Prevention of Unintentionally Retained Objects Through a Count Resolution Pathway

The Problem

Unintentional retention of objects is a "Never Event". Lack of effective communication, object recognition and standard workflow practices were found on two occasions to contribute to the unintentional retention of foreign object during a surgical procedure.

Aim/Goal

1. Embed forced communication between the members of the team when resolving incorrect counts
2. Standardize the mechanism responding to incorrect counts
3. Establishment of clear processes for the resolution of incorrect counts in the OR

The Team

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The Results/Progress to Date

Count Safety Checklist (Pilot Tool) **Patient Name and MRN:**

Incorrect Count
(Complete in order to reconcile an incorrect count)
Circulating Nurse:
- ☐ Notify Surgeon ☐ Notify Anesthesia
- ☐ Notify Resource Nurse to acquire assistance
- ☐ Implement "No Hand-off Zone" No breaks or relief until count resolved
- ☐ Conduct Search
- ☐ Room ☐ Trash ☐ Linen ☐ Sponge Buckets
- ☐ Reopen and recount bagged items
- ☐ Missing needle: record needle size _____mm (listed on suture pkg)
- ☐ Call for X-ray(s)
- ☐ patient information/ cavity to be studied
- ☐ item deemed missing
- ☐ Document participation in conversation that all potential cavities that could harbor a retained object have been searched
- ☐ Surgeon ☐ Scrub Person
- ☐ Circulating Nurse ☐ Surgical Assistant
- ☐ Complete entry of incident into Patient Safety Reporting system
- ☐ Record status of the count in the Periop Record

Scrub Person:
- ☐ Implement "No Hand-off Zone" No breaks or relief until count resolved
- ☐ Search back table and surrounding field
- ☐ Organize all countables on back table to insure ease in viewing
- ☐ Communicate with all members of the team

Surgeon
- ☐ Conduct a search of all potential cavities that could harbor a retained object
- ☐ Initiate a discussion that all cavities that could harbor a retained object have been x-rayed
- ☐ Surgeon ☐ Scrub Person
- ☐ Circulating Nurse ☐ Surgical Assistant
- ☐ Communicate with attending radiologist to corroborate on the results of the x-ray

Method ☐ Phone ☐ In person
Name of Radiologist: _____

Sign-off
Count Reconciled ☐ Yes ☐ No
Signature of Nurse _____
Signature of Surgeon _____
Signature of Scrub Person _____

The Interventions

- Structured communication results in a more effective response to resolving count issues
- Create mechanisms for forced communication when responding to incorrect counts
  - Count Safety Checklist
  - Mandating Attending to Attending communication in "Real-time"
- Development of a Web-based Digital Library of Countable items to enhance radiology recognition
- Implementation of a *No-Hand Off Zone* which prevents changes in team members during count resolution
- Creation and implementation of a *Count Safety Checklist* to standardize the intraoperative interrogation of an incorrect count
- Creation of the pathway for managing situations in which items are intentionally retained or intentionally not retrieved
- Education and Implementation
  - Each discipline presented Safety Rounds on Retained Objects
  - Electronic communication of all changes to all disciplines
  - All incorrect counts require OR management notification and pathway institution

Lessons Learned

- Structured communication results in a more effective response to resolving count issues
- Object recognition is essential for successful recognition of retained objects
- Multidisciplinary standardization of practices is critical

Next Steps/What Should Happen Next:

- Ongoing vigilance of compliance to protocols
- Utilize the information gathered from the *Count Safety Checklist* to study the implications of near-miss experiences
- Directed at definition and guidelines for items intentionally left behind.

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