ABSTRACT

Patient safety is one of the top priorities of anesthesia and perioperative care in the operating room. The patient safety is greatly compromised due to administered medication and the actual operating performance in the perioperative care. The risks of anesthesia and the operational performance are many, starting with the fall of the patient, the possible wrong-site, wrong-procedure, wrong-patient errors, adverse reactions to administered medication, difficult airway management or an unexpected perioperative bleeding. Patient harm in hospital care leads not only to increased costs for additional treatment, prolongation of the hospitalization time, but also significantly affects the subsequent quality of life. Most adverse events are preventable, since most of them are caused by susceptible factors, such as incomplete or incorrect information or the lack of communication between the members of the operating team. Due to the increasing number of such adverse events around the world, including those of the most serious, The World Health Organization has created a program called The Save Surgery Saves Lives, whose aim was the identification of key risk areas in ensuring the safety of patients. On the basis of the identified risk areas the Surgical Safety Checklist was introduced in 2008. It is aimed at reducing errors and adverse events before, during and after surgical procedures. At present it is extended almost all over the world and to the awareness of the medical professionals in the Czech Republic it got roughly five years ago in the form of a pre-op safety procedures.

The aim of this master thesis was in the form of in-depth personalised interviews with perioperative nurses and anaesthesiology nurses analyze their opinions and attitudes to a security procedure, whether the safety procedure suits them as follows or whether they would like to change something. Another important objective of the work was to find out what obstacles during the introduction of this procedure the nurses met.

The presented empirical dates are focused on the process of implementation of the safety preoperative treatment. The main object of the research was to ascertain the opinions and attitudes of anaesthesiology and perioperative nurses to modification of the document Surgical Safety Checklist created by the assessed medical institution. Individualized interviews revealed a misunderstanding of the preoperative safety procedures and its non-use in its entirety in order to increase patient´s safety in the operating room. "Sign-in" phase of the process is carried out by all the addressed nurses, but is not defined the responsibility for its implementation. "Time out" phase does not carried out correctly according to the applicable directive issued by the medical establishment, which is in accordance with the recommendation of the Ministry of Health. "Sign out" phase is actively initiated by perioperative nurses by numerical control of the instruments, the abdominal sponges and other consumables. But it is not implemented in its entirety and the lack of consistency in the implementation of this phase was noticed. This phase is completely absent even in the document "preoperative safety procedure", which is a modified version of the original "Surgical Safety Checklist". Yet the majority of the interviewed nurses perceive the safety procedure positively and as an important part of their job in order to increase the safety of the patients. Possible obstacles for the full implementation of the safety process were recorded

during the interviews. In particular, it is a duplication of some of the data (patient identification), lack of competence, lack of communication in the team and especially the reluctance of physicians to cooperate in the implementation of security procedures.

Preoperative safety procedure is by some seen as a waste of time and bureaucratic act that does not lead to improvement of the patient's safety. The staff training highlighting the importance of the whole procedure would certainly be beneficial and at the same time it would be an opportunity to instruct the employees how to use this tool. Furthermore it would be appropriate to determine the team consisting of senior anestesiology doctors and senior surgeons that would be involved in the implementation of safety procedures and whose aim would be active assistance in the implementation of this procedure. I would also recommend the precise definition of the competences in the management of individual stages of the safety procedures. I recommend inclusion of the third phase to the document of preoperative safety procedure.

Keywords*: *preoperative safety procedure, safety of the patient, anaesthesia care, perioperative care, barriers to preoperative safety procedure