

INTRODUCTION

Retained surgical items are surgical items unintentionally left inside the patient during the invasive procedure. They are NEVER events that can result in patient harm leading to complications, prolonged hospital stay, and potentially death. Prevention of retained surgical items needs to be on the mind of every perioperative team member.

ISSUE

Surgical item was retained in the patient. Fortunately, the removal did not require extensive surgery and final patient's outcome was good. Team pointed out that lack of clear communication as to the exact number of items on/off the field contributed to this event.

PROJECT DESIGN

Operating Room Unit Practice Council with the active input of staff members and leadership followed the steps:

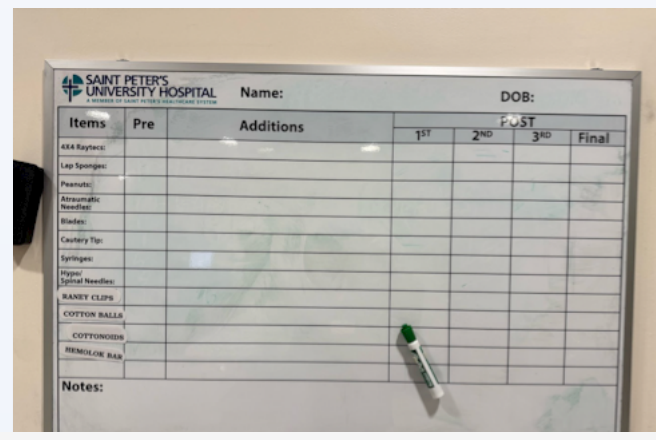
- PLAN:**
- Perform literature search
 - Ask what other facilities found helpful
 - Brain-storm and discuss possible solutions
- DO:**
- Decision was made to use count board
 - Sample was brought in
 - Staff decided on the layout
 - Count board was tested in a mock case
 - UPC walked through the ORs and planned the placements of count boards
 - Staff survey was created

MATERIALS AND METHODS

- Survey was distributed to 35 staff members
Survey was answered by:
- 28 people – initial
 - 24 people – one-week
 - 24 people – 2 months
 - 30 people – 6 months

- The following questions were asked in the survey:
- Overall, how satisfied are you with the concept of the white board?
 - Overall, how safe do you feel with count policy?
 - Do you feel that adding a count board promotes better communication about the count?
 - Do you think a count board is a good visual tool to help prevent retained surgical items?
 - Overall, how comfortable are you with using a count board?
 - Do you feel that adding a count board would enhance the safety of the count?

Materials needed to use the count board were purchased and made easily available in each OR.



RESULTS

