



Thinking in 3's


Patient Safety First
Hospital Association of Southern California
May 15, 2012

Verna C. Gibbs MD
Professor of Surgery, UCSF
Staff Surgeon, SFVA
Director, NoThing Left Behind®


Quality Surgical Care

➔ 1. Knowledge-driven
2. Patient-centered
3. System-based




Knowledge

- Pace of new knowledge in ALL the surgical disciplines is beyond an individual surgeon's capacity
- Knowledge must be shared, flow freely
- We expect best available scientific and clinical knowledge to be practiced
- Development of expertise requires experience



Knowledge Application

1. Pre-Operative Planning
2. Intra-Operative Practice
3. Post-Operative Performance




Surgical Checklist

World Health Organization SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ••••• Before skin incision ••••• Before patient leaves operating room


SIGN IN	TIME OUT	SIGN OUT
<ul style="list-style-type: none"> PATIENT HAS CONFIRMED <ul style="list-style-type: none"> IDENTITY PROCEDURE CONSIST SITE MARKING/NOT APPLICABLE ANAESTHESIA SAFETY CHECK COMPLETED PULSE OXIMETER ON PATIENT AND FUNCTIONING DOES PATIENT HAVE A: <ul style="list-style-type: none"> KNOWN ALLERGY YES NO DISPOSIT AIRWAY/ASPIRATION RISK YES NO YES AND EQUIPMENT/ASSISTANCE AVAILABLE RISK OF SEVERE BLOOD LOSS CONSIDER IN CONSULT NO YES AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED 	<ul style="list-style-type: none"> CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEWER CONFIRM: <ul style="list-style-type: none"> IDENTITY PROCEDURE ANTICIPATED CRITICAL EVENTS SURGEON REVIEWER: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE CHALLENGES, ANTICIPATED BLOOD LOSS ANAESTHESIA TEAM REVIEWER: ARE THERE ANY PATIENT SPECIFIC CONCERNS? NURSING TEAM REVIEWER: HAS STERILITY INCLUDING THE OPERATIVE AREA BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OF ANY CONCERN? HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES? <ul style="list-style-type: none"> YES NO NOT APPLICABLE IS ESSENTIAL IMAGING DISPLAYED? <ul style="list-style-type: none"> YES NO NOT APPLICABLE 	<ul style="list-style-type: none"> NURSE VERBALLY CONFIRMING 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 ORIENT MARKS) WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEWER: ARE THE CONDITIONS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT?

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




Quality Surgical Care

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Reality



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

Think of the patient


- Rather than thinking of yourself and your needs
 - “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
 - Good information
 - Safe operation
 - Uncomplicated recovery

Quality Surgical Care

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System Problem

- A case of a retained surgical item should be thought of as a “canary in the surgical coal mine”.
- It tells you there is a system problem in the OR
- System problems require system solutions



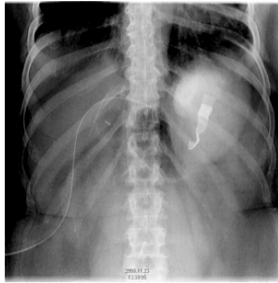
Case



Can’t Happen to You?

- This is a system problem

1. Surgeon’s inadequate sweep
2. Nurse’s incorrect count
3. Radiologist’s incorrect film interpretation




Dimensions of Quality
 Donabedian, JAMA 260:1743-1748, 1998

- 1. Structure**
 the attributes of how system is organized and its components
- 2. Process**
 the collection of individual steps to achieve desired outcome
- 3. Outcome**
 change in status attributed to the process

SPONGE ACCOUNTING SYSTEM (SAS)
Monitoring "Sponge Traffic"


- **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.



STRUCTURE

SPONGE ACCOUNTING SYSTEM
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PROCESS

NoThing Left Behind
 ZOOMING IN ON

ZERO

RETAINED SURGICAL SPONGES

OUTCOME

Surgical Patient Safety

Establish structure of safe surgical care

Prevent surgical errors

Optimize human performance

FedEx delivers 7.5 million packages a day at low cost with low error rates yet surgical teams using 10 sponges per case fail to retrieve them all

**Patient Safety First...
 a California Partnership for Health**

Anthem | HOSPITAL ASSOCIATION OF CALIFORNIA | HOSPITAL ASSOCIATION OF SOUTHWESTERN CALIFORNIA | Hospital Council of Northern & Central California | AHA

Time to Coordinate Efforts in Surgical Patient Safety

1. The Wrongs
2. Surgical Fires
3. Retained Surgical Items

The Wrongs

- Wrong patient
 - Planned operation performed on the wrong person
- Wrong operation
 - Wrong operation performed on the right person
- Wrong site
 - Planned operation performed at the wrong place (usually wrong side or wrong level)

Surgical Safety Checklist

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 ADO ALL SECTIONS

REQUIREMENTS:

- Checklist is to be completed by the surgical team
- Checklist is to be completed by the anesthesia team
- Checklist is to be completed by the scrub team

SEE THE NEW SFVA SURGICAL PATIENT SAFETY CHECKLIST (SAPST) WITH US!

