CIIG Workshop

IS YOUR ICU AND SURGICAL SETTING "BIRD-STRIKE PROOF"?

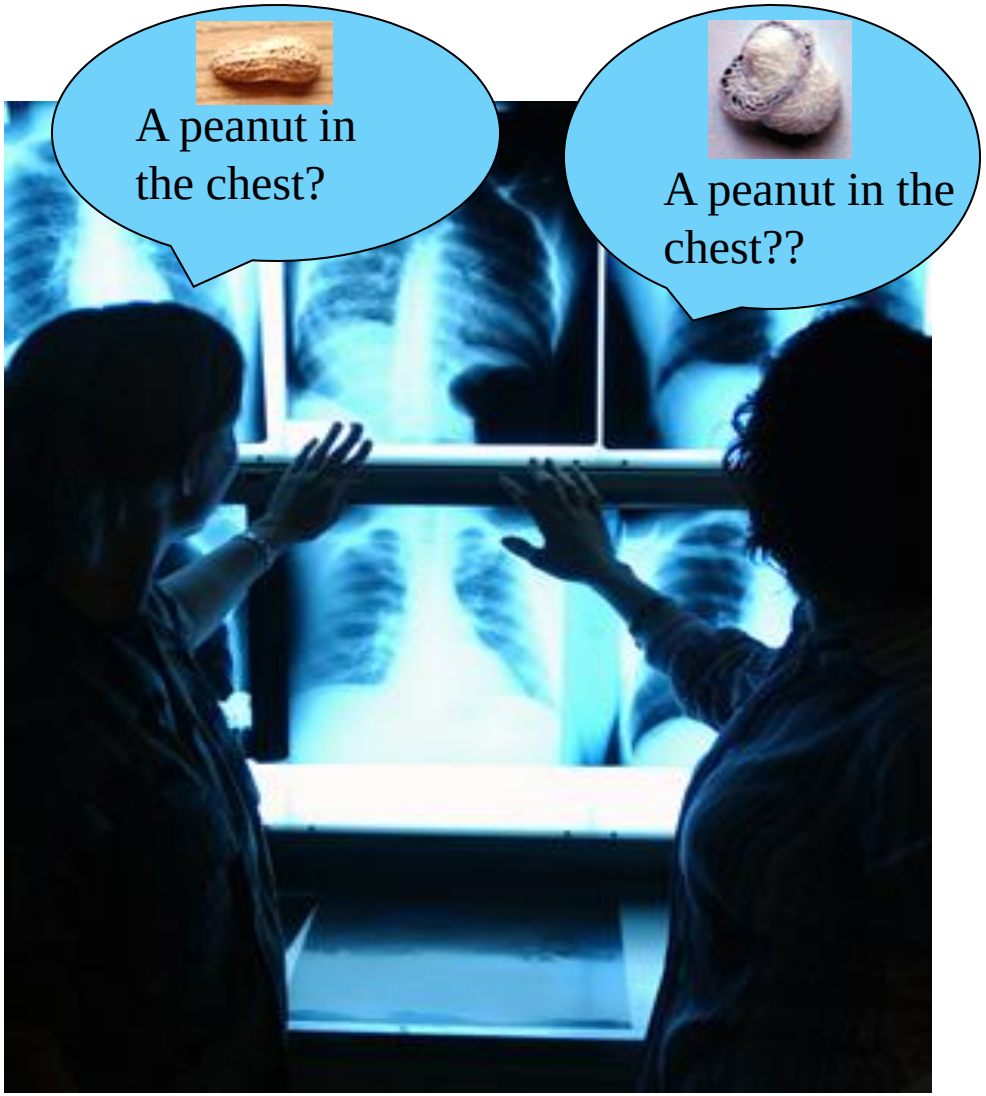
Verna C. Gibbs M.D.
Director, NoThing Left Behind
Professor Clinical Surgery UCSF
Staff Surgeon, SFVAMC
www.nothingleftbehind.org

Common Language

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Common Language

- If radiologists know what they are looking for they have a better chance of finding it
- Important to fill out the request from the OR for a specific film with all the information



©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Communication

- **It's <u>what</u> is right not who is right**
  - Between nurses and surgeons
    - "We're missing a sponge" "Lets re-explore the wound!"
    - "Dr. Is this a good time for lunch relief?"
  - Between nurses and scrub techs
    - "Separate each raytex so we can make sure we have 10"
    - "Let's verify the sponge holders before you take permanent relief"
  - Between surgeons
    - "Make sure you check behind the heart for any raytex before you close"
    - "Let's do our wound exam and look for sponges"

