

What we have learned:

Perception	Reality
<b>Nursing Process Observations</b>	
<p>Nurses place undue reliance and trust in the “count”. Each individual nurse is sure that “his/her count is correct” yet there are retained sponges.</p>	<p>Current manual counting practices are not standardized between personnel or within ORs. Error rates are ~10-15%. Usual errors occur in the “out-counting” phase because nurses are counting items in multiple places and adding up to get a pre-determined number. Miscounts are frequent and since the item is usually found miscounts become part of the norm in many ORs. Because a retained sponge is an infrequent event in any one nurses’ career think it can’t happen to them and over-estimate their ability to detect error. When a retained sponge case does occur credibility of all the OR staff can become an issue. Adopting a transparent, verifiable, standardized system will give real meaning to the phrase “the counts are correct” and prove there is NoThing left behind.</p>
<p>Resistant to practice change. “I’ve been doing it this way for thirty years and have never had a retained sponge”</p>	<p>Nurses use practices they learned during nursing training and are resistant to change especially if they personally have never had a sentinel event. Important to demonstrate the way in which errors occur and how moving to a safer system will be better for patients</p>
<p>Think improvement will come from adding more counts or counting more frequently</p>	<p>Simplifying the process actually will increase the reliability. Reducing the number of counts and improving the practice to “accounting” rather than just counting should succeed. Teaching nurses and scrub technicians about the faults in their thinking about the practice patterns they have adopted should improve performance. Specifically learning about normalization of deviance, loss of situational awareness, presumption of package number, diminution of risk and confirmation bias as it applies to the practice of sponge ACCOUNTing helps them work smarter.</p>

<p>Don't want to change to multiples of 10 or change the way they record surgical counts</p>	<p>Multiples of 10 standardizes practice between the different types of sponges that are used "free" in the OR and makes use of the plastic hanging sponge-holders as a unified process. There will always be a full 10 pocket holder, one sponge in each pocket. One system for laps and raytex. Using a dry erase board and a standardized process to record the counts means greater transparency and less reliance on oral transmission of information between personnel. Nurses move about from OR to OR giving relief and aren't usually assigned to the same cases every day. The process in use throughout the OR has to be the same for each room and doesn't depend on the presence of any one individual nurse.</p>
<p>Why can't they use the sponge holders in groups of 5 for laps, pulling open the pouches. When there are 5 laps they will still have a full holder.</p>	<p>This would work for a case that only had 5 laps for the entire case. But throughout an OR this is not the most frequent situation. In large busy ORs, the average number of sponges used/case in an OR is 40. Many cases have laps and raytex in addition to the other sizes of cotton gauze disposables. If you put the laps in the holders in groups of 5 you will have twice as many holders by the end of a case, the laps tend to fall out, especially if bloody. If you also have raytex being used in a case, which are in groups of 10 and more than 5 laps you will immediately have two different systems in place and may end up with some holders completely full and some with 5 empty pockets. Counts in groups of 10 mean one system for all free sponges and no empty pockets at the final count!</p>
<p>Think can't leave 5 laps in a patient so 5 empty pockets shouldn't be a concern</p>	<p>Multiple cases of 5 retained laps have occurred. These cases have had the counts called correct. Nurses think that they have incorrectly entered the total number of sponges on the field and just didn't include one pack of lap pads on the board rather than realize 5 laps can easily be left in the abdomen, chest or retroperitoneum.</p>

<p>Think manufacturing and packaging errors are events too rare to worry about and think if there are packaging errors they will catch them</p>	<p>Sponge manufacturing and packaging has human process components. Human beings weigh the sponges before banding them (they aren't counted and it's not a machine) and when they are re-packaged by distributors they are counted by humans. People make mistakes and 9 or 11 sponge packages of raytex and 6 lap pad packages of laps occur frequently. In any group of nurses or scrub technicians that has been on the job &gt;10years there are multiple individuals who have encountered these "bad packs". AORN practice of two person "see, separate and say" when adding sponges to the field is designed to identify these errors. Failure to perform this task correctly or minimizing or cutting corners at the IN count(s) is contributory to why retained sponges occur.</p>
<p>Think they don't need to use the sponge holders "to count"</p>	<p>Old practice with the use of "counters" still has sponges at the end of the case in multiple sites where nurses add them up. Putting all the sponges in one place at the end of the case provides a highly visible system where the sponges are being held for everyone in the OR to easily see.</p>
<p>Place undue blame on surgeons as being uncooperative and the reason why retained sponges occur</p>	<p>Errors in surgeon behavior and knowledge is responsible for 20% of retained sponge cases. Expanding the knowledge to all stakeholders in the OR, developing a teamwork model empowers all individuals to make sure no patient leaves the OR unless all the sponges have been accounted for</p>
<p>Use of adjuncts pose environmental harm</p>	<p>The plastic hanging sponge holders must be disposed of as biohazard waste. It is an additional bioburden. The significance of this burden is not known.</p>

