Retained Sponge

- Most common retained surgical item that requires a re-operation
- Detection can be difficult and remote from the initial operation
- The sponge must be removed
- Primary problem is faulty OR practices

Laparoscopic removal of retained raytex sponge
• **Nurses** use a standardized process to put sponges in hanging plastic holders and document the counts on a wall-mounted dry erase board in every OR.

• **Surgeons** perform a methodical wound exam in every case and before leaving the OR - verify with the nurses that **all** the sponges (used and unused) are in the holders.

50 lap pads accounted for.
NOT business as usual

• Practice change for nurses and surgeons, accounts for sponges
• Visible, transparent system
• Different process for use of sponge holders (not counters), dry erase board data for all to see
• “Show me” step proves that “the count is correct”
WHERE ARE THE SPONGES?

EASY AS

1 @ IN COUNT(S) ALWAYS

2 @ CLOSING COUNT TAKE A

3 @ FINAL COUNT SAY

CHECK SPONGES

PAUZE FOR THE GAUZE

SHOW ME

Three Operational Phases
Terminology

1. **IN COUNT(S)** a continuous process. Moment to discover packaging errors. All data is documented on the dry-erase board so everyone in the OR can see them.

2. **CLOSING COUNT** take a “pauze for the gauze”, information exchange between surgeon and nurse, critical phase to prevent retention, cooperative team opportunity.

3. **FINAL COUNT** - “show me” verification step, ideally between surgeon and nurse. Last chance to get it right before patient leaves the OR.
SURGEONS EASY AS 1,2,3

SPONGE ACCOUNTING PROCESS

CLOSING COUNT
Methodical Wound Examination (MWE)

Don’t just “Swish or Sweep”
The goal is to get all the sponges OUT so they can be accounted for.

A methodical exploration of the operative wound must be conducted prior to closure in every operation. The space to be closed must be carefully examined. Special focus should be given to closure of a cavity within a cavity (ie, heart, major vessel, stomach, bladder, uterus, and vagina). Surgeon should strive to SEE and TOUCH during the exploration whenever possible; reliance on only one element of sensory perception is usually insufficient. Surgeon should make every effort to remove all sponges so that nurses can account for them.

The general process is to look and feel in the recesses of the wound and examine under any protuberances and soft-tissue appositions.

Unless clinically contraindicated for a specific patient, the following steps should be taken for procedures performed in the abdomen or pelvis. These steps should be performed before removing stationary or table mounted retractors.

1. Examine all four quadrants of the abdomen with attention to:
   a. Lifting the transverse colon.
   b. Checking above and around the liver and above and around the spleen.
   c. Examining within and between loops of bowel.
   d. Inspecting anywhere a retractor or retractor blades were placed.

2. Examine the pelvis:
   a. Look behind the bladder, uterus (if present) and around the upper rectum.
   b. The vagina should be examined if it was entered or explored as part of the procedure.

3. Unless clinically contraindicated for a specific patient, the following general steps should be taken for procedures performed in the mediastinum or thorax.
   a. In a mediastinal procedure, if the mediastinal pleura were opened, examine the collateral pleural cavity.
   b. In a cardiac procedure, elevate the apex of the heart and examine the retrocardiac space.
   c. In a thoracic procedure, examine the thoracic cavity with attention to the thoracic apex and base of the lungs, paravertebral sulcus, and inferior recesses of the diaphragm. Place a hand or finger behind the lung and palpate from apex to base.

SHOW ME

FINAL COUNT
GET TO 0 in 2016

Nothing Left Behind®

CHECK SPONGES
IN COUNT(S)
Only use xray detectable sponges or towels.
Don’t alter them. Avoid use of small sponges in large cavities.

PAUZE FOR THE GAUZE

PAUZE FOR THE GAUZE

CLOSING COUNT
Perform a methodical wound exam (MWE), to get all the sponges out. CALL OUT “I think all the sponges are out” THEN ask for closing suture.
• Only use x-ray detectable sponges or towels
  ➡️ White towels with markers work well
• Don’t alter them
• Avoid use of small sponges in large cavities
Retained Towel

- Drapes NOT Dressings
  - Different grade and quality of cotton
- No radiopaque marker
- Not included in the count
- Change practice or
- Purchase dressing quality towel with radiopaque marker
- Include on board when added to the field

Camazine, Contemp Surg 2005;61:398
PERFORM a methodical wound exam in every case

LOOK for sponges- not just a “swish or sweep”

CALL OUT “I think all the sponges are out

Then ask for closing suture
Don’t Just “Swish or Sweep”, perform a Methodical Wound Examination (MWE)

The goal is to get all the sponges OUT so they can be accounted for

1. A methodical exploration of the operative wound must be conducted prior to closure in every operation. The space to be closed must be carefully examined. Special focus should be given to closure of a cavity within a cavity (i.e., heart, major vessel, stomach, bladder, uterus, and vagina). Surgeons should strive to SEE and TOUCH during the exploration whenever possible; reliance on only one element of sensory perception is usually insufficient. The surgeon should make every effort to remove all sponges so the nurses can account for them.