Surgical Fires

Surgical Fire Risk Assessment Protocol

Assess fire risk for each case. Do not proceed if risk is high. If risk is low, proceed with caution.

Risk Level	Assessment	Prevention	Response
High	High risk for fire	Prevent fire	Evacuate area
Low	Low risk for fire	Prevent fire	Evacuate area

Airway Fire

Endoscopic view of a patient's airway showing a fire burning on the larynx.

Retained Surgical Items

- New preferred term rather than RFO
- Foreign Objects include swallowed pennies, pins, shrapnel, bullets
- Surgical Items are the tools and material that we use in procedures to heal not to harm
- It's a surgical patient safety problem

Retained Foreign Body

IMAGES IN CLINICAL MEDICINE

A Foreign Body

Retained Foreign Body X-ray image showing a foreign body in the abdominal cavity.

Retained Surgical Items

THE JAMA JOURNAL OF MEDICINE

ISSUES IN CLINICAL MEDICINE

Gossypiboma in the Pouch of Douglas

A 60-year-old woman, asymptomatic until a routine ultrasound of her pelvic region, was found to have a 10-cm gossypiboma in the pouch of Douglas. The patient underwent laparoscopic removal of the mass. The patient was discharged on the 3rd postoperative day. At 10-month follow-up, she was asymptomatic and had no evidence of recurrence. This case highlights the importance of thorough surgical counts and the potential for retained surgical items to present as a diagnostic challenge.

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Recently in California

CA.gov California Department of Public Health CDPH

CDPH Issues \$850,000 in Penalties to California Hospitals

Date: 12/20/11
Number: 15382

1. Fresno Surgical Hospital
2. LAC+USC
3. Mission Hospital Regional Med Ctr
4. Scripps Memorial
5. Sutter Solano
6. Torrance Memorial
7. Ventura County Med Ctr

December 2011

14 Hospitals cited with Administrative Penalties.
Vary from \$25,000 to \$100,000.

7 of the 14 related to retained surgical items

Incidence 2012

STILL > ZERO

When is it Retained?

- After all incisions have been closed in their entirety
- Devices have been removed
- Final surgical counts have concluded
- Patient has been taken from the operating/procedure room

http://www.qualityforum.org/projects/hacs_and_sres.aspx

Why do they occur?

- Communication and Practice problems with the THREE major stakeholders
 - ➔ 1. Surgeons
 - ➔ 2. Nurses
 - ➔ 3. Radiologists

Elements of Causation

Applying Swiss Cheese Model of Sir James Reason BMJ 2000;320:768



Common Language

Who's on First?

- Final count "correct"
- That's 8 + 2 in the vagina
- Is that correct?
- Yes, there are two
- No, 8+2 that's 10, the count is 10
- Oh, yes, count correct

Bud Abbott & Lou Costello perform "Who's on First"

But there were two sponges left in the vagina!

Communication

- It's what is right not who is right
 - ➔ Between nurses and surgeons
 - "We're missing a sponge" "OK, 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/Technologists: film quality, review
- Risk Managers/Administrators: resources

Perception vs Reality

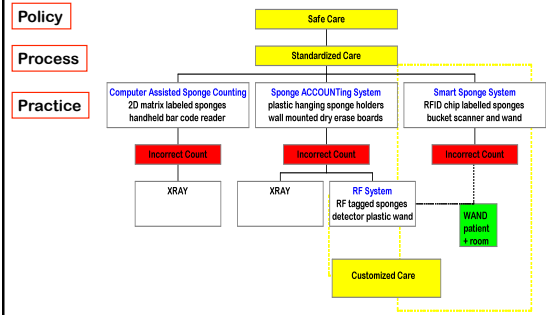
OR MANAGER – How I think things work (or should work)

OR STAFF – How things really work: unintended variation

Practice Issues

- Variable counting processes exist throughout an OR - no standardization, little transparency, counting in unit of issue
- 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 occurred when low numbers of sponges (≤ 20 sponges) have been used or in any size wound - it's not about counting!