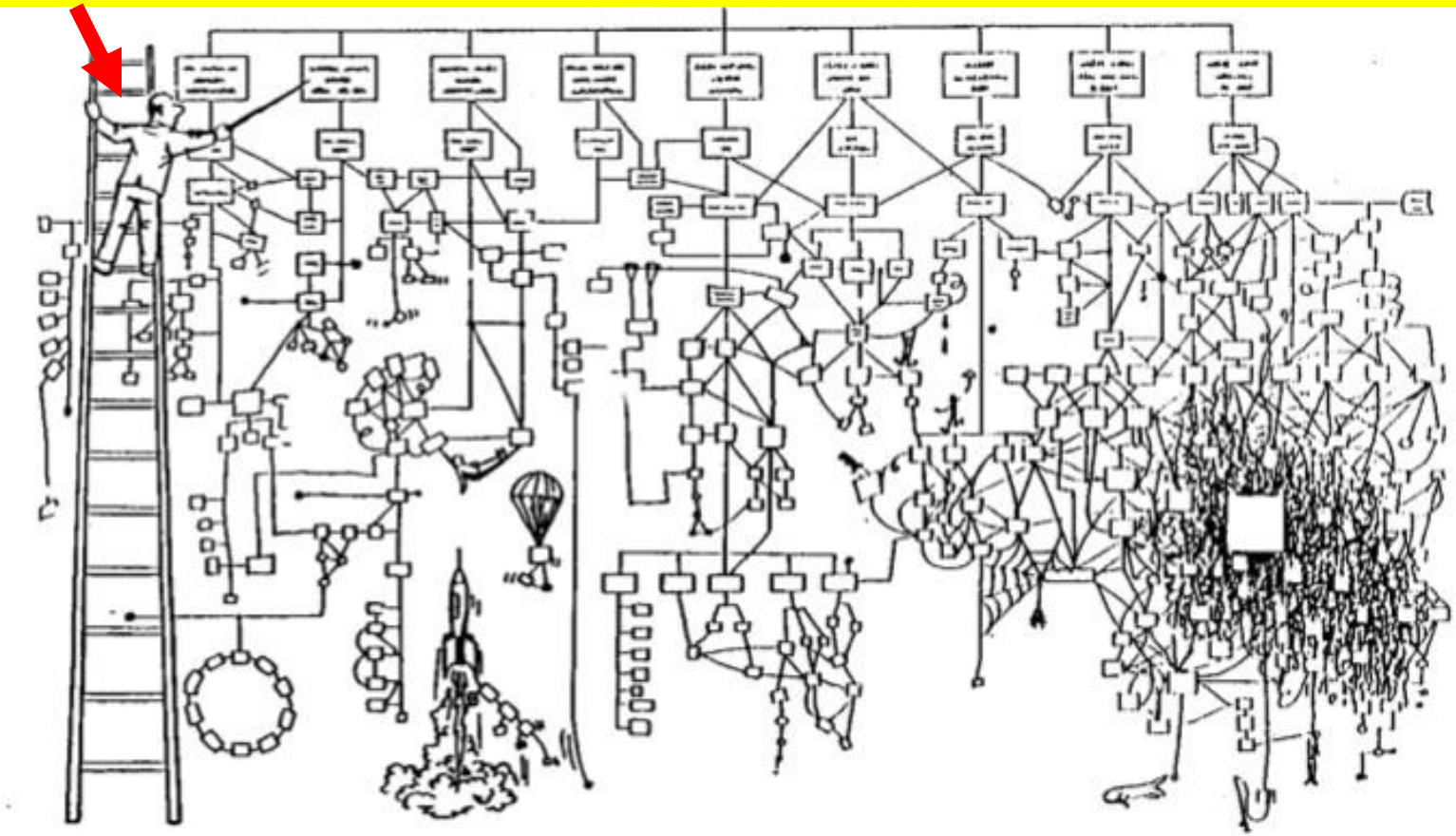
OR Practices

- What we do and how we manage our work

  We = Multiple Stakeholders
- Anesthesiologists: 4X4 management, coordinated reversal from anesthesia
- Surgeons: use only radiopaque items, perform a wound exploration
- Nurses: surgical item accounting process
- Scrub Techs: organize field, know equipment
- Radiologists/Technicians: film quality, timely review, appropriate images

Perception vs Reality

OR MANAGER – How I think things work (or should work)



OR STAFF – How things really work: unintended variation

Practice of Counting

- Currently, most of the responsibility for preventing retained sponges resides with the nurse's ability "to count".
- Surgeons place undue reliance on the task
- Nurses place unjustified trust in the practice
  - Current counting practices ~10-15% error rate
- Counting in the unit of issue
  - 1,2,3,4,5.....1,2,3
  - Bagging sponges in bundles
  - Keeping counts on pieces of paper
- Adding up sponges in multiple places

Findings

- 80% of retained sponge cases occur in the setting of a CORRECT COUNT
  - Problems with OR practices
- 20% occur in the setting of an INCORRECT COUNT
  - Problems with knowledge and communication

Practice Issues

- Variable counting practices exist throughout an OR - no standardization, little transparency….”my practice”
- Frequent confirmation bias between scrub and circulator
- Loss of situational awareness and missing events that occur outside the scrub or circulator’s locus of control
- Normalization of deviance
- Retained sponge cases have occured when low numbers of sponges (≤20 sponges) have been used

What's the Count?

The Count was Correct!

The Gorilla in the OR

- The resident who came in the room and took a raytex off the back table and wiped his glasses and threw the sponge away
- The surgeon who took a towel from the stack of blue drape towels and used it to retract the bladder
- The scrub tech who put the sponge in the stainless steel canister and went on break
- The circulator who used a pack of 5 laps as a knee bump for the patient

Findings

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

- Problems with the practice of counting relate to nurse and scrub tech
  - over-estimation of their ability
    - "I know how to count 10 raytex"
  - under-estimation of the degree of risk
    - "I've never had a retained sponge"
- Lack of understanding about human fallibility
  - Fail to adhere to safety rules
  - Trust without verification

It’s not only about Counting!

Our learning?

- Sponge ACCOUNTing is hard to implement because people don't want to change *their* practices even though they say they do….
- Multiple stakeholders MUST change their way of thinking about the problem of RSI and let-go of their perceptions to face reality

Culture

- Constellation of shared beliefs and ways of interaction, common rules
- OR safety and a safety culture is built on RELATIONSHIPS
  - Mutually respectful
  - Collaboration with shared knowledge
  - Trust with Verification
  - Credibility earned from Expertise

A Just OR Culture

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

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*,[1] 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.[2,3]

Most health care providers embraced the "no blame" model as a refreshing change from an

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.[7,12,13]

NEJM 361:14, October 1, 2009

Multi-stakeholder

- Need engagement and participation from multiple people usually from multiple disciplines
  - SCIP measures
    - examples
  - ICU improvement in delirium
    - examples
    -

TEAMWORK

"It is the ability to work together which determines success."

Who is on the team?

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Who is NOT?