2. The general process is to look and feel in the recesses of the wound and examine under fatty protuberances and soft-tissue appendages. Unless contraindicated for a specific patient, the following steps should be taken for procedures performed in the abdomen or pelvis. These steps should be performed before removing stationary or table mounted retractors.
   a. Examine all four quadrants of the abdomen with attention to:
      i. Lifting the transverse colon
      ii. Checking above/around the liver and above/around the spleen
      iii. Examining within and between loops of bowel
      iv. Inspecting anywhere a retractor or retractor blades were placed
   b. Examine the pelvis
      i. Look behind the bladder, uterus (if present) and around the upper rectum.
      c. The vagina should be examined if it was entered or explored as part of the procedure.

3. Unless contraindicated for a specific patient, the following general steps should be taken for procedures performed in the mediastinum or thorax.
   a. In a mediastinal procedure, if the mediastinal pleura were opened, examine the (ipsilateral pleural) cavity.
   b. In a cardiac procedure, elevate the apex of the heart and examine the retrocardiac space. Examine the transverse sinus to the right and left of the aorta and pulmonary artery.
   c. In a thoracic procedure, examine the thoracic cavity with attention to the thoracic apex and base of the lungs, paravertebral sulcus, and inferior recesses of the diaphragm. Place a hand or finger behind the lung and palpate from apex to base.

FINAL COUNT

SHOW ME
Incorrect Count

- STOP CLOSING THE WOUND!
- Repeat the MWE
- Call for Xray early if sponge not immediately found
  - Take two views if the sponge is not found and not obvious on xray
  - Call for another pair of hands to look and feel if sponge still not found
Incorrect Count

- STOP closing the wound
- Repeat the methodical wound exam
- Call for an Xray early, obtain full views of the wound, get another view (oblique) if needed
- Patient can’t leave the OR until the Xray is read by radiologist (preferably) or surgeon and/or sponge is found
• Before leaving the OR say “show me”
• You aren’t being asked to count!
• Ask to see the holders and look at them.
• Each pocket should be full - 10 sponges per holder.
**Sponge Accounting Process**

*Use plastic hanging sponge-holders for laps and Raytex*

This process involves the use of plastic hanging blue-backed sponge-holders which contain 5 pouches. Each pouch has a thin center-divider which separates each pouch into 2 pockets. One sponge should be placed in each pocket. One sponge per pocket, 2 pockets per pocket, and 5 pouches per holder means that each holder can accommodate 10 sponges. We recommend that each holder always be set up to hold 10 sponges to be the sponges in the sponges in the bags in the OR to be easily visible in each room. This process should be standardized for use throughout all operating rooms to provide consistency in all types of operating cases.

The single most important element in the use of the hanging sponge-holders is to make sure that the final count is taken when ALL the sponges that have been opened during the case (used and unused) have been placed in the holder. The surgeon and nurse can then visually verify that all sponges have been accounted for and none remain in the patient.

1. Use sponge holders on all cases that require a sponge count. Add Laps and Raytex in groups of 10.
2. Hang the holders on the special racks attached to the OR poles. Use a separate holder for each sponge type; e.g., one for laps, one for Raytex.
3. Used sponges coming from the OR should be placed into a clear plastic bag with a lint-free chenille. This will make it easy to see the used sponges.
4. If one used sponge is removed from the OR, make sure you have only one sponge. Open it up to its full length and then fold it into an end. Place one (1) sponge per pocket. Two (2) sponges per pocket; ten (10) sponges per counter.
5. Put the first sponge in the last pocket in the bottom of the holder. Load the holder horizontally from the bottom to the top, filling first the bottom two pockets and continuing upwards. This process (going from the bottom to the top) will make visual determination of the number of sponges easier to see from the OR table.
6. Place the folded sponges inside the pockets with the blue tag or blue stripe visible. The blue stripe must be visible because this is what differentiates the sponge from the dressings.
7. When placing the sponges in the dressings, make sure you have only one sponge. Place another sponge in the other pocket in the other side of the pouch. Periodically throughout the case, put all sponges in the holder.
8. At the time of the final count, ALL sponges MUST be in the sponge holders and the final verification must be taken by two people viewing the sponge holders.
9. Keep a running total of the sponges added to the surgical field and dry erase board, using the same format that is used at the conclusion of the case. The total should be a multiple of 10. The last number should always be the total number of sponges currently on the field.
10. At the point when the true count is taken, make sure the number of sponges in the holders is physically removed using visual and audible communication between the circulating nurse changing position before the inferred nurse departs the OR.

