

Lessons Learned, 2008 #01

“Is it as easy as 1, 2, 3 ??”

The Cases

A 65-year old man has abdominal surgery to remove a malignant tumor. For weeks after the procedure, he experiences severe pain and runs a slight fever. He visits his physician complaining of intense discomfort and the physician orders a CT scan. The scan reveals a lap pad that was mistakenly left inside his body after surgery. The man then undergoes a second surgery to remove the lap pad and recovers without incident.

A 23-year old G1P0 arrives 39 weeks pregnant, in active labor. She delivers an 8 lb baby girl by spontaneous vaginal delivery and has a 2nd degree vaginal laceration. A sponge is used at the site of repair for the laceration. Three days after discharge she spikes a fever and has intense vaginal pain. Upon examination in the physician's office, a sponge is found and is removed from the patient's vagina.

The Commentary

Although the cases described above are fictional, they are representative of what can and has occurred.

- It is estimated that surgical tools and supplies are unintentionally left in more than 1,500 individuals each year. These unintentional retained objects can lead to severe illness due to bowel perforations, organ damage and sepsis; which can sometimes lead to death.
- Unfortunately, research shows that in 90% of cases involving an unintentionally retained foreign object, a count was performed and showed that all equipment and supplies were accounted for. Obviously, in these cases, there were incorrect counts.
- Possible causes for an incorrect count include:
 - Staff fatigue
 - Distractions and interruptions
 - Stressful environment
 - Inconsistent count procedure
 - Missing information in count policy
 - Missing or inaccurate information during handoff
 - Lack of a questioning attitude
 - Failure to escalate

Discussion Points:

- 1. All members of the operating team will have a responsibility in the prevention of retained foreign objects.**
- 2. All areas performing surgical procedures will follow the standardized VCUHS count policy (Surgical Services Policy #4102.02).**

3. All areas will follow the *Incorrect Count Algorithm*:
 - a. Circulating nurse or equivalent will inform the surgeon of what item(s) is/are missing
 - b. Count will be repeated
 - c. If item(s) cannot be located, the team will begin immediate search of the sterile field, the area under the table/bed and all areas of the room to include search of the laundry and trash bags
 - d. If item(s) still cannot be located, the circulating nurse will notify the attending surgeon
 - e. The circulating nurse will place an order for a STAT x-ray for "rule out retained foreign body" to be done in the OR suite
 - f. Circulating nurse will notify the charge nurse
 - g. Circulating nurse will enter a PSN which will include: the description of the missing item(s), name of the attending surgeon that was notified, that an x-ray was taken, the name of the person who read the x-ray, the full name of person submitting report and all witnesses.

4. An x-ray is recommended in the following *high-risk situations*:
 - a. Patient with a high body mass index (not pregnant)
 - b. An emergent procedure
 - c. Cases involving multiple surgeons or multiple surgical fields
 - d. Unexpected change in the procedure
 - e. Any time there is permanent change of staff during a procedure

5. RFID will be implemented as an adjunct to counts and in high risk surgical cases.

6. Department Chairs, Program Directors and Nursing Leaders in the Department of Surgical Services and Labor and Delivery shall communicate these messages to all faculty, housestaff, nurses and other clinical staff immediately.

Remember: Nothing gets left behind