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

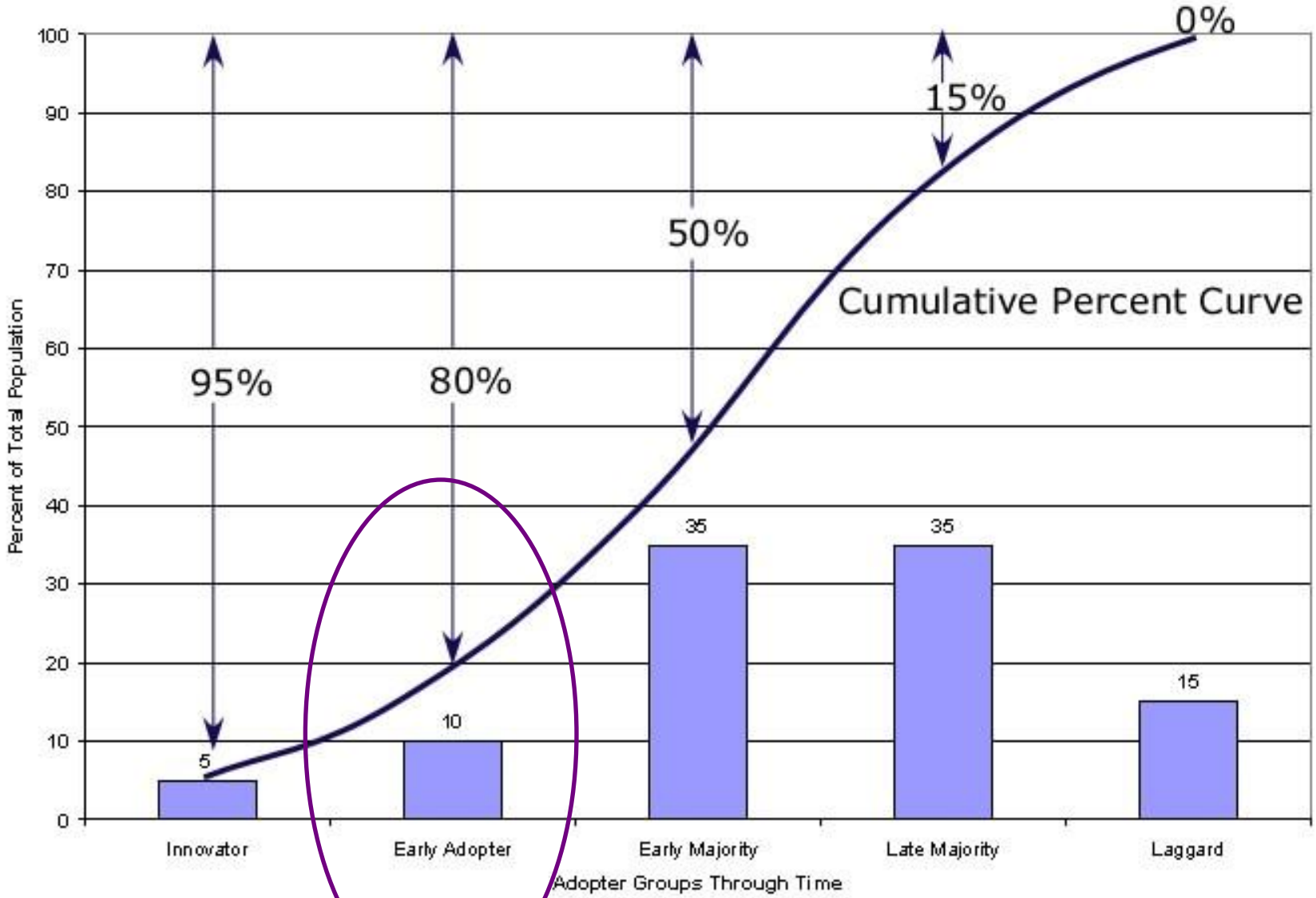


Figure 2. Cumulative Percent Distribution of Diffusion Theory Adopter Groups Showing Remaining Opportunity

Complex Adaptive System

1. Heterogenous interdependent decision making agents
2. Frequent interaction with each other creates learning
3. Development of emergence - the whole is greater than the individual parts

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Learning System

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

- Goal is to create continuously learning organizations that generate and transfer knowledge from every patient interaction to yield greater performance predictability and reliability
- Leadership has to the support vision of continuous improvement

Best Care and Lower Cost:The Path to Continuously Learning Health Care in America, IOM August 2012

Complex System

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

- Explosion of biomedical and clinical knowledge
- Escalating cost of care
- Expanding array of care providers
- Organizational and technological options increase
- Patient engagement