Sponges should be remaining hanging in their boxes from the OR walls. They should then be placed in the OR lap and Raytex lap counts. However, the final count must be visual confirmation of all sponges in the bags in the OR to be easily visible on each pocket. Each holder is fully loaded with 10 sponges, with normal use of 10 laps / 10 Raytex / 10 pockets / 10 steps...

GET TO
Easy as 1,2,3

1. Add “free” sponges [laps, raytex] to the field in groups of ten, count is only in multiples of ten, document running total on wall-mounted dry erase board

2. Use blue plastic hanging sponge holders, 1 sponge/pocket, tag faces forward. 10 sponges per holder

3. At final count all sponges (used and unused) in holders. Before surgeon leaves the OR “show” the full holders
Hanging Sponge Holders

- Cheap
- One sponge per pocket, Two sponges per pouch, Ten sponges per holder
- Blue radio-opaque marker visible, always 10 sponges
- One holder for each type of sponge
- ALL sponges in the holder
- MUST take final count from holders
Plastic Hanging Sponge Holders

BLUE BACKED

WHITE BACKED
Unsafe
Dry Erase Board

<table>
<thead>
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<th>LARGE (&gt;15mm)</th>
<th>SMALL (≤15mm)</th>
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<tbody>
<tr>
<td>11</td>
<td>16</td>
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</tr>
<tr>
<td>4</td>
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</tr>
</tbody>
</table>

K: 1
VC: 1
Bull: 5
Grey: 1
AM: 2
Angio: 1
Shades: 10
K8: 4

N/A
2 units PROB.
Line kick buckets with clear plastic bags

UNUSED SPONGE IN WHITE BAG

CLEAR PLASTIC BAG

BLOODY SPONGE IN RED BAG
Fig. 18.—A converted bath-poncho rack of the same type, in use at St. Louis Hospital.

Fig. 19.—Bradley's sponge rack described in the text. (Bradley—Am. J. Nursing.)

Fig. 20.—Jett's sponge rack, described in the text. (Jett—J. Indiana State M. A.)
Fig. 51.—Kubinyi's method. Sponge tape in the ten perforations of the metal plate, sponges attached ready for wrapping.

Fig. 52.—Kubinyi's method. The metal plate and its ten sponges wrapped for storage.

Fig. 53.—Kubinyi's method. Package unwrapped at operation, and sponge ready for use.

Fig. 54.—Kubinyi's method. Sponges drawn to metal plate at close of operation, for counting and inspection.
Sponges in Multiples of 10

• Ten pockets in holder will always have one sponge/pocket
• What does 5 empty pockets mean?
  ➤ Forgot to add one pack of laps to count?
  ➤ Really had 25 out?
  ➤ Or there are 5 retained sponges?
No Empty Pockets!

Empty pocket
Balancing “No Blame” with Accountability in Patient Safety

Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D.

This year marks the 10th anniversary of the Institute of Medicine’s report To Err Is Human, the document that launched the modern patient-safety movement. Although the movement has spawned myriad initiatives, its main theme, drawn from studies of other high-risk industries that have impressive safety records, boils down to this: Most errors are committed by good, hardworking people trying to do the right thing. Therefore, the traditional focus on identifying who is at fault is a distraction. It is far more productive to identify error-prone situations and settings and to implement systems that prevent caregivers from committing errors, catch errors before they cause harm, or mitigate harm from errors that do reach patients.  

Many health care organizations (including our own) have recognized that a unidimensional focus on creating a blame-free culture carries its own safety risks. But despite this recognition, finding the appropriate balance has been elusive, and few organizations have implemented meaningful systems of accountability, particularly for physicians. In this article, we describe some of the barriers to physician accountability, enumerate patient-safety practices that are ready for an accountability approach, and suggest penalties for the failure to adhere to such practices. We focus on situations in which the action (or inaction) of individual physicians poses a clear risk to patients, rather than on the broader issues of clinical competence or disruptive behavior; readers who are interested in the latter issues are referred to other sources.

NEJM 361:14, October 1, 2009
Safe Surgery

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