Original research article

Checklist for nurse anaesthetists in Poland for the safety of patients: a mixed methods design study

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Abstract
The aim of this study is the further development and verification of “The Check-List for Nurse Anaesthetists” (CLNA). A mixed method study design was applied in order to do so. A focus group consisting of 13 nurses – with a long-standing professional experience in anaesthesiology and intensive care nursing – participated in the first stage of testing. They developed a check-list for nurse anaesthetists. Then, the group attempted to validate and standardise the developed tool. The check-list made it possible to gather information on the procedures performed by nurse anaesthetists which were grouped in six sections. In total, 130 check-lists were validated during the second stage of testing. The Check-List for Nurse Anaesthetists increases the safety of the nursing staff and patients; it helps to maintain a safe working environment, increase responsibility for safe working conditions and awareness of the responsibility among nurse anaesthetists, as well as collect information on the causes of adverse events in anaesthesiology nursing, record them and modify practice accordingly. According to the Working Group of the Polish Association of Anaesthesiology and Intensive Care Nurses, The Check-List for Nurse Anaesthetists should be included in the mandatory or minimum list of additional internal patient documentation.

Keywords: Anaesthetist; Check-List; Nurse; Nursing Documentation; Patient Safety; Validation Studies

Introduction
The level of care and the quality of the healthcare system in general determines the safety of patients using the healthcare services. These can be assessed through an accurate analysis of causes, through monitoring and reporting of adverse events and medical errors. Taking into consideration the ergonomic aspects of the events makes it possible to limit their number and contain the damage. An example of a proper preventive measure against medical errors is the introduction of appropriate documentation for the medical personnel. The Regulation of the Minister of Health (MH) of 12 December 2018 on the organisational standard of healthcare in the field of anaesthesiology and intensive care in Poland defines the obligations connected with completing the anaesthesia record card and the organisation of anaesthesiological work. Article 9 of the above Regulation states, inter alia, that an anaesthetist may simultaneously anaesthetise only one patient, and a nurse anaesthetist cooperates with an anaesthetist during anaesthesia (Dziennik Ustaw, 2018). The physician administering anaesthesia should be close to the patient for the duration of the anaesthesia. According to article 9 (12) of the above Regulation, the physician administering anaesthesia should complete the anaesthesia record card (Dziennik Ustaw, 2018). This legal act does not specify the type or form of medical record in which the nurse anaesthetists tasks with the anaesthesiological care are obliged and authorised to record and document their activities. At the same time, according to Polish law, a nurse cannot replace a physician in performing activities which, under the applicable laws, are their sole responsibility (PTPAiIO, 2012). The role of the nurse anaesthetist during anaesthesiological care is defined as a collaboration with the physician administering anaesthesia. This situation gives rise to some doubts as to whether the lack of documentation concerning the activities performed by nurse anaesthetists could...
lead to professional liability issues in the event of a claim. In response to these concerns, in February 2012 the Working Group (WG) of the Polish Association of Anaesthesiology and Intensive Care Nurses (PTPAiIO) developed “The Check-list for Nurse Anaesthetists (CLNA)”, and recommended its use for individual patient documentation (PTPAiIO, 2012). The aim of this study is the further development and verification of “The Check-List for Nurse Anaesthetists (CLNA)”.

The expert group consisted of 13 nurses with a long-standing professional experience in anaesthesiology and intensive care nursing, an average mean score of 19.3, SD = 8.5 years of professional experience in working at the Anaesthesiology and Intensive Care Unit (A&ICU), Min-7, and Max-30. One of the hospitals in which the regional branch of the PTPAiIO operates was selected at random to validate the tool. The study was conducted at the Anaesthesiology and Intensive Care Unit in the period between 1 and 30 June 2013.