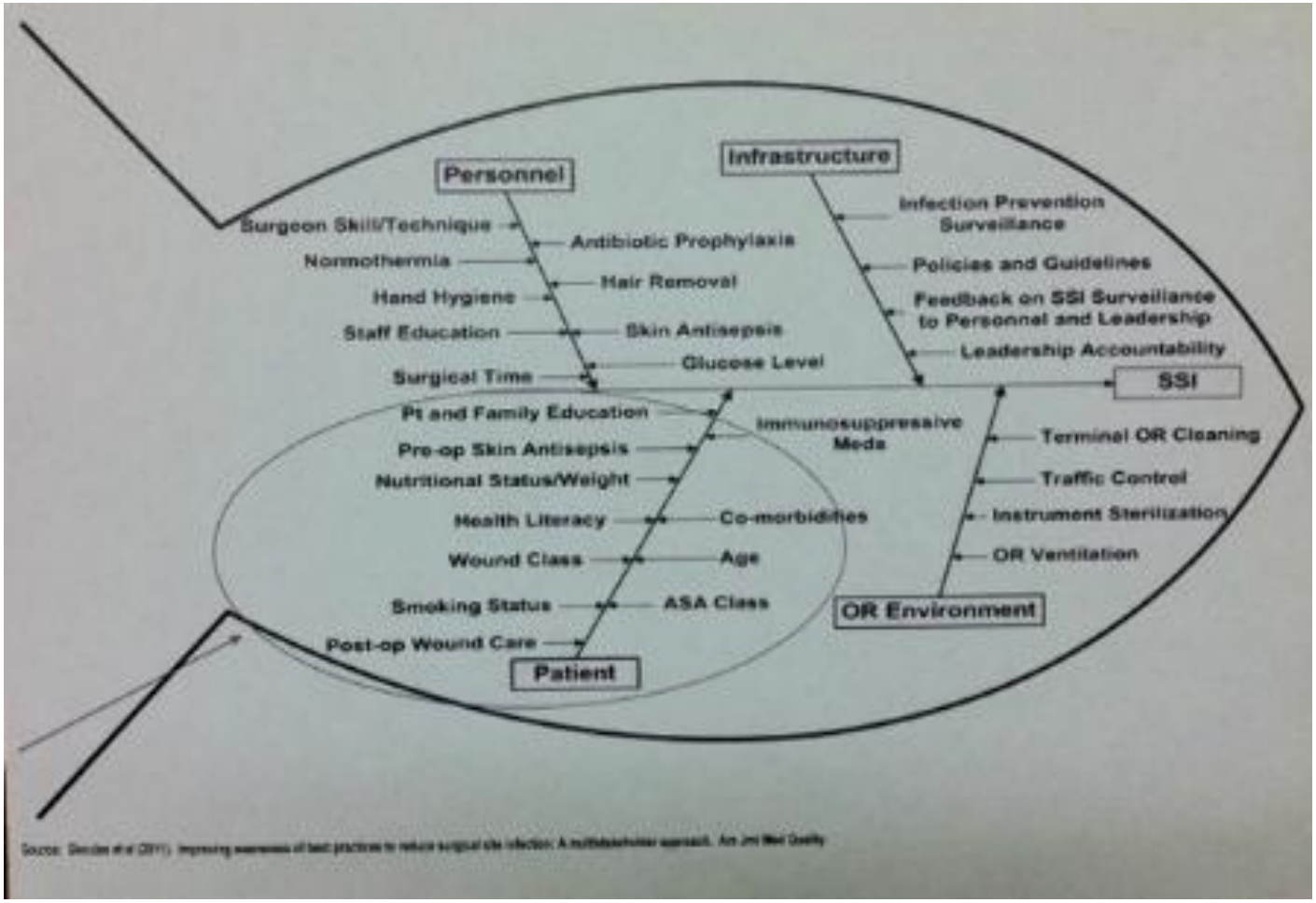
Include all of this?

Cynosure HEALTH

Easy as 1,2,3 NoThing Left Behind®

ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED



Or this?

Cynosure HEALTH

Easy as 1,2,3 NoThing Left Behind®

ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

STANFORD

Complex Change

bowel prep
oral antibiotics
preop diet
bathing
Scheduling process

Epidual/spinal
preoperative temperature warming
standardized protocols
variable dosing based on weight
Skin prep product
duration
performer
hair clipping
Rectal irrigation
Risk assessment
vashing prior to
rative heparin

Dressing type
Dressing duration
topical ointment to incision

Discipline: colorectal, general, gyn
Years in practice
Individual that does closure
wearing of scrubs outside OR

In/out of room traffic
Intraoperative room temperature
criteria for leaving wound open

handsewn vs. stapled
testing anastomosis
Interrupted vs. continuous suture
Skin staples/ subcuticular/subcutaneous suture
Tissue handling
Incision with scalpel/cautery
Duration of operation
Method of dividing the mesentary
Reperitonealization
wound protector
change gloves
assessment of quality of blood supply
perioperative fluid management

protocol for redosing
Case duration
Wound protector
Use of intra-abdominal drain
Use of subcutaneous drain
Use of ioban
IV fluid adminstration
Wound irrigation
Fixed vs. nonfixed retraction

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Have an Action Plan
Think of the project as an experiment

Neuro Infections

Cynosure HEALTH

Easy as 1,2,3 NoThing Left Behind®

ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

NEUROSURGERY RULES

TO REDUCE THE RISK OF WOUND INFECTION

ANESTHESIA:

- ❑ **Temperature** always ≥ 36
- ❑ **Glucose** < 150
- ❑ **FiO2** ≥ 80%
- ❑ **Antibiotics** within 30 min of incision:

  Cefazolin 1 or 2 gm → Re-dose q 4 hrs

  If allergic: ***Vancomycin*** *15mg/kg → re-dose q 8hrs at 10mg/kg*

  If transphenoidal or transoral: ***Chloramphenicol*** *500mg → re-dose q6 hrs (confirm with Neurosurgeon)*

SCRUB/CIRCULATING NURSES:

- ❑ **Hair removal**: minimal clipping
- ❑ **Skin scrub**: Chorhexidine, then Chloroprep
- ❑ **For DBS and VNS**: do not open implants until requested by surgeon; only surgeon handles
- ❑ **No street clothes** under paper scrubs for visitors

SURGEONS:

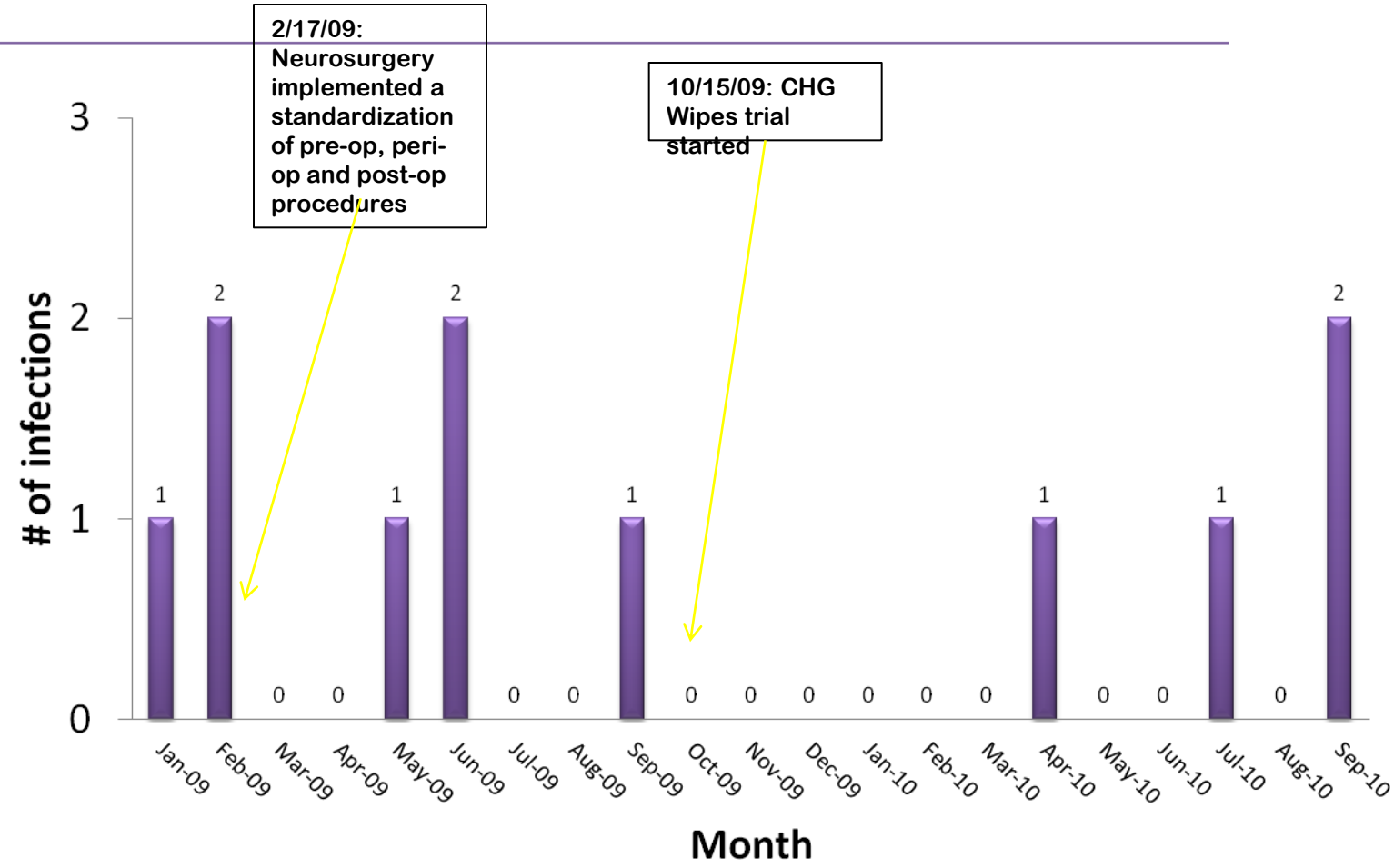
- ❑ **Use Kefzol irrigation** (or vancomycin if giving vancomycin IV)
- ❑ **Cover wound with blue towel** when fluoro passes over field *(except when not practical, such as XLIF)*
- ❑ **Avoid drains** for simple lumbar cases
- ❑ **Minimize bone wax**
- ❑ **If CSF leak:** close fascia with interrupted sutures PLUS a running Prolene
- ❑ **Dropped bone flap:** soak in 50/50 betadine/antibiotic irrigation and replace
- ❑ **Clean scrubs** to start each day
- ❑ **Change masks** between cases

6/2010

Questions? Contact Dr. Paul Larson

Neurosurgery Infections
January 2009 to September 2010

(updated 10/15/10)



©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

VTE Prevention

- Separate protocols for General Surgery, Neurosurgery, Orthopedic Surgery, Urology
- Any VTE event: within weeks analysis
- Coordination with ATS service in clinical management and decision making
- Review, review, review

VTE Prevention

Cynosure HEALTH

Easy as 1,2,3 NoThing Left Behind®

ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

GENERAL SURGERY POST-OP VTE PROPHYLAXIS

Sequential compression devices/SCDs (foot pumps) to be used in all patients unless specific lower extremity contraindications.

HEPARIN DOSING FOR VTE

Patient Size:

REGULAR -size patient (BMI < 40)
Heparin 5000 units sq q 8 hrs

BIG patient (BMI ≥ 40)
Heparin 7500 units q 8 hours

SMALL patient wt ≤ 50 kg (110 lbs)
Heparin 5000 units q 12 hours

Chronic Kidney Disease: (CrCl < 15ml/min)

Heparin 5000 units sq q 8 hrs

Epidural Catheter or Spinal Anesthesia:

***Discuss pre-operatively w/ anesthesia plan: Traumatic Puncture, Need for Full Anticoagulation, Use of Antiplatelet or LMWH Agents ***

PROPHYLACTIC Anticoagulant	Anticoagulant OK while catheter in place?	Time after catheter *PLACEMENT* until next dose	Time after Spinal *PLACEMENT* until next dose	Time after catheter *REMOVAL* until 1st or next dose	Time after last dose until catheter *REMOVAL*
Heparin q12h SQ *AND* 10K units/24h or less	Yes	1 hour	1 hour	1 hour	>6-8 hours ¥
Heparin q8h SQ *OR* >10k units /24h	* Yes with caution	1 hour	1 hour	1 hour	> 6-8 hours ¥
Enoxaparin BID SQ	No	Remove prior to dosing	24 hours	>2 hours	BID: Should not occur
Enoxaparin QD SQ/ Dalteparin QD SQ	* Yes with caution	6-8 hours If traumatic 24h	6-8 hours If traumatic 24h	>2 hours	QD:10-12h

*Consider periodic neurological assessments ¥ Consider assessing coagulation status in critically ill pt or pt with altered excretion

DALTEPARIN FOR CANCER-RELATED SURGERY

- Post-op VTE risk higher
- VTE risk highest first 30 days post-op
- Risk reduction potential with one month post-op VTE prophylaxis

Specific cancer-related guidelines:

Regular Size: Dalteparin 5000 units sq daily

Big Size: 7500 units sq daily

Small Size or CrCl < 15ml/min: 2500 units sq daily

Discharge: Provide Rx to complete 30 days of post-op anticoagulation

Monitoring: Arrange post-discharge follow-up appointment via CPRS consult to Anticoagulation & Thrombosis Service (ATS)

For any questions, call ATS (x4095 or 739-9083)

