# What's Your Count Made Of?

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CONE HEALTH

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

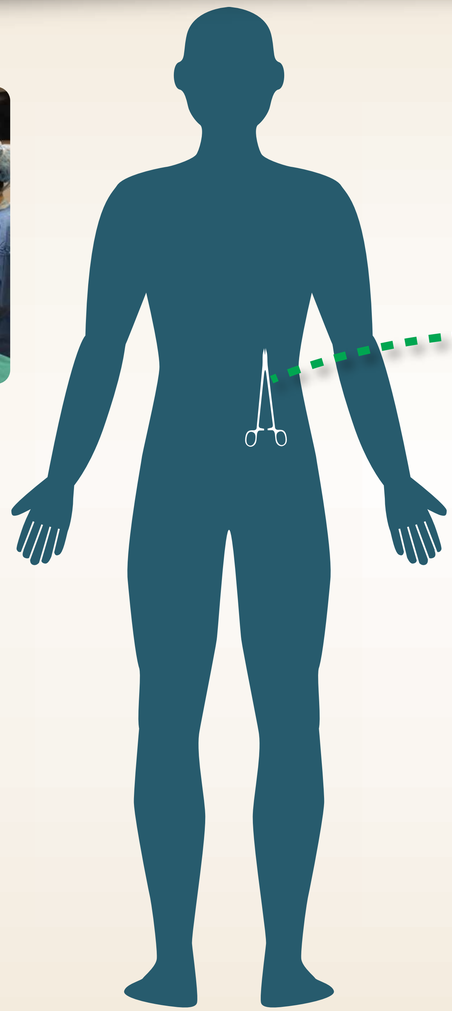
Poster #132

## BACKGROUND:

A retained foreign object after any procedure is a serious and devastating medical error. Consequences of a retained foreign object can be profound for the patient and their family and can result in patient death. Any procedure resulting in an unknown retained foreign object is considered below the standard of care and a preventable error.

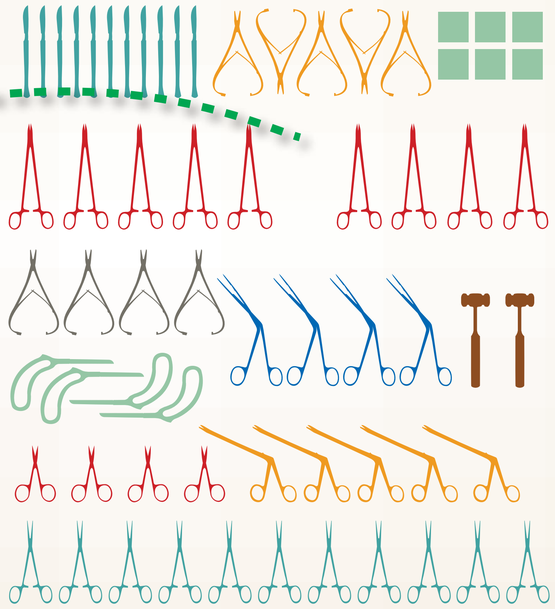
## INITIATIVE:

After recent events of retained foreign objects, our organization completed an in-depth self-assessment focusing on all aspects of our current counting process. This in-depth assessment revealed the lack of standardization in many dimensions across our 6 OR sites, potentially placing our patients at risk for a retained foreign object. As a result, a system-wide inter-professional Counting Task Force was convened to evaluate the current counting process and was charged with addressing the specific issues identified. Key to success was the standardization of not only our clinical practice, but also our worksheets and instrument trays. The Count Task Force also discovered an opportunity to not only challenge established practice, but to redefine best practice in the operating room. Our journey to best practice started with understanding the implications of a retained foreign object, being knowledgeable regarding the risk factors contributing to a retained foreign object, and empowering nurses to implement interventions to prevent a retained foreign object.



## Data deep dive:

An analysis of incorrect counts over a year time-frame (n=74).




**6%** Clinical Error: Opportunity to educate OR staff as to what is best practice

**11%** Practice Issue: Opportunity for one on one coaching related to best practice, holding staff accountable for their practice

**14%** Emergency procedure, no count performed: Opportunity to reinforce education for procedures where it is appropriate not to count

**25%** Clerical Error. Opportunity for standardization for nomenclature, clinical practice and worksheets

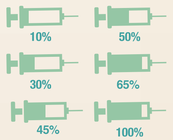
**36%** Needle gauge too small for radiologic identification

## Outcomes:

- Challenged established practice to get to best practice
- Standardization of clinical practice
- Standardization of nomenclature
- Standardization of worksheets
- Staff led/driven practice change (not driven from top down, but from bottom up)
- Implemented new countingprocedures beyond the OR in other procedural areas at risk for a retained foreign object — interventional radiology, cath lab, labor and delivery
- Next step is to standardize instrument trays

## Building best practice by:

Standardization of clinical practice across multiple OR sties




Collaboration/ Shared Governance framework

Interprofessional teamwork (OR Registered Nurse, Surgical Technologist, Sterile Processing Department, Risk Management, Quality)