

118: A STUDY FOR NURSING ACCIDENT IN THE OPERATING ROOM

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Objective:

The purpose of this study is to examine causes and nurses' awareness, based on their experiences, of accidents for which they are responsible in operating rooms (OR), and thereby to construct a basic material for preventing accidents by nurses in OR.

Methods:

Data were collected through the self-reported questionnaires from 112 OR nurses from 3rd of September in 2000 to 22nd of September in 2000. The instrument consists of 44 items with three domains; infection control (15 items), direct nursing practice(16 items), environmental management and related(13 items), with 4-point Likert scale(total score range: 44-176). Data were analyzed by t-test, ANOVA, ANCOVA, and Scheffe test with SPSS PC+ program.

Results:

The results of this study are as follows:

1) The average score 73.84(total score range: 44-176) of respondents have experienced the OR accidents by nurses. That is, 27.75 (score range: 15-60) of them have experienced accidents in infection control, 26.57 (score range: 16-64) in direct nursing practice, and 19.52 in environmental management and related (score range: 13-52), respectively.

The amount of the nursing accident experiences in OR was correlated with the length of OR experience ($F=4.325$, $p=.003$), length of clinical experience ($F=2.741$, $p=.032$), and age ($F=3.027$, $p=.033$) among general characteristics of respondents with statistical significance. The experienced group (6-8 years) reported the most accidents with statistical significance.

2) As the causes of nursing accidents in OR, 54.5% of respondents pointed out the deficiency of professional knowledge and skills and 18.8%, overwhelming work load.

As for sequence of accident reports, 63.4% of them reported to a nurse in charge first, 27.7%, to head nurse first.

As for the shift in which accidents occurred frequently, 50.0% of respondents responded independent of shift, and 27.7%, evening shift.

Awareness of accidents was 2.84, and 2.06 in education level, with 2.49 in training level on average, respectively.

3) As for the punishment given by hospitals to the nurse responsible for accidents, official exhortation was documented for 32.3% of them and 29.2% were exhorted verbally.

43.8% of the nurses responded that they had documented an accident report. The contents of accidents included "incorrect count of gauze"(51.0%), "incorrect count of needle"(20.4%), and "incorrect instrument count"(14.3%). Incorrect count accounted for 91.8% of accident reports.

39.9% said that both doctors and nurses have equal responsibilities for accidents in which foreign bodies like gauze or any operating instruments remain in patients.

4) As for prevention, 74.1% responded that the additional nurses are needed, 66.1% in strong professional responsibility of nurses, and 49.1% asked for an intensive follow-up education for nurses.

As for the risk management program, 72.3% of respondents had no clue on it and 13.4% reacted they were under this program.

As for insurance fee with hospitals allotting higher portion to hospitals and 22.3% wanted that nurses should equally share the fee with hospitals.

Conclusions:

In conclusion, the most reported accidents in the OR were related to nursing practice deficiencies in infection control. The study revealed the experienced group (6-8 years) to show the most accidents with statistical significance. To minimize further accidents, I propose an extensive follow-up education intervention the experienced nurses to cure deficiencies in needed areas of nursing practice. In addition, the study showed by statistical significance a greater measure of reported accidents in the OR. Further studies need to be conducted to analyze the reason for the experienced group's high reportings.