Surgical Service/SSQI **GOAL: AVOID PREVENTABLE VTE** March 2011

VTE Prevention

Cynosure HEALTH

Easy as 1,2,3 NoThing Left Behind®

ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

NEUROSURGERY VTE PROPHYLAXIS

VTE Prophylaxis Guidelines

High Risk Patients:

Elderly (≥75) having any procedure
Motor weakness or *any* condition preventing OOB on POD1
Active cancer
History of VTE
Crani for tumor or combined anterior-posterior spine procedure

Heparin 5000 units q 12 hours
(to start 24-36 hrs postop)
and SCDs

Low Risk Patients & Non-Tumor Crani:

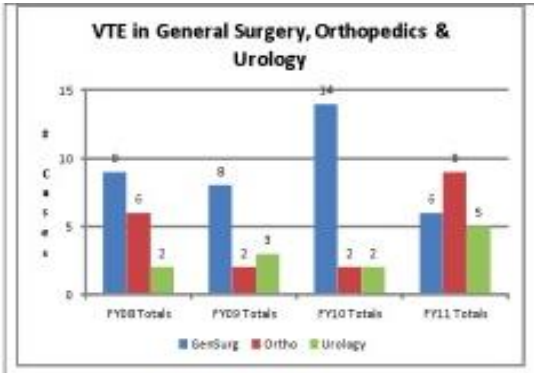
Sequential compression devices/SCDs (foot pumps) are to be used in all patients unless specific lower extremity contraindications.