In the second stage of the research, the check-list was completed randomly by nurse anaesthetists during surgery. After collecting the research material, a statistical analysis was performed. The average age of the patients amounted to a mean score of 48.3, SD = 24.0 years. The youngest examined person was 4 months old and the oldest was 93 years old. The experts compiled 55 groups of questions that referred to specific activities performed by nurses tasked with anaesthesiological care, ranging from a patient’s admission to the operating theatre to transferring the patient back to the ward, which should be included in “The Check-List for Nurse Anaesthetists”. These questions were grouped in such a way as to reflect the order of nursing activities during anaesthesia and were divided into: preparation of the operating theatre, preparation of the anaesthesia (according to standards), preparation of the patient, and the course of the anaesthesia, patient status, and cleaning of the anaesthetic environment.

Stage 1, Focus Group Verification. A focus group was formed. The average age of the patients amounted to a mean score of 19.3, SD = 8.5 years of professional experience in working at the Anaesthesiology and Intensive Care Unit (A&ICU), Min-7, and Max-30. One of the hospitals in which the regional branch of the PTPAiIO operates was selected at random to validate the tool. The study was conducted at the Anaesthesiology and Intensive Care Unit in the period between 1 and 30 June 2013.

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Materials and methods
A sequential mixed methods design (qualitative and quantitative research) was used for the purposes of this project (Creswell, 2003) as illustrated in Fig. 1. A mixed methods design answers both “what?” and “how?”.

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The analysis was conducted using the Polish version of the Statistica 13.3 statistical package. The statistical analysis included the basic descriptive measures adjusted to variables, i.e. average, standard deviation, median, quartile distribution, upper and lower quartiles, and minimum and maximum values. The following rules were adopted: \( p < 0.05 \) indicated statistically significant dependence (this was marked with \(*\)); \( p < 0.01 \) indicated a highly significant relationship (this was marked with \(*\)\(\)\).
with **); p < 0.001 indicated a very highly statistically significant relationship (this was marked with ***). The reliability of the card was based on the Cronbach’s alpha coefficient, where the value of 0.6–1.0 was assumed as a value confirming the reliability of the scale.

**Results**

As part of the quantitative research, the CLNA was used to gather information on the activities carried out in anaesthesiological care, which were later grouped into six sections. (Table 1).

In each section, the activities of nurse anaesthetists during anaesthesiological care were enumerated and assigned a value of 1 or 2 points (for activities requiring more work). Each section had a variable distinguished as the general indicator, including the sum of points from the individual activities in the section and a variable as a general normalised indicator from 0 to 100 for comparative purposes between sections, where 82 points represents 100. The general (normalised) index allows the specification of the number of activities (level of activity) performed during a single surgery with respect to all possible activities in a given section (Table 2).

The total score in the activities of Section 1 – Preparation of Anaesthetic Environment – ranged from 0 to 12 points. The mean score obtained in the study group was 7, SD = 0.21 points with a median of 7 points. For standardised results, the average level of activity in Preparation of Anaesthetic Environment amounted to a mean score of 58.3, SD = 0.21 with a median of 58.3. The total score in Characteristics of the Surgery ranged from 0 to 6 points. The mean score obtained in the study group was 0.78, SD = 0.21 points with a median of 1 point. For standardised results, the average level of activity in Type of Surgery and Anaesthetist’s Exposure amounted to a mean score of 35.54, SD = 0.71 with a median of 20. Subsequently, the total score in Preparation of the Patient ranged from 0 to 18 points. The mean score obtained in the study group was 8.1, SD = 2.01 points with a median of 9 points. For standardised results, the average level of activity in Preparation of the Patient amounted to a mean score of 47.27, SD = 11.18 with a median of 50. The total score in The Course of Anaesthesia ranged from 0 to 32 points. The mean score obtained in the study group was 12.21, SD = 6.18 points with a median of 10 points. For normalised results, the average level of activity in The Course of Anaesthesia amounted to a mean score of 38.15, SD = 19.31 with a median of 31.25. The total score in Transfer of the Patient after Surgery ranged from 0 to 11 points. The mean score obtained in the study group was 3.30, SD = 1.56 points with a median of 3 points. For normalised results, the average level of activity in The Course of Anaesthesia was 30, SD = 14.21 with a median of 27.27. The score in the section Cleaning of the Anaesthetic Environment ranged from 0 to 3 points. The mean score obtained in the study group was 2.63, SD = 0.94 points with a median of 3 points. For normalised results, the average level of activity in Cleaning of the Anaesthetic Environment amounted to a mean score of 87.69, SD = 31.37 with a median of 100. A general index of a nurse’s activity in anaesthesiological care was calculated. The mean score obtained in the study group was 35.42, SD = 10.03 points with a median of 33 points. For normalised results, the average level of activity of a nurse anaesthetist amounted to a mean score of 42.20, SD = 12.23 with a median of 40.24 (Table 3).