Sponge Management



New Technology

At least right now there are:

THREE CHOICES

Count

Two dimensional data matrix label. Sponges passed under reader and counted in at the beginning of case and then counted out at the end of case



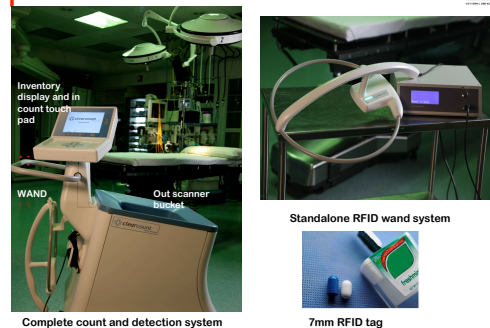
Maintains "line of sight", provides accuracy, all sponges

Detect

Reusable detecting wand, 9ft cord attaches to console. Can scan trash in any receptacles in room. Reads through tissue up to 24 inches. Readout on console



Count and Detect



Which one to choose?



- Local environments will need individual solutions
- All new systems are adjuncts to a manual count (at least for now)
- Cost vs benefit
- Behavior change needed for surgeons and nurses for successful adoption of any program to prevent retained items

Analogy



- Glucose
- Sugar
- Sweet & Low (saccharine)
- Equal (aspartame)
- Splenda (sucralose)
- Stevia
- ? What's next
- Manual Practice (SpongeACCOUNTing)
- SurgiCount (2D matrix counter)
- RF Surgical (RF tag detection)
- ClearCount (RFID)
- OR Locate (RFID)
- ? What's next

New Standard



Reliable Manual Practice

DON'T JUST COUNT - ACCOUNT!

NoThing Left Behind



- Multistakeholder project
- Work with any hospital
- Adoption of simple principles and if needed, technological adjuncts
- Engage in research studies to define best practices
- Develop an evidence base to inform policies and procedures that can be systematically applied

What I see is



- Lots of practice variation within OR
- Focus on "counting"
- Massaging the policy
- Adding steps that aren't part of natural work flow
- Reliance on Memory - "don't forget to...."
- Not seeing how people have set themselves up for failure
- Risk management trumps patient safety

SPONGE ACCOUNTING SYSTEM

Monitoring "Sponge Traffic"

- **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

[NoThing Left Behind]

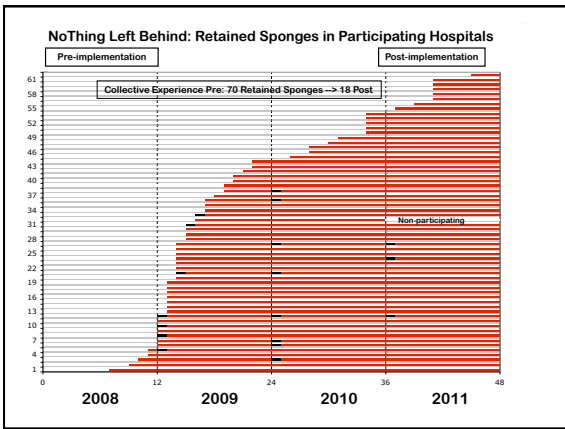
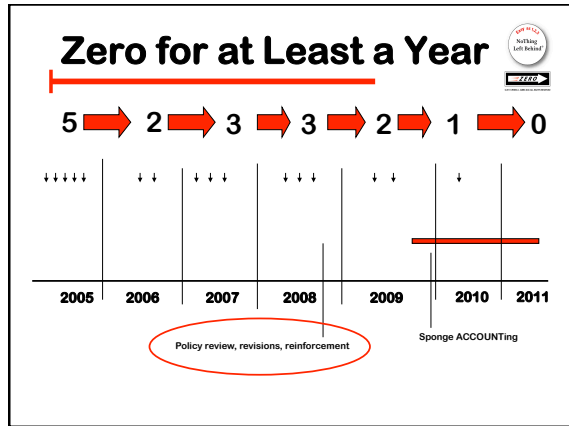
NLB Policy & Practice

POLICY
NoThing Left Behind®:
Prevention of Retained Surgical
Items Multistakeholder Policy

PRACTICE
WHERE ARE THE SPONGES?
ALL SPONGES
(used and unused)
ARE HERE

SPONGE ACCOUNTING

<http://www.nothingleftbehind.org>



Findings

