

FORGOTTEN SOMETHING? RETAINED SURGICAL ITEMS

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Case 1

Retained
Surgical
Items

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CASE 1

- You are asked to relieve the staff for tea break in theatre 7 on a very busy day
- Mr Jones is on the table undergoing a repair of a lacerated liver following a motor car accident
- Considerable blood loss is experienced and it takes time to control the bleeding
- As you commence your first count there is some confusion about the Raytec

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DISCUSSION

- It appears that you are missing 5 swabs
- However after counting the Raytec packages in the bin you realize that +5 must have been written twice
- The count is thus deemed correct.
- **Thoughts**

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UNINTENTIONAL RETAINED ITEMS

Old research

- An Australian article described a 19 year old girl who died following 5 swabs had been left behind eight years before (Chiarella 1998)
- Another Australian case where a pack was left behind:
 - o it was removed 8 months later
 - o the patient sued the doctor and the hospital for negligence

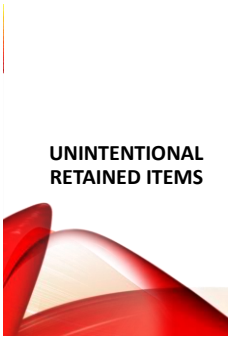
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UNINTENTIONAL RETAINED ITEMS

Old research

- A jury found the doctor to be negligent not the nurses
- The doctors appealed, saying that they were negligent, but so were the nurses who counted the packs
- The appeal was allowed
- The accuracy of the count rests with the nursing staff
- It must be recognized that the accuracy of the count is the primary duty of the nursing staff (Chiarella, 1998)

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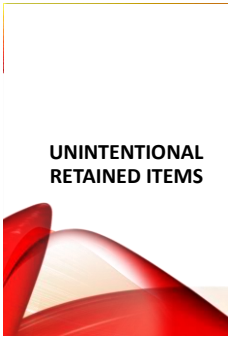


UNINTENTIONAL RETAINED ITEMS

Two types of errors

- The first – is where an item is lost
- The second - is a documentation error, when the count sheet & the actual number of items differ
- In either case, or when any doubt exists, an 'incorrect count procedure' must be followed
- This procedure would include x-raying of the patient
- Would the use of the Image Intensifier (II) be acceptable?

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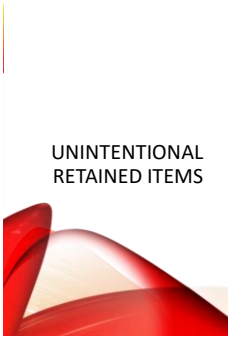


UNINTENTIONAL RETAINED ITEMS

Older research
Possible contributing factors

- In an Australian study, routine elective surgery featured as a risky time as there were so many distractions to the scout (Butler, Boxer & Southerland-Frazer 2003)
- Abdominal surgery followed by obstetric surgery (Patterson 2003)
- ADD Emergency LUSCS
 - ??? Packs from labour ward???

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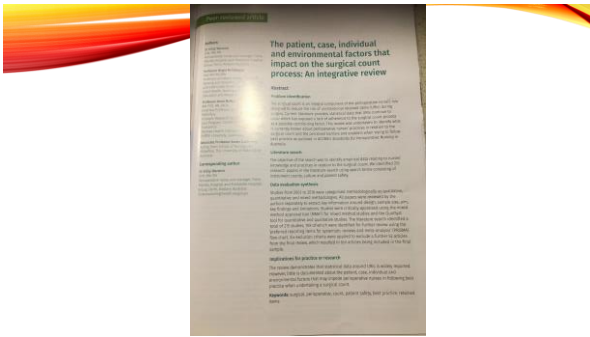
UNINTENTIONAL RETAINED ITEMS

This were our thoughts 16 years ago.....

- Bleeding patient
- Obese patient (Gawande, Studdert, Orav, Brennan & Zinner, 2003)
- **Packs, Raytec not separated properly at the original count**
- Staff rushed to count
- Inexperienced staff
- Staff change over

Should we count EVERYTHING???

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UNINTENTIONAL RETAINED ITEMS

Research-Integrated review (Warwick et al.)

- A vital component of the perioperative nurse's role is the surgical count which is designed to reduce the risk of unintentional retained items during surgery (Warwick et al. 2019).
- However, less documentation is available on patient, cases, individual or environmental factors that may have impeded the perioperative nurses in following best practice when undertaking a surgical count (Warwick et al. 2019).


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UNINTENTIONAL RETAINED ITEMS

Research

- All healthcare facilities have a duty to comply with best practice standards for the surgical counts, however sentinel events concerning 'unintentional retained items' during surgical procedures is an ongoing problem (Warwick et al. 2019).
- Contributing factors include non-adherence to hospital policy, procedure, process and guidelines; poor communication; a fast-paced work environment and the levels of knowledge, skills and competence of practitioners involved' (Warwick et al. p. 9 2019).

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**UNINTENTIONAL
RETAINED ITEMS**

Recent research

- Patient related factors
- Case related factors
- Individual factors
- Environmental factors

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**UNINTENTIONAL
RETAINED ITEMS**

Research (Warwick et al.)

Patient-related factors

- The only patient factor that was revealed was a high body mass index (BMI) (Warwick et al.)
- A high BMI may lead to deeper surgical incisions that potentially can fill with bodily fluids and make it difficult to keep track of surgical packs and instrumentation (Elsharydah et al.)

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**UNINTENTIONAL
RETAINED ITEMS**

Research (Warwick et al.)

Case-related factors

- Contributing factors:
 - emergency, unplanned and planned surgery
 - length of time to undertake a procedure
 - multiple surgical teams
 - perioperative nurses undertaking dual roles / multiskilling

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**UNINTENTIONAL
RETAINED ITEMS**

Case-related factors (Warwick et al.)

- Emergency and unplanned surgery accounted for 5 cases that contribute errors
- Emergencies, a change in the patient's status and a sudden change in the surgical procedure may leave insufficient time to account for all surgical instruments and consumables at the commencement of the procedure
- However, 4 cases identified planned surgery as a contributing factor, with staff more complacency during the count process for elective procedures

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**UNINTENTIONAL
RETAINED ITEMS**

Case-related factors (Warwick et al.)

- Complications and length of time to undertake a procedure was identified as a case-related factor in three papers
- One study identified multiple teams in a surgical procedure as potentially contributing to an incorrect count
- Another study identified the instrument nurse having to undertake a dual role as a contributing factor

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**UNINTENTIONAL
RETAINED ITEMS**

Individual factors (Warwick et al.)

- Adhering to hospital policy was a major contributing factor in five of the review papers.
- This was also identified as complacency around the count process, with documentation errors also identified
- Rowlands and Steeves found that teams working together ad hoc were less likely to share relevant case-related information, contributing to an incorrect count

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UNINTENTIONAL
RETAINED ITEMS

Individual factors (Warwick et al.)

- The type of leadership in an operating room (OR) and the way tray lists were discussed
- The impact of hierarchy was identified with surgeons sometimes not allowing nurses to undertake the correct count procedure
- Two papers identified the need to treat other members of the perioperative team with respect as an individual factor

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UNINTENTIONAL
RETAINED ITEMS

Individual factors (Warwick et al.)

- Two studies documented individual factors like untidy instrument trolleys and the inability to find instrumentation in a timely fashion
- Difficulty in handling certain pieces of equipment (for example, ratcheted and non-ratchet needle holders) and disparate views of team members in relation to count practices contributed to a lost item
- Surgeons not being aware of which count process was being followed or documented was also noted

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17cm scissors left in granny after surgery



Saved in the
nick of time

In Early
A GRANDMOTHER was saved from a life-threatening infection after a 17cm pair of surgical scissors was found in her abdomen during a routine check-up.

The 72-year-old woman, who had undergone a routine abdominal surgery, was found to have the scissors in her abdomen during a follow-up scan. The scissors were found to be in her abdomen for several weeks.

The woman, who lives in a care home, was found to have the scissors in her abdomen during a routine check-up. The scissors were found to be in her abdomen for several weeks.

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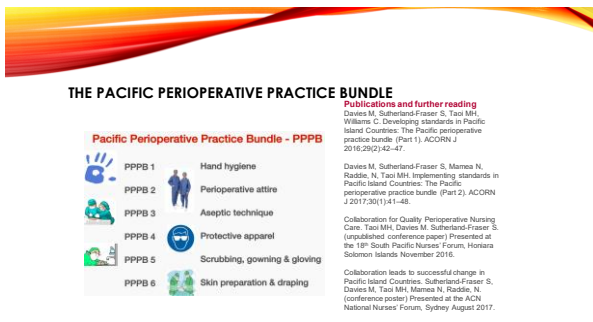
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ASSESSMENT VERSES AUDIT

Competency assessment	Practice audit
Gathering a combination of evidence to make a judgment on an individual's ability to perform against a predetermined standard	Gathering of evidence through observation only to assess compliance of a group of individuals against a predetermined standard

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DIFFERENTIATION

	Competency assessment	
Purpose	Can you do it?	
Subject	Individual	
Evidence	Combination (Direct, Indirect, Supplementary)	
Applications	Evaluate training / measure outcomes of education programs Identify learning deficits	

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DIFFERENTIATION

	Competency assessment	Practice audit
Purpose	Can you do it?	Did we do it?
Subject	Individual	Group, teams, workplace
Evidence	Combination (Direct, Indirect, Supplementary)	Direct (Observation of practice)
Applications	Evaluate training / measure outcomes of education programs Identify learning deficits	Compliance Practice improvement Change management

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ASSESSMENT VERSES AUDIT



Focuses on 1 person




Notifies many people

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	Competency assessment	Practice audit
Purpose	Can you do it?	Did you do it?


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Practice Audit Tools 1: Asepsis and clinical care

1. Perioperative attire
2. Asepsis and Infection prevention
3. Surgical hand antisepsis, gowning and gloving
4. Preoperative patient skin antisepsis
5. Specimen identification, collection and handling

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Practice Audit Tools 2: Staff and patient safety

- 6. Documentation (from Professional practice)
- 7. Surgical safety
- 8. Medication safety
- 9. Management of sharps in the perioperative environment
- 10. Safe patient positioning in the perioperative environment and Safe manual handling
- 11. Management of accountable items used during surgery and procedures
- 12. Surgical plume and Electrosurgical equipment (from Equipment and environment)

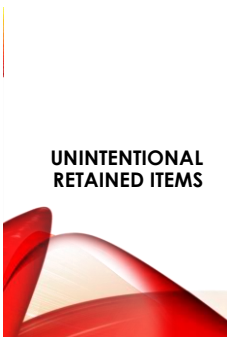
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BENCHMARKING

Competition between theatres

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UNINTENTIONAL RETAINED ITEMS

Environmental factors

- Non-technical factors encompassed communication breakdowns, adherence to policy, respect for each other, hierarchy structures, multiple perioperative teams and surgical counts being documented as correct (even when the count was later found to be incorrect)

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REMEMBER NOISE REDUCTION

<http://www.belowtenthousand.com>

- Smith, P & Gibbs, J 2016, 'Below ten thousand': An effective behavioural noise reduction strategy?', *The Journal of Perioperative Nursing in Australia*, vol. 29, no. 3, pp. 29-32.
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UNINTENTIONAL RETAINED ITEMS

Environmental factors

- A breakdown in communications was identified in three papers as a major contributor
- The pace of surgery, production pressure and time constraints were also causative factors

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UNINTENTIONAL RETAINED ITEMS

Discussion...

'Time pressures related to the surgical and anaesthetic teams pushing to get patients in and out of the OR quickly evidently had a negative impact on nurses' ability to undertake the count process and complete documentation' (Warwick et al., p.17, 2019)

'Team fatigue leading to diminished concentration and change of perioperative personnel mid-procedure was identified as a contributing factor to poor documentation and count process' (Warwick et al., p.17, 2019)

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Production Pressure

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Stable teams

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UNINTENTIONAL RETAINED ITEMS

- **Food for thought!!!**
- **Discussion**

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References

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