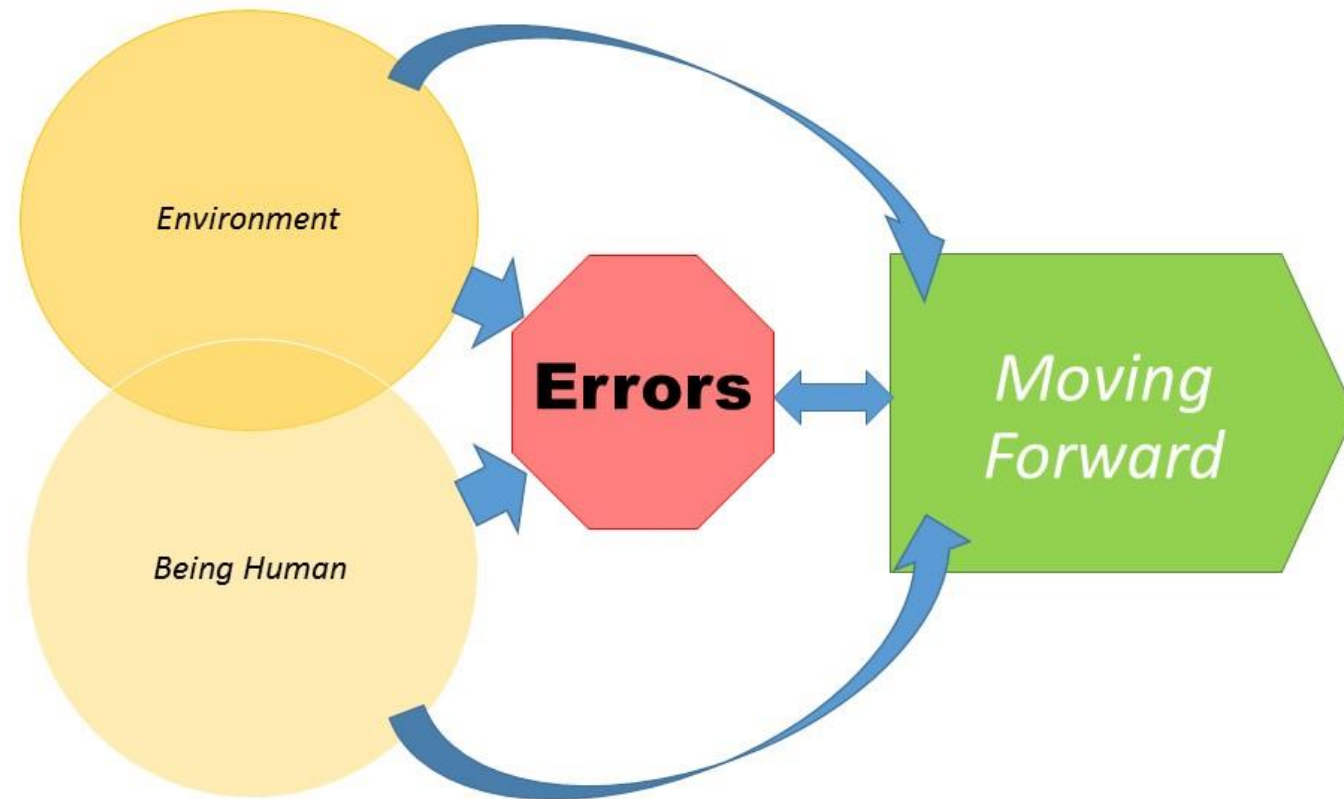➡ Sharing their stories

➡ Teamwork

➡ Evidence-based practice

➡ Quality orientation programs

"I think when an error happens - I know with me, with that one incident - you have to take something bad and make something positive out of it. To one, make yourself feel good, that "Okay, this happened, it could happen to me, it could happen to anybody else," and start formulating a plan, a policy, a something. If something can be written to help the next group of people behind you, or whatever, to make it better."

"… talk about it, share it. Every single person that-- not just at this health care system, but share it, "Hey, this happened at our hospital. Don't let it happen at yours."

Themes

Trustworthiness of Findings

- Credibility
  - Prolonged engagement- trust, understanding of culture
  - Triangulation- sources, investigators
  - Member checks
- Dependability
  - Credibility strategies
- Confirmability
  - Triangulation
  - Audit trail
- Transferability
  - Thick description

Discussion

- In 2016, Makary and Daniel concluded medical error to be the third leading cause of death in the United States

- Greater emphasis on culture of safety
  - Encouraging team members to speak up if they have concerns about patient safety

- Similar themes found in recent studies
  - Environment-intimidation, communication and being rushed (2 descriptors from the theme-environment) continues to be a major cause of errors

Significance

- Gave voice to operating room nurses, an often unseen and highly specialized group

- Inform policies and procedures to ensure safe, quality care outcomes for surgical patients

- Provide information that will allow a targeted revision of the Perioperative Nurse Questionnaire used in a previous study

Limitations

- Recruitment

- Truthfulness

- Researcher bias

- Researcher experience

Select References

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Questions???

thank you!