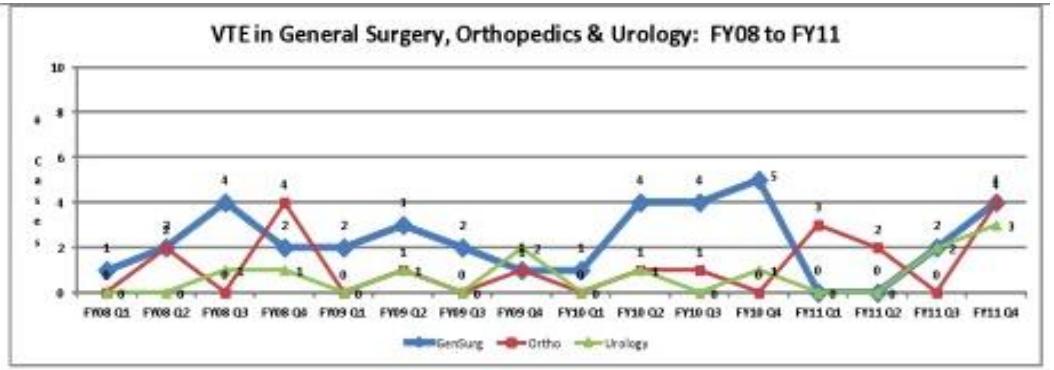
Surgical Service/SSQI

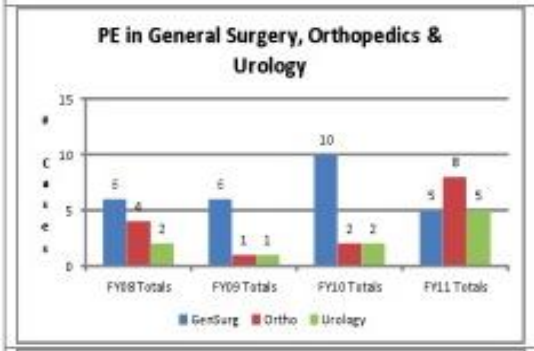
GOAL: AVOID PREVENTABLE VTE

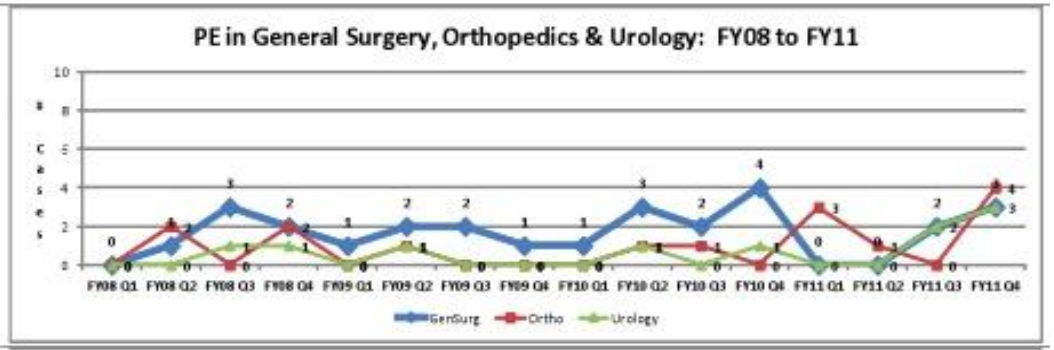
March 2012

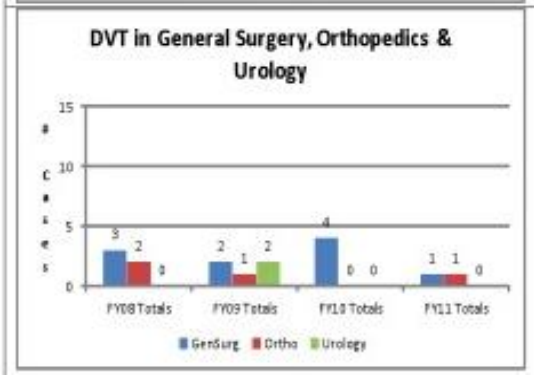
Review, review, review

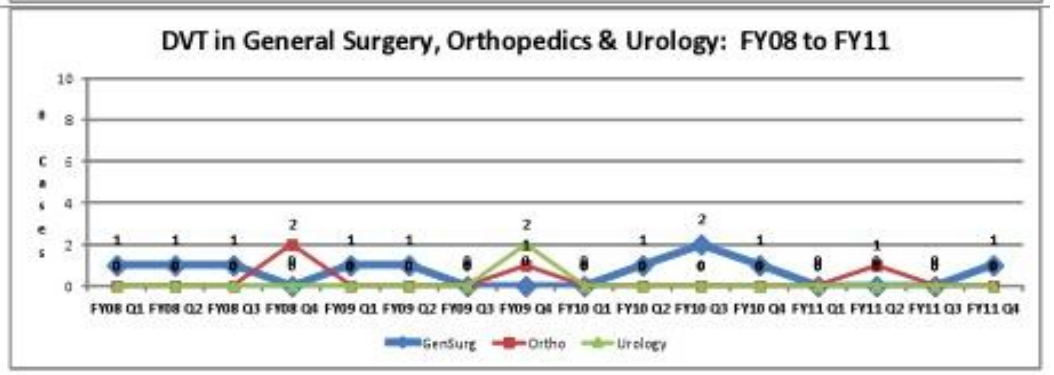












Process Improvement

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

- Any process is composed of a number of steps
- Only two ways to improve a process
  - Reduce the number of steps involved
  - Improve the reliability of individual steps

NLB Vernacular

Reliability

- "high reliability" refers to a low rate of product defects or service delivery

Healthcare reliability

- consistent use of appropriate treatments and processes of care that have been shown to produce more favorable outcomes

Sponge Counts

1. Count before start of case
2. Count at cavity closure
3. Count when new sponges added
4. Count at fascial closure
5. Count at skin closure
6. Count when all sponges off field = FINAL COUNT

1. Reduce # of steps

1. Count at start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field (FINAL COUNT) 95%

OVERALL reliability?

1. Reduce # of steps

1. Count at start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field (FINAL COUNT) 95%

OVERALL reliability = 78%

1. Reduce # of steps

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 78%

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%

X

6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 87%

1. Reduce # of steps

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 78%

9%

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%

X

6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 87%

Standardization

- Develop and implement a standardized process for the tracking of surgical sponges
- Every case, every OR, every time
- Make it simple and easy to use
- REDUCE VARIATION……. DECREASE COMPLEXITY

STOP JUGGLING!

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

2. Improve Reliability

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 95%

1. Count b4 start of case

At the IN count the critical step is to SEPARATE the sponges when doing the 3S's

At the final count all sponges (used and unused) MUST be in the holders

5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT

2. Improve Reliability

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 78%

5%

1. Count b4 start of case 98%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 98%

OVERALL 83%

Simplify and ↑Reliability

1. Count b4 start of case 95%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count at skin closure 90%
6. Count when all sponges off field = FINAL COUNT 95%

OVERALL 78%

1. Count b4 start of case 98%
2. Count at cavity closure 99%
3. Count when add sponges 98%
4. Count at fascial closure 99%
5. Count when all sponges off field = FINAL COUNT 98%

OVERALL 92%

14%

What 14% means?

- 14% improvement means instead of 22 miscounts in every 100 cases there are only 8 miscounts per 100 cases
- in one year if you do 10,000 cases per year instead of having 2,200 miscounts you have 800
- Instead of 42 events/week you have 15/week; from 8/day to 3/day
- How many ORs do you have? How many miscounts do you have?

Change Practice

- Rewriting the policy or adding a step to an existing policy is unlikely to prevent recurrence and actually decreases reliability
- Problem is with error prone, non-verifiable practices
- Have to engage multiple stakeholders; each a content expert in their domain

Surgical Checklist

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia

SIGN IN

- ☐ **PATIENT HAS CONFIRMED**
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ **SITE MARKED/NOT APPLICABLE**
- ☐ **ANAESTHESIA SAFETY CHECK COMPLETED**
- ☐ **PULSE OXIMETER ON PATIENT AND FUNCTIONING**

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

Before skin incision

TIME OUT

- ☐ **CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM**
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ **SURGEON REVIEWS:** WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ **ANAESTHESIA TEAM REVIEWS**: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ **NURSING TEAM REVIEWS:** HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

Before patient leaves operating room

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ **THE NAME OF THE PROCEDURE RECORDED**
- ☐ **THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT** (OR NOT APPLICABLE)
- ☐ **HOW THE SPECIMEN IS LABELLED** (INCLUDING PATIENT NAME)
- ☐ **WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED**
- ☐ **SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT**

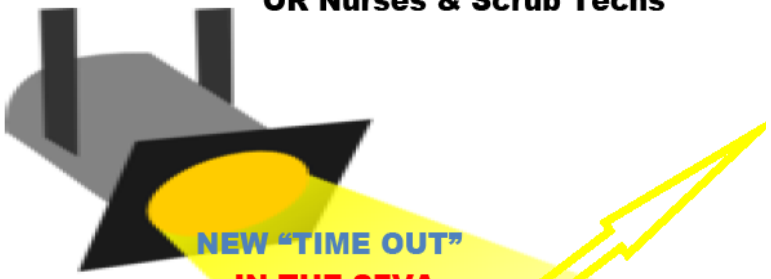
THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

Surgical Safety CheckList

Easy as 1,2,3 NoThing Left Behind® ZERO

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

To: Surgeons, Anesthesiologists & CRNAs, OR Nurses & Scrub Techs



NEW "TIME OUT"
IN THE SFVA
SURGICAL PATIENT SAFETY ✓LIST

GO LIVE: Friday, October 1, 2010
ALL TEAM MEMBERS AND ALL SECTIONS

REQUIRED ACTIONS:

OR BRIEFING
Who: Any surgeon, circulating RN, anesthesia staff
When: Prior to or after induction

New **TIME OUT**
Who: Must be called by the Attending surgeon who must be present in the OR. The "Time Out" cannot be done by a resident. The Attending does not have to be scrubbed but must be in the room.
When: "Time Out" must be performed just before the incision is made. The scalpel will not be provided until the "Time Out" is completed.

OR DEBRIEFING
Who: Any surgeon, circulating RN, anesthesia staff
When: At the completion of the case

SEE THE NEW SFVA SURGICAL PATIENT SAFETY CHECKLIST (aka MTT tool)

SF VA Surgical Patient Safety ✓List

DATE:	SURGICAL SECTION:	SECTION CHARGE RN IN OR?	BRIEFING CONDUCTED: ☐ Pre-induction
CASE #:	ATTENDING SURGEON:	☐ Yes ☐ No	☐ Post-induction

OR BRIEFING *Introductions of team members and their names recorded on whiteboard. If anyone identifies a concern during the case, please communicate to the team.*

Surgical Items:	Anesthetic management Items:
Name / SS# verification Procedure verification Estimated length of operation Laterality / Position with safety check *(see below)* Safety check: lines, sheets, cables free from bed rail? ☐ Yes	☐ NKA ☐ Yes Allergies_____ ☐ Yes ☐ NA IV antibiotics ☐ Yes ☐ NA Re-dose discussed ☐ Yes ☐ NA Special precautions *(HIV, HCV, MRSA, etc)*
>>Surgical Fire Risk Assessment Score<<: _____ *(from back)* *Required: See reverse for fire risk assessment protocol & scoring*	Pain management *(e.g. local anesthetic; multimodality)* Temperature control
Surgeon's description of procedure: Conduct of operation, critical aspects of case Equipment/insts/supplies/ medications available ☐Yes ☐No Implants available, sterility verified ☐ N/A ☐ Yes ☐ No	☐ Yes ☐ NA DVT Prophylaxis ☐ Yes ☐ NA Beta Blockade ☐ Pertinent lab results *(e.g. Cr/BUN/eGFR wnl; Na/K+, etc.)* ☐ Yes ☐ NA Glycemic Control If Yes: Intraoperative, ☐ Yes Postoperative ☐ Yes
☐Yes ☐ NA Pre-op Imaging reviewed & verified ☐ Yes ☐NA Fluoro, x-ray or ultrasound needed	
☐*Yes* ☐*NA Pathology notified for frozen section*	☐ Yes ☐ NA Type & cross or screen ☐ Yes ☐ NA Blood availability ☐ Yes ☐ NA Special (cell-saver, Jehovah's witness, etc.)
Post-op disposition Bed availability	
Issue(s) identified:	

TIME OUT Called by Attending surgeon just before incision *(scalpel not provided until Time Out completed):*
- ☐ **CORRECT PATIENT:** RN checks consent; Anesthesia confirms identity
- ☐ **CORRECT OPERATION:** Surgeon says operation; RN checks consent
- ☐ **CORRECT SITE:** Surgeon says "I see the mark"; RN confirms site

OR DEBRIEFING ☐ Completed Case ☐ Aborted Case, *list reason*_____

Methodical Wound Exam (MWE) (both need to be checked): ☐ "Call out" by surgeon for MWE: "All sponges are out" ☐ MWE performed	☐ Counts performed: Sponges/Sharps/Instruments ☐ Sponge count verification (*3 counts required & checked off*): ☐ INITIAL ☐ CLOSING ☐ FINAL *(count same as INITIAL#)*
☐ WOUND CLASS VERIFICATION (Closing circulator RN will verify with surgeon wound class and correct as needed) ☐ Procedure performed verified with surgeon for surgical package	☐ Yes ☐ NA Critical Care Notified or ASU/PACU if it is a change in planned disposition *(e.g. admit vs home DC).*

How did the case go overall? *(Please mark the category that best reflects the team's experience for this case.)*
(1) ☐ Major issue(s) (e.g. hand-off, equipment, delays, communication problems) that impacted case - need plan for f/u
(2) ☐ Minor issue(s) that impacted case – need plan for f/u
(3) ☐ Major / minor issues with patient post-op plan for f/u, no impact on case
(4) ☐ Major / minor issues but resolved by team intra-op, no impact on case, no need for f/u
(5) ☐ No problems – case went well

Recognition of good teamwork!(If so, please provide an example):

Intra-op hand-off issue(s)? ☐ No ☐ Yes (please indicate what the issue was):

Delays *(If delay occurred, please complete next section if referral was made):*	Identified issue referred to:
☐ Pre-op delay(s), specify:_____ ☐ Procedural delay(s), specify: _____ ☐ Equipment/instrument malfunction ☐ Equipment/instrument/supplies not available ☐ Other:_____	☐ SPD ☐ form filled out ☐ Biomed ☐ work order request ☐ Surgical Section ☐ Anesthesia Service ☐ Nursing Service ☐ Other:_____
☐ Need to revise "Pick List" ☐ Pick list revised	
☐ Issue(s) requiring follow-up	Name Label

SSQVbr (9/22/10)

Have an Action Plan
Not only what you're going to do but also…. How you are going to do it.

Change Strategy

- A tool to help in the development of a case for change
- DVF > (greater than)R
- Data + Vision + First Steps > Resistance

Data

- 80% of retained sponge cases have occurred in the setting of a correct count
- We have had 5 cases of retained surgical sponges in the last 2 years
- The total outlay of liability coverage has been in excess of 2 million dollars

Vision

- Retained sponges have to be removed with another operation and that causes patient harm. As healthcare providers we try to heal not harm
- We want our OR to be considered the safest, the best place to have an operation

First Steps

- Find a surgeon champion, a nurse champion and a radiology champion to engage in the process change
- Discuss with leadership their unequivocal support to push forward when the pushback starts
- Define needed resources and make sure they are available

Resistance

- I haven't ever had a retained sponge so why do I have to change my practice?
- Why are you wasting your time?
- I'm only a radiology technologist so that isn't a member of the team
- If I do that I will increase my liability

Pogo gets it

- The biggest resistance to change will come from within
- Everyone will tell you however it comes from without

©2011 VERNA C. GIBBS M.D. ALL RIGHTS RESERVED

Think of the patient

- Rather than thinking of yourself and your needs
  - WIIFM
  - "If I do that it will increase my liability"
  - "But this is my practice and it works for me"
  - "I only read what I see"
- Think of the patient's needs FIRST

SAFER SURGERY

drgibbs@nothingleftbehind.org