<b>Surgeon Process Observations</b>	
Think it can't happen to them, if it does it isn't their fault, all the effort not worth the cost, no big deal if sponge left in the vagina, doesn't cause harm	80% of retained sponge cases occur in the setting of a correct count but 20% occur with an incorrect count. Counting alone is insufficient. Realize need for a better system and that it can happen to anyone. It's a problem with relationships (behavior, practices) in the OR. Average "cost" of a malpractice settlement: >\$150K. Changing practice and behavior: \$0 . Patients suffer no matter where a sponge is left behind.
think they are being asked to count and it's the nurses job "to count",	Surgeons aren't being asked to count and it's not about "counting", ACCOUNTing for the sponges and making sure they aren't in the patient is a joint and shared responsibility
If they participate in Sponge ACCOUNTing they think it will increase surgeon liability	Surgeons usually overestimate their risk of liability 3-5x. If they participate and make sure all sponges are accounted for, their actions reduce the risk of a retained sponge, reduces liability. Encourage surgeons to think first of the patient.
Most think that sponges are retained more frequently when there are a lot of sponges to count	Retained sponges occur in cases where only 10 sponges were used in the entire case. There is no relation between the number of sponges used and the chance of having a retained sponge occur
They usually rely on the nurse to tell them if something is missing or the count to be "off" before they perform a sweep or swish or look for sponges	A Methodical wound exam should be performed first instead of a sweep to get the sponges out so the nurses can count them and then determine if something is missing
Many perform a "sweep" of the wound area and think it is adequate and think they will be able to find any sponge with this technique (e.g. in the vagina)	Sweeping and swishing is inadequate. A methodical wound exam using two sensory modalities (seeing and feeling) and actively looking for the sponges should be performed. Soiled sponges can be balled up and difficult to find in large spaces. If the surgeon thinks that the sponge is NOT in the wound it affects the way the examination is performed.

<p>They state that a MWE will take too long to perform. If they do it, they will disrupt the anastomosis, cause arrhythmias, and generally do more harm than good</p>	<p>The MWE takes very little time to perform and will enable the surgeon to remove sponges so the nurses can get them in the sponge holders to prove that none have been inadvertently left in the patient</p>
<p><b>Concerns about Use of Xrays</b></p>	
<p>If there is an incorrect sponge count indicating that there is a sponge missing, an intraoperative xray read by the surgeon is good enough to rule out retention</p>	<p>Sponges can be difficult to detect on intraoperative quality xrays. The complete operative field should be able to be seen. Two views should be taken (AP and oblique) if the sponge is not seen on a single view film. Xrays should be read by a radiologist.</p>
<p>The wound should be closed to prevent infection before taking an xray in the setting of an incorrect count.</p>	<p>If the wound is completely closed and a sponge is found to be still in the patient this is considered a retained sponge and in many states is a reportable event. It is better to place a sterile non-radiopaque towel or plastic drape over the wound during the taking of the xray to prevent infection rather than closing the wound.</p>
<p>If you have a rule to have a mandatory xray with an incorrect count, the nurses won't count at all</p>	<p>Nurses are healthcare professionals and part of their OR practice is to perform surgical counts.</p>
<p>If there is an incorrect count and the item is never found but an xray has been taken there isn't any need to disclose to the patient</p>	<p>If there is an incorrect count and the item is never found, the patient needs to be informed of the situation and consider getting a CT scan to definitively rule out the possibility of a retained item.</p>