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**Table 1. The Check-list for nurse anaesthetists**

| Section 1 – Preparation of anaesthetic environment (by standards); total score: 0–12 points | 1. Control of anaesthetic machine |
| 2. Preparation of monitoring equipment |
| 3. Preparation of intubation kit |
| 4. Preparation for peripheral venous catheter insertion |
| 5. Preparation for central catheter insertion |
| 6. Preparation for arterial catheter insertion |
| 7. Preparation of anaesthesia |
| 8. Preparation of kits for conduction anaesthesia – epidural |
| 9. Preparation of kits for conduction anaesthesia – subarachnoid |
| 10. Preparation of kits for conduction anaesthesia – nerve block |
| 11. Control of the resuscitation kit, medication and accessory equipment |
| 12. Patient warming system |

| Section 2 – Characteristics of the surgery; total score: 1–6 points | 1. Type of surgery (1 – scheduled; 2 – emergency) |
| 2. Exposure to hepatitis C |
| 3. Exposure to HIV |
| 4. Exposure to injury |
| 5. Exposure to haemorrhage |

| Section 3 – Preparation of the patient; total score: 0–18 points | 1. Identification of a patient |
| 2. Confirming the kind of surgery |
| 3. Identification bracelet |
| 4. Written consent to surgery |
| 5. Written consent to anaesthesia |
| 6. Initial assessment of the patient – time from last meal |
| 7. Initial assessment of the patient – problems concerning communication |
| 8. Initial assessment of the patient – problems concerning mobility/pain |
| 9. Initial assessment of the patient – visible skin damage |
| 10. Initial assessment of the patient – infectious disease |
| 11. Initial assessment of the patient – allergies |
| 12. Initial assessment of the patient – consciousness – oriented |
| 13. Initial assessment of the patient – consciousness – confused |
| 15. Initial assessment of the patient – consciousness – drowsy |
| 16. Prosthesis |
| 17. Blood and fluids warming system |
| 18. Disinfectant |

| Section 4 – The Course of anaesthesia; total score: 0–32 points | 1. Assist (by standards) – Total score – 8 points |
| 2. Performed activities and procedures – Total score – 11 points |
| 3. Monitoring (0 – none, 1 – basic, 2 – advanced) – Total score – 2 points |
| 4. Nursing procedures – Total score – 7 points |
| 5. The course of anaesthesia (0 – none, 1 – uneventful, 2– adverse events) – Total score – 2 points |
| 6. Jewellery – Total score – 1 points |
| 7. Other – Total score – 1 points |

| Section 5 – Transfer of the patient after surgery; total score: 0–11 points | 1. Infusion pumps |
| 2. Drainage |
| 3. Medical documentation |
| 4. Patient’s condition – unconscious |
| 5. Patient’s condition – conscious |
| 6. Patient’s condition – drowsy |
| 7. Patient’s condition – agitated |
| 8. Patient’s condition – intubated |
| 9. Patient’s condition – ventilated |
| 10. Operative pain (0 – none, 1 – pain on transfer, 2 – severe pain) |

| Section 6 – Cleaning of the anaesthetic environment; total score: 0–3 points | 1. Disinfection of the equipment |
| 2. Disinfection of the position |
| 3. Supplementing shortages |
Table 2. Characteristics of descriptive statistics of the indices of the procedure level divided into sections in the study group

