

Getting to Zero: How an Operating Room Committed to “No Sponges Left Behind”

Kim Raney, MS, BSN, RN; Gayle Mastrandrea, RN, CNOR; Jodi Wolsky, BSN, RN, CNOR
Providence Portland Medical Center, Portland, OR

What is a Retained Surgical Item?

- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Includes medical or surgical items intentionally placed by providers that are unintentionally left in place
- Discovered after all incisions or procedural access routes have been closed in their entirety, devices have been removed and the patient has been taken from the operating/procedure room

How Big is the Problem?

It is estimated that 2000-4000 incidences of RSI's occur each year. The majority of the items left behind are surgical sponges which may not be discovered for days or years after the initial surgical or procedural event. In over 80% of these cases the counts are documented on the record as correct.

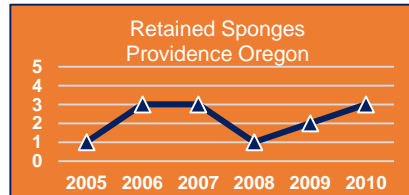
It is also difficult for staff involved in these cases. Emotions are raw as they examine how this could have occurred and the role they played in unintentionally causing harm to a patient for which they have been entrusted to care and advocate for. Additionally, most of these cases require a second procedure to remove the sponge or RSI that has been left behind. Calculating the costs associated with an additional surgery or procedure coupled with the care prior to and after the discovery of the RSI make it very difficult to determine the financial impact.

The Providence Portland Story:

In 2010 two of our patients experienced a retained sponge both within 6 months of each other. It was during the root cause analysis of these cases we made a decision that a different approach had to be taken to eliminate this from occurring again.

Our policies were reviewed and were in alignment with AORN standards. We decided to turn our practice inside out, creating a very prescriptive approach. In both instances counts were documented as counts were correct. Most circulating nurses had varied approaches when it came to the practice of counting. Most commonly this had to do with where and how they were trained.

Providence in Oregon has an integrated approach to review of sentinel events. The incidence of RSI's across facilities in our state numbered 13 over 5 years, 9 of these were surgical sponges



Goal:

Eliminate variation and standardize our approach to sponge counting at Providence Portland Medical Center and spread the practice to all 8 of the Providence Ministries in Oregon.

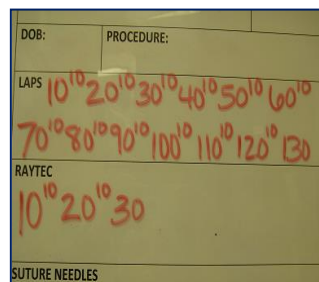
The Plan:

After reviewing this information Providence Portland Medical Center went on a journey to eliminate retained surgical sponges and decided to adopt “sponge accounting” a system developed by Dr. Verna Gibbs. We began the journey of changing our practice in June 2011.

What's Different?

The paradigm shift that needed to occur was embedding the concept of Accounting rather than Counting Sponges. The process occurs during the entire procedure and at the end of the case there is final verification. The steps are noted as follows:

The final count is visual and requires that the sponge holders are viewed to determine all the pockets are filled.



The nurse will ask the surgeon and other room staff to verify that the sponges are present in the holders and all pockets are full.

We had full support of our medical staff and quality departments to institute this practice. There were 80 people (surgeons, staff, and anesthesiologists) in attendance at our opening conference.

Mandatory staff training included small group sessions to practice each step of the new process. (Initial training was completed on 100% of our staff nurses and surgical techs totaling 98 people.)



We have made this an annual competency and all staff are trained in the practice in orientation.

Audits:

Audits were done to hardwire the practice change.

Sponge Accounting Audit	OR # Date: _____ Time: _____
Room Set Up: • Clear Liners • Sponge Holders	✓
Documentation on white board is horizontal & keeps a running total	Yay!
All sponges counted in groups of 10	Yes
Sponge holders loaded from bottom up	Yes
If the initial sponge count was observed, was it done correctly?	Yes
	No

Results:

Providence Portland Medical Center has had no retained sponges since June 1, 2011.

Regional Roll-Out:

Results were recognized across the region. All Oregon ministries completed adoption of the practice by April of 2013. We have had zero retained sponges in the region since that time.

