"I Think, Therefore I Count": Changing the Count Process While Encouraging Critical Thinking

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Changing the Count Process While Encouraging Critical Thinking

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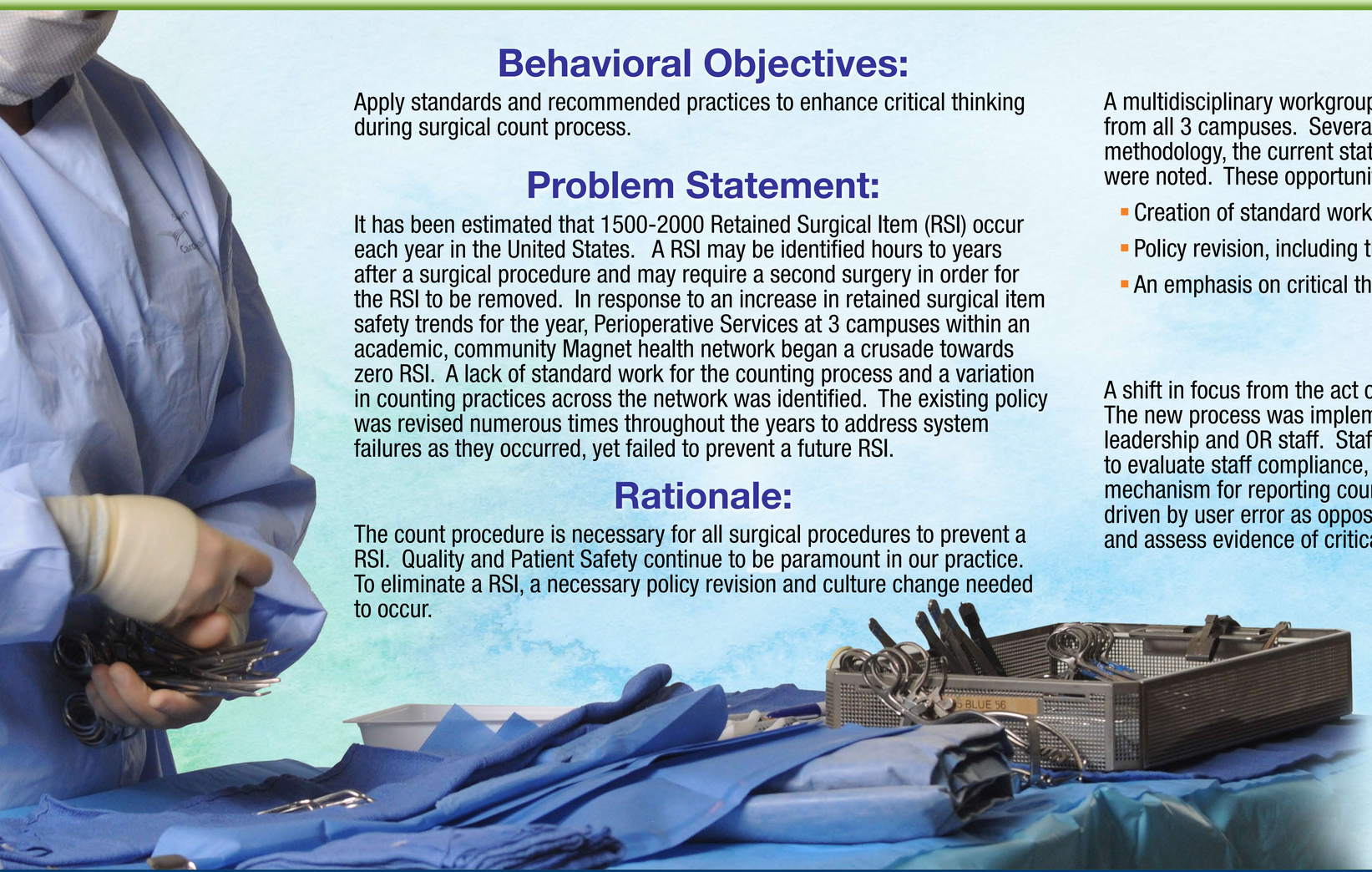

Behavioral Objectives:

Apply standards and recommended practices to enhance critical thinking during surgical count process.

Problem Statement:

It has been estimated that 1500-2000 Retained Surgical Item (RSI) occur each year in the United States. A RSI may be identified hours to years after a surgical procedure and may require a second surgery in order for the RSI to be removed. In response to an increase in retained surgical item safety trends for the year, Perioperative Services at 3 campuses within an academic, community Magnet health network began a crusade towards zero RSI. A lack of standard work for the counting process and a variation in counting practices across the network was identified. The existing policy was revised numerous times throughout the years to address system failures as they occurred, yet failed to prevent a future RSI.

Rationale:

The count procedure is necessary for all surgical procedures to prevent a RSI. Quality and Patient Safety continue to be paramount in our practice. To eliminate a RSI, a necessary policy revision and culture change needed to occur.

Methodology:

A multidisciplinary workgroup was formed with nursing, surgical technologist and leadership representation from all 3 campuses. Several half-day retreats were held to examine and discuss the problem. Using Lean methodology, the current state of the process was mapped out and various opportunities for improvement were noted. These opportunities led to the following changes:

- Creation of standard work for the counting process
- Policy revision, including the use of evidence-based practices
- An emphasis on critical thinking

Results:

A shift in focus from the act of counting to Prevention of Retained Surgical Items was highlighted for the staff. The new process was implemented in early July 2012 after network wide education for physician champions, leadership and OR staff. Staff concerns were mitigated by an engaged leadership team. Audits conducted to evaluate staff compliance, also revealed critical thinking was being applied to the count process. The mechanism for reporting count discrepancies showed a decrease trend in count errors. Errors reported were driven by user error as opposed to policy violation. Ongoing audits will continue to track policy compliance and assess evidence of critical thinking.

Take Home Messages:

- Know and apply standards that drive practice
- Encourage critical thinking in staff driven practice
- Empower staff to initiate a culture change
- Trust, but verify – complete audits to ensure compliance