<table>
<thead>
<tr>
<th>Section</th>
<th>Preparation of anaesthetic environment</th>
<th>Characteristics of descriptive statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>General indices</td>
<td>$N = 130$, $x = 7.0$, $Me = 7.0$, $Min = 4.0$, $Max = 10.0$, $Q1 = 6.0$, $Q3 = 8.0$, $SD = 1.4$, $Skewness = 0.1$, $Kurtosis = -0.97$</td>
<td></td>
</tr>
<tr>
<td>General indices normalised</td>
<td>$N = 130$, $x = 58.3$, $Me = 58.3$, $Min = 33.3$, $Max = 83.3$, $Q1 = 50.0$, $Q3 = 66.7$, $SD = 12.1$, $Skewness = 0.1$, $Kurtosis = -0.97$</td>
<td></td>
</tr>
</tbody>
</table>

| Section 2 – Characteristics of the surgery |
| General indices | $N = 130$, $x = 1.78$, $Me = 1.00$, $Min = 1.00$, $Max = 4.00$, $Q1 = 1.00$, $Q3 = 3.00$, $SD = 0.98$, $Skewness = 0.1$, $Kurtosis = -0.97$ |
| General indices normalised | $N = 130$, $x = 35.54$, $Me = 20.00$, $Min = 20.00$, $Max = 80.00$, $Q1 = 20.00$, $Q3 = 60.00$, $SD = 19.65$, $Skewness = 0.71$, $Kurtosis = -1.07$ |

| Section 3 – Preparation of the patient |
| General indices | $N = 130$, $x = 8.51$, $Me = 9.00$, $Min = 0$, $Max = 14.00$, $Q1 = 8.00$, $Q3 = 9.00$, $SD = 2.01$, $Skewness = -0.64$, $Kurtosis = 4.74$ |
| General indices normalised | $N = 130$, $x = 47.27$, $Me = 50.00$, $Min = 0$, $Max = 77.78$, $Q1 = 44.44$, $Q3 = 50.00$, $SD = 11.18$, $Skewness = -0.64$, $Kurtosis = 4.74$ |

| Section 4 – The Course of anaesthesis |
| General indices | $N = 130$, $x = 12.21$, $Me = 10.00$, $Min = 0$, $Max = 23.00$, $Q1 = 8.00$, $Q3 = 18.00$, $SD = 6.18$, $Skewness = 0.12$, $Kurtosis = -1.1$ |
| General indices normalised | $N = 130$, $x = 38.15$, $Me = 31.25$, $Min = 0$, $Max = 71.88$, $Q1 = 25.00$, $Q3 = 56.25$, $SD = 19.31$, $Skewness = 0.12$, $Kurtosis = -1.1$ |

| Section 5 – Transfer of the patient after surgery |
| General indices | $N = 130$, $x = 3.30$, $Me = 3.00$, $Min = 0$, $Max = 7.00$, $Q1 = 2.00$, $Q3 = 5.00$, $SD = 1.56$, $Skewness = -0.03$, $Kurtosis = -0.34$ |
| General indices normalised | $N = 130$, $x = 30.00$, $Me = 27.27$, $Min = 0$, $Max = 63.64$, $Q1 = 18.18$, $Q3 = 45.45$, $SD = 14.21$, $Skewness = -0.03$, $Kurtosis = -0.34$ |

| Section 6 – Cleaning of the anaesthetic environment |
| General indices | $N = 130$, $x = 2.63$, $Me = 3.00$, $Min = 0$, $Max = 3.00$, $Q1 = 3.00$, $Q3 = 3.00$, $SD = 0.94$, $Skewness = -2.31$, $Kurtosis = 3.62$ |
| General indices normalised | $N = 130$, $x = 87.69$, $Me = 100.00$, $Min = 0$, $Max = 100.00$, $Q1 = 100.00$, $Q3 = 100.00$, $SD = 31.37$, $Skewness = -2.31$, $Kurtosis = 3.62$ |

The reliability of the questionnaire for a nurse anaesthetist was analysed. In the statistical analysis, attention was paid to the calculation of psychometric values (Cronbach’s alpha coefficient) being 0.90 for the whole questionnaire, which indi-cates its very high reliability (Table 4, Annex 1).

