**BACKGROUND**

- 44,000 to 90,000 Americans die each year as a result of healthcare errors
- *To Err is Human* called for a redesign of the delivery of healthcare to build safety into processes of care and urged a retreat from the culture of silence that pervaded healthcare with regard to errors (IOM, 2000).
- This report was followed by the National Safety Goals in 2004 (Joint Commission), and Quality and Safety Education for Nursing Education (QSEN) in 2005.

**PURPOSE**

The purpose of this study was to explore the historical and contemporary role of nursing in patient safety through content analysis of articles in the American Journal of Nursing (AJN). This journal was chosen because it is the oldest continuous journal for nurses and is directed at practicing nurses.

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**METHODS**

All issues of AJN from 1900 to 2007 were accessed through the database JSTOR. Issues from 2008 to 2015 were accessed through OVID. Tables of contents for each issue were searched for titles that suggested a focus on nursing care or patient safety. After identifying and reading articles, we met to compare notes and identify themes after each two decades. Data were examined and contemplated as a whole and in parts over 10 months.

**RESULTS**

**1900-1919**
- Safety in nursing care largely centered on the germ theory
- Articles often written by physicians and focused more on pathophysiology than on nursing care
- References rare
- Interventions utilized without safety precautions: e.g., hydrotherapy, electrotherapy, “baking ovens”, IV warmers and hot water bottles

**1930-1939**
- Fall prevention was not addressed
- Insulin identified as high risk due to multiple concentrations
- Methods to prevent medication errors proposed:
  - No interruptions while medications are being prepared or administered
  - Consistent use of either trade names or “official” names
  - Accurate patient identification before administration

**1940-1949**
- Kardex system developed
- WWII nurses identified improved survival with shock wards and recovery rooms (surgical and obstetric patients)
- Post WWII nursing shortages led to alternate staffing practices
- Numerous hospital fires resulted in safety regulations

**1950-1959**
- Staffing patterns developed to match patient acuity
- Specialized care for premature infants
- Increasingly ambulatory patients resulted in greater need to identify patients for medication administration
- Addressograph utilized to prevent transcription errors
- Suicide/self-harm were suggested to be preventable

**1960-1969**
- Technology increased complexity
- Fall prevention was cursory
- Bed rails became standard (despite evidence that they caused injury)
- Burns from hot water bottles cautioned against
- Hospital acquired infections recognized

**1970-1979**
- Comprehensive medication reform recommended
- Patient care equipment found to be hazardous
- Urinary catheters discouraged
- Presence of family advised to avoid restraints
- IPPB treatments recognized as potentially dangerous

**1980-1989**
- Accident awareness and fall prevention encouraged
- Unit dose medication systems introduced
- Reuse of single-use equipment questioned

**1990-1999**
- Focus on medication error prevention
- Increased use of assistive personnel
- Reduction in the use of restraints emphasized

**2000-2016**
- Systemic factors emphasized
- Dangers of side rails recognized
- Rapid response teams instituted
- Bar coding of medications became common
- Changes in payment systems result in improved safety efforts for preventable “never events”

**DISCUSSION**

**Driving Forces:**
- Increasing complexity of procedures, medications, and equipment
- Technology
- Independent professional identity
- WWII
- Nursing shortage
- Increased use of assistive personnel

Many missed opportunities identified

**IOM Report successful in terms of systemic solutions**

**LIMITATIONS**

All articles were from one journal and subject to selection by editor and reviewers.