

## STAFFS PRECEPTIONS OF CAUSTION OF RETAINED ITEMS POST SURGERY

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**Background:** Retained items in surgery effect patient safety and has an economic impact on heath care's scare financial resources. It is estimated that one item is retained for every 1000-1500 intra-abdominal surgeries per year. Litigated cases of retained items showed between 88-90% of the time the count was indicated as correct (Gawande A.A.). Litigation cost for retained items represents 750 million to 1.5 billion dollars annually (Surgicount Medical Inc.).

**Objectives:** The object of the study was to identify obstacles that impact the counting processes during surgery and predispose the patient to the risk of a retained item. The evidenced based fellowship focused on the staff perception of caution of retained items post surgery and selected a method to improve accuracy and counting.

**Methods:** Two questionnaires were administered to staff (RN's, ST's and MD's). The first questionnaire asked the staff their perception of the leading cause of retained items. The second questionnaire focused on perceptions of appropriateness and compliance with the current policy on counting. In addition to the questionnaires nursing intraoperative records were audited for compliance to mandatory x-ray based on 6 high risk indicators for retained items. A small test of change involving education of results of the surveys and reminders of the indicators for x-ray were presented in verbal and written format. The intra operative records were then audited to ascertain if a change in compliance occurred.

*Results: A total of 104 initial surveys were returned. Key comments related to retained item risk included rushing, communication issues and failure to follow procedure. A total of 58 second surveys were returned, 77% of the staff felt the policy did comply with national recommendation and met the community standard. It also identified that if the policy was followed it was felt that retained items could be prevented. Auditing May's intra op records revealed that 18 cases had one or more of the criteria for a mandatory x-ray and 3 did not get requited x-ray. Audit of July's records after education revealed 9 cases where x-ray would be mandatory and 1 failure to x-ray*

**Discussion:** The small test of change did show slight improvement with procedurvcompliance. Counting is an error prone process with possibility of cognitive lapses, repetitive activities, interruptions and distractions during counting. Compliance with the procedure, taking time for count pause, attention to process and reduction of interruption while counting is taking place should provide a safer practice environment. New technology and products are available to assist with counting process.

**Key words:** Retained items, surgery