Table 3. Characteristics of descriptive statistics of the indices of the anaesthetic nurse activity in the anaesthetic environment in the study group, for the whole scale

| Index of activity level of anaesthetic nurse in the anaesthetic environment | $N = 130$, $x = 35.42$, $Me = 33.00$, $Min = 7$, $Max = 54.00$, $Q1 = 28.00$, $Q3 = 45.00$, $SD = 10.03$, $Skewness = -0.14$, $Kurtosis = -0.43$ |
| General index | $N = 130$, $x = 43.20$, $Me = 40.24$, $Min = 9$, $Max = 65.85$, $Q1 = 34.15$, $Q3 = 54.88$, $SD = 12.23$, $Skewness = -0.14$, $Kurtosis = -0.43$ |

Table 4. Cronbach’s alpha coefficient for the Polish version of the questionnaire

<table>
<thead>
<tr>
<th>Cronbach’s alpha</th>
<th>Number of positions</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
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<tr>
<td>0.598</td>
<td>11</td>
<td>35.42</td>
<td>130</td>
</tr>
</tbody>
</table>

Discussion

Medical documentation has a number of functions in healthcare. It supports clinical decision-making related to planning and nursing care, supports the patient transfer between medical establishments, and provides clarity in terms of the quality and continuity of patient care (Alexander et al., 2011; Braaf et al., 2011; Phipps et al., 2018; WHO, 2018). International accreditation organisations specify that documenting the provision of healthcare services to patients must support clinical decision-making and enhance the continuity of patient care; documentation is a condition for the safety of patients and for ensuring quality in nursing (Braaf et al., 2011; Phipps et al., 2018; WHO, 2018). Furthermore, it is the basis for internationally recognised quality assurance methods, such as the European Commission requirement stating that documentation, quality control, and quality development and evaluation are an integral element of medical services (Braaf et al., 2011; Phipps et al., 2018; WHO, 2018). Therefore, nursing documentation plays a key role in improving the quality of patient care and clinical procedures (Braaf et al., 2011; Chappy, 2006). In a number of research studies and practical publications, few global sets of requirements for recording specialised perioperative anaesthesiological nursing care were found (Chappy, 2006; Junttila et al., 2002), although there is a general consensus that documenting perioperative nursing care is of key importance for the safety of patients and the continuity of nursing care within the operating theatre (Chappy, 2006; Wilbanks, 2013). International documents show significant differences in documentation practice in the field of perioperative nursing. A multicentre quality analysis (Junttila et al., 2002) and literature reviews (Braaf et al., 2011; Wilbanks, 2013) provide incomplete knowledge, data and understanding for further improvements in this area.
of the perioperative nursing documentation practice, suggest-
ing that the data are random and of low quality, which is a
source of serious health risks for patients. The research shows
that documentation-related practice differs in particular wards
and hospitals; there are organisational and individual differ-
ences in the content, tools and levels of nurses’ involvement in
record-keeping (Braaf et al., 2011; Wilbanks, 2013).

Maintaining medical records is the duty of every medical
facility, but also every physician, nurse and midwife who runs a
practice. The obligation to keep medical records is to ensure
the possibility to control and verify whether the healthcare
services were correctly performed. Proper medical records
are closely connected with the legal responsibility of nurses
(Rudnik, 2015). In the event that the patient or their family
files a claim, such medical records will be the basis for the au-
thorities conducting the investigation to determine whether
any legal or professional ethics provisions have been violated.
Medical records are often the only evidence in such cases and,
depending on how well they were kept, they can contribute to
dismissing or confirming legal charges. Medical records can be
a tool for the defence of a nurse or a basis for civil, criminal,
disciplinary or professional liability (Rudnik, 2015).

Analysis of the applicable legal regulations regarding
anaesthesiological nursing documentation in Poland

The Regulation of the Polish Minister of Health of 9 May 2015
on the types, scope and templates of medical records and their
processing (Dziennik Ustaw, 2015, item 2069) regulates in
detail the principles of keeping medical records and assigning
specified tasks to entities participating in the implementation
of health services (Dziennik Ustaw, 2015). This Regulation
specifies, among others, who (physician, nurse or midwife) is
legally obliged and who is entitled to maintain certain medical
records (Dziennik Ustaw, 2015). Where the Regulation of the
Minister of Health assigns the right to make entries in a doc-
ument to a given person, then no one else has such authority,
and if another person makes such a record despite this Regu-
lation, it is in breach of the law. It should also be noted that
the rules governing medical records, set out in a high-level le-
gal act, i.e. a regulation subject to an act, cannot be regulated
by lower-level acts, such as ordinances or internal regulations
adopted by the management bodies of medical entities.

In the event of providing medical services related to anaes-
thesia for an operative procedure, the Regulation of the Polish
Minister of Health of 9 May 2015 on the types, scope and tem-
plates of medical records and their processing imposes the ob-
ligation to maintain internal individual records – the medical
history accompanied by additional documents including, but
not limited to, the anaesthesia record card, the surgical opera-
tion note and the perioperative control card.

According to the Regulation of the Minister of Health, en-
tries in the perioperative control card are made by its coordina-
tor, who is the person defined in the organisational regulation
of the medical entity. The perioperative control card contains
identification of the patient and grouped information on the
necessary procedures: before administering anaesthesia to the
patient, before the incision and before the patient leaves the
operating theatre (Dziennik Ustaw, 2015). The perioperative
control card, in the section on procedures performed before
the patient’s anaesthesia, includes, in particular, the name of
the patient, the date of the surgery, the name of the organisa-
tional unit in which the patient was staying, the number in the
main book of admissions and discharges, the type of surgery,
the operative site, the operating procedure, the consent for
surgery, the type of anaesthesia, information on marking the
operative site, confirmation of the anaesthesia safety assess-
ment, confirmation of the basic monitoring, allergy informa-
tion, information on the anticipated difficulties in maintain-
ing airway patency, and information on the risk of bleeding
>500 ml in adults or >7 ml/kg of body weight in children (Mel-
lin-Olsen et al., 2010).

The perioperative control card, in the section on proce-
dures performed before the incision, includes in particular the
confirmation by the members of the surgical team that they
know each other’s identity and function in the team, informa-
tion that all members of the surgical team were introduced to
one another if they do not know one another, information that
the surgeon, anaesthesiologist, nurse anaesthetist and operat-
ing nurse confirmed the patient’s identity, the surgical site, the
operating procedure, and the correct patient position. Further
requirements include a confirmation from the operating nurse
of the correct set of tools, information on possible deviations
from the planned operating procedure, type or technique of
surgery, prolongation of surgery time, change of anaesthesia,
expected loss of blood, supplementation or change in the kit of
tools by the surgeon, the anaesthetist or the operating nurse,
information on the use and documentation of perioperative
antibiotics up to 60 minutes prior to the surgery, on the use
of anticoagulant prevention, and on the preparation of im-
ing results (Dziennik Ustaw, 2015). The perioperative con-
tral card, in the section on the procedures performed prior to
transferring the patient out of the operating theatre, includes
in particular confirmation by the surgical team of the name
of the procedure performed, confirmation by the operating
nurse of the compliance of the number of tools and materi-
als used, information on the samples taken, on the occurrence
of complications in surgery, on problems with equipment or
technical issues, information on the possible postoperative
problems provided by the surgeon and anaesthetist, on the
perioperative orders by the surgeon and anaesthetist and on
documenting the patient’s condition prior to their transfer
from the operating block to the postoperative ward or post-
operative room. The perioperative control card is signed by the
card coordinator (Dziennik Ustaw, 2015). On behalf of the Pol-
ish Association of Anaesthesiology and Intensive Care Nurses,
we fully support the promotion of safe perioperative care, the
goals of which are described in detail in the Helsinki Declara-
tion on Patient Safety in Anaesthesiology (Mellin-Olsen et al.,
2010; Pettrini et al., 2010; Whitaker et al., 2011).

Patients have the right to expect safety and protection
when they are provided with healthcare services, and anaes-
thesia plays a key role in improving perioperative patient safe-
ty. Therefore, we fully accept and declare our willingness to a-
dhere to the International Standards for Safe Anaesthesia of the
World Federation of Anaesthesia Societies. Patients need to be
educated and should be given an opportunity to provide feed-
back to facilitate further improvements in anaesthetic care.
Entities responsible for financing the healthcare system have
the right to expect safe services in perioperative care for which
they are required to provide adequate financial resources.
Education plays an important role in improving patient safety,
so we fully support the development, dissemination and im-
plementation of patient safety training (AORN, 2020; Mellin-
Olsen and Staender, 2014; Schleppers et al., 2011; Steander et
al., 2013). Human factors are an important element in the
process of patient care, so to increase safety we will be respon-
sible for promoting the work standards of nurse anaesthetists.
The successes of modern anaesthetics derive from improved
technology, pharmacology, training and education, improved
systems, focus on human effectiveness, and the standardisa-
tion and development of core information. All these aspects are crucial and relevant for widely accepted, state-of-the-art general practice, but they also refer to nursing care (Horváth et al., 2012; Staender, 2015).

Nurse anaesthetists encounter a number of technical and practical issues related to nursing documentation (Braaf et al., 2011; Sorensen et al., 2014). A template documentation tool must be adjusted to and compliant with the applicable clinical practice (Yontz et al., 2015). Perioperative documentation is made in parallel with the nursing practice; this creates a time-related challenge, as the documentation tool must be compliant with the relevant practice (Braaf et al., 2011; Sorensen et al., 2014; Tiusanen et al., 2010; Yontz et al., 2015). Perioperative nurses deal with patient safety, pointing to the relationship between proper medical documentation and the safety of patients (Braaf et al., 2011; International Federation of Perioperative Nurses, 2014; Junntila et al., 2000; Park et al., 2007). In the perioperative practice, emphasis is placed on the safety of patients, preventing their injuries and ensuring the coherence of the patient pathway in general (Braaf et al., 2011; Park et al., 2007; Sorensen et al., 2014).

Limitations of this study
This study has certain limitations. The studied lay-person respondents and healthcare workers were from south-east Poland (Podkarpackie). Research in a more diverse group of patients is recommended.

Conclusions
The introduction of the record card would allow an increase in patient safety, a safe working environment, greater responsibility for safe working conditions, increased awareness of the responsibility of a nurse anaesthetist, information on the causes of adverse events in anaesthesiology nursing, their recording and modification of practice. According to the Working Group of the Polish Association of Anaesthesiology and Intensive Care Nurses, “The Check-List for Nurse Anaesthetists” should be included in the mandatory or minimum additional internal patient documentation.

Authors’ contributions
DO, WM-D, AG-W, and PW drafted the initial manuscript; AZ, JM, and DO provided expertise. MJ conceived the concept underlying the manuscript and is the senior author of the paper. All authors were involved in writing and editing the manuscript, including the table, and read and approved the final version.

Ethical aspects and conflict of interests
This study was conducted according to the guidelines laid down in the Declaration of Helsinki, and all procedures involving human subjects were approved by the Bioethics Committee, Poland (No. 1239, 18 December 2008). A written informed consent was obtained from each subject. The authors have no conflict of interests to declare.

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Kontrolní seznam pro zajištění bezpečnosti pacientů určený pro anesteziologické sestry v Polsku: smíšená (kvalitativní a kvantitativní) studie

Souhrn

Klíčová slova: anesteziolog; bezpečnost pacientů; kontrolní seznam; validační studie; zdravotní sestra; zdravotnická dokumentace

References


