AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Information Statement

Unified Information Statement on Orthopaedic Surgical Safety

This Information Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

In 1997 the American Academy of Orthopaedic Surgeons (AAOS) introduced surgical site identification through the '*Sign Your Site'* program designed to reduce Wrong Site Surgery (WSS).[1] In 2002 the Joint Commission (JC) incorporated surgical site marking into an expanded surgical safety program - Universal Protocol (UP).[2] Despite the introduction and adoption of many surgical safety initiatives including UP, improvements in surgical care and reduction of preventable harm remains an important shared safety goal for surgical patients, surgeons, healthcare organizations and payers. [3,4] A recent survey of orthopaedic surgeons reveals that most orthopaedic surgeons use safety processes in hospital settings but use safety processes much less frequently for procedures performed in surgical centers and office settings.[5]

All orthopaedic surgeons support minimizing - with a goal of eliminating - all types of preventable surgical harms including wrong site/side/level/procedure/patient/implant surgeries.

Safest surgical care can be provided through highly organized surgical systems of care designed to minimize preventable harms by effectively managing the interfaces among patients, families, physicians, surgical staffs, suppliers, equipment, and surgical environments. Several important components of safe surgical care have been identified as deficient or absent in adverse surgical events reported to the JC including:[6]

- **Surgical Consent – accurate, timely and understandable**
- **Surgical Team and Patient Communication – effective, team-based, and transparent**
- **Surgical Site/Side/Level/Procedure/Patient Identification/Implant – clearly marked, identified and confirmed as accurate surgical site, side, level, procedure, and patient**
- **Surgical Checklists – standardized evidence-based and/or consensus-based 'best' surgical practices used consistently for key elements of surgical procedure(s)**
- **OR Environment Supportive of Concentration – Focused surgical team effort without distraction**
- **Surgical Safety Data Collection – regular collection and analysis of surgical safety and quality data supporting surgical performance improvement**

Orthopaedic surgeons and organizations recognize the national safety goals of the JC, National Quality Forum (NQF) and Agency for Healthcare Research and Quality (AHRQ) designed to minimize preventable harms and improve surgical outcomes.
Orthopaedic surgeons also recognize the important role of leadership and collaboration with hospital administration, anesthesia, nursing and other surgical support services to insure that these surgical safety practices are supported and regularly used at the 'unit level' of care for all orthopaedic surgical patients.[7] Regular use of these safe surgical care processes has been shown to improve the safety, quality, and value of surgical care.[8]

All orthopaedic surgeons and organizations support routine utilization of appropriate and effective surgical safety practices and processes in all orthopaedic settings – hospital ORs, ambulatory surgery centers and office procedure rooms – providing the best possible surgical care and outcomes for all orthopaedic patients.

References:

1. American Academy of Orthopaedic Surgeons: *Wrong-Site Surgery,* Information Statement 1015.Adopted 1997, revised 2008. http://www.aaos.org/about/papers/advistmt/1015.asp
2. Joint Commission: Universal Protocol, 2002
3. JC, NQF and AHRQ National Patient Safety Goals, 2012
4. US Department of Health and Human Services – Partnership for Patients. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html
5. AAOS Surgical Safety Survey, 2011
6. JC Senntinal Events Data Base, 2011
7. AHRQ SUSP Program, 2012
8. WHO *Safe Surgery Saves Lives* Program, 2009

For additional information, contact the Marketing and Communications Department at 847-384-4036.