Archives of Nursing and Care

Improving Patient Safety and Governing Surgical Count Process through Effective Communication and Teamwork

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Introduction: A retained surgical item (RSI) is any item inadvertently left behind in a patient's body in the course of surgery. In the patient's safety field, this is widely considered a "Never Event" as it is preventable. The consequences of RSI include injury, repeated surgery, excess monetary cost, loss of hospital credibility and in some cases death. Hence, prevention remains a top priority for the perioperative team members and healthcare organizations. Several incidences (Sentinel Events) occurred within the operating rooms related to RSI with recommendations for the Operating Room Services Administration (ORSA) to improve the situation.

A short summary of the literature review citing the author and year e.g. Derwing et al. (2002) mentions…etc.
Prudent medical practice and laws in all states of the USA, require that medical and surgical items not intended to remain inside of patients, not be negligently left behind. Inadvertently leaving devices, needle, sponges, instruments or other miscellaneous items inside of patients (retained surgical items) is a preventable event is generally considered to be a "never event". An RSI is a surgical patient safety problem. An event occurs because of problems with faulty procedural practices and poor communication strategies between personnel. To prevent RSIs, it is important to change practice and the exchange of knowledge and information, with an understanding of human fallibility in perception and risk assessment. (Gibbs, Verna C. NoThing Left Behind: The Prevention of Retained Surgical Items Multi-Stakeholder Policy – Job Aid – Reference Manual, 2018)

RSI pose serious consequences for patients and are significant threat to patient safety. Perioperative team members are morally and ethically responsible for the prevention of RSIs and should understand how to reduce the risk of occurrences. The prevention of RSIs does not rest in the hands of one individual. It is a multidisciplinary endeavor that aims to reduce risk of RSIs and team members should hold each other accountable. (Spruce, Lisa. Association of Operating Room Nurses (AORN) Journal of 2016 with the title of Back to Basics: Counting of Soft Surgical Goods)
Our main challenge was resistance from the surgical team, anesthesia team and nursing team to comply with the new modified surgical count process. We successfully overcome the challenge through the intensive education training and Speak Up initiatives.
Monitoring tool for compliance on surgical count standard practice that was created during the project showed improvement in reporting RSI and has brought solutions to address some of the gaps.
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Biography

MS. Merlyn C. Tayo has finished her Diploma Degree in Nursing in the academic year (2011-2012), then she started to work on some researches related to nursing care, nursing profession and nursing job satisfaction. She is currently working with MSF international organization as a maternity nurse and train the paramedical staff to develop their skills.

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