Taking Patient Safety into A Count

EMORY SAINT JOSEPH'S HOSPITAL

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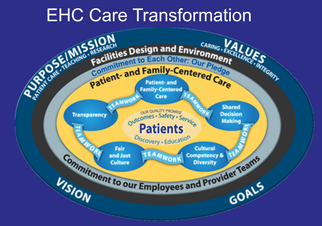
EHC Care Transformation



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Background

Retained surgical items (RSIs) have been and continue to be one of the most frequent sentinel events every year, and they have a significant consequence for the health and safety of patients in the operating room (OR). Staff and hospitals are also affected by consequences of RSIs. Surgical counts are one of the most important factors in preventing RSIs, and the lack of a standardized process can lead to count discrepancies and increased RSIs. It has been suggested that variances in count documentation among staff contributes to incorrect counts and count confusion during shift change. Variability and inconsistency leads to incorrect counts, potential sentinel events, unnecessary patient exposure, and compromised patient safety.

Purpose / Aim

The purpose of this project is to implement a standardized documentation count process for soft items and instruments to reduce the incidence of incorrect counts and retained surgical items.

The aim of this project is to increase the confidence of OR staff in performing safe surgical counts by 5% and to decrease the amount of incorrect count-related incidents by 30%.

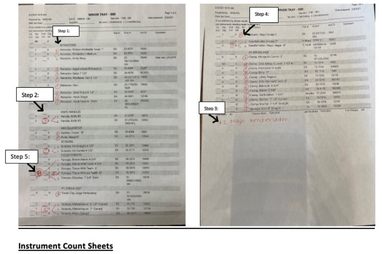
Standardized Count Process

Counts Boards

1. Count boards should be completely filled out prior to the start of the case.
2. To record added items to the counts board, the amount added should be written next to the initial count with a plus sign. The total number of that item on the field should then be written clearly and circled. This process will continue for the duration of the case.

Balfour Retractor

1. The Balfour retractor is to be counted as 9 pieces. The wingnut is included as a separate piece in this count.



Instrument Count Sheets

1. Number of instruments should be circled or clearly written on the left side.
2. Groupings of similar instruments distinctly marked with a bracket and the total number written to the left and circled.
3. Peel packed instruments added to field written at bottom of sheet with an addition sign and the number and type of instrument added.
4. Incorrect number of instruments on sheets crossed out with the correct number clearly written and circled.
5. If there is an incorrect amount in a group, correct the number, and add or subtract accordingly to total number in the group.

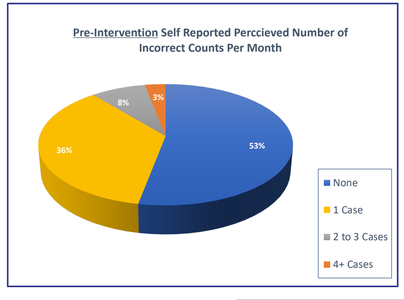
Methodology

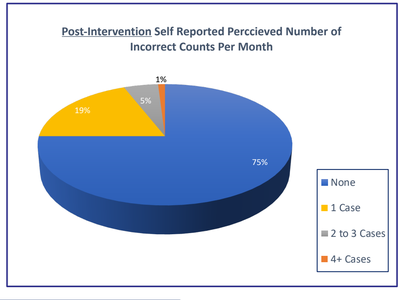
A pre-survey consisting of six questions was administered to 62 OR staff members. Incidents related to incorrect counts were collected for a three-month period. The count-related incidents were analyzed and reviewed to determine commonalities and variances amongst incorrect counts. Based on AORN guidelines, the project team developed several tasks standardizing the count process and implemented an education in-service which informed all staff members of the change. Education included:

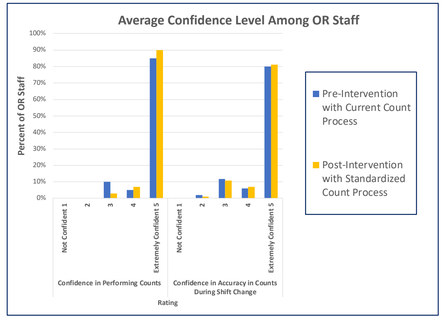
- Timing of surgical counts
- Facility count policy
- Use of an addition symbol when adding new items to field/count
- Use of a circle to identify total items
- Use of brackets to identify groups on instruments counted together
- Use of a slash to indicate missing items with incorrect amounts
- Use of an addition symbol & instrument name when adding peel packed instruments
- Documentation difference on count boards, count sheets, and instrument count sheets
- Balfour retractor = 9 counted items

The standardized count process was implemented for three months during which instrument count sheets were collected to measure compliance of staff. A post-survey was administered after three months of implementation

Results

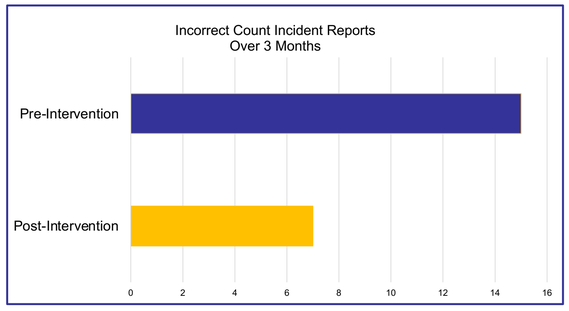






Discussion

After implementation, the average level of confidence by OR staff performing counts increased by 5%. Staff reported feeling extremely confident in the new standardized count method. In addition, there was a 1.2% increase in staff reporting confidence in maintaining accuracy through shift change with the new count process. Initially, 53% of OR staff self-reported not having any incorrect counts within the past 30 days. Post-intervention, there was a 22% increase to 75% in staff self-reporting no incorrect counts within the past 30 days. Additionally, over the three-month implementation period, there was a 53.3% decrease in the number of incidents related to incorrect counts, exceeding the initial project goal.



Implications For Practice

Preventing RSIs continues to be a priority among operating room staff. Performing safe surgical counts by members of the surgical team requires standardization to improve patient safety and outcomes. With current staff turnover and changes, having a standardized method of counting can ensure uniformity amongst all members of an entity.

Implementing a new standardized count process has increased the level of confidence among OR staff in performing accurate counts and has also decreased the amount of perceived self-reported incidents. The number of actual incidents has decreased after implementation, thus attributing to the increase in confidence and a decrease in patient safety risks.

Due to the positive impact and improved outcomes, the facility has implemented this project for current and future practice among all staff in the OR, including education for all new staff members and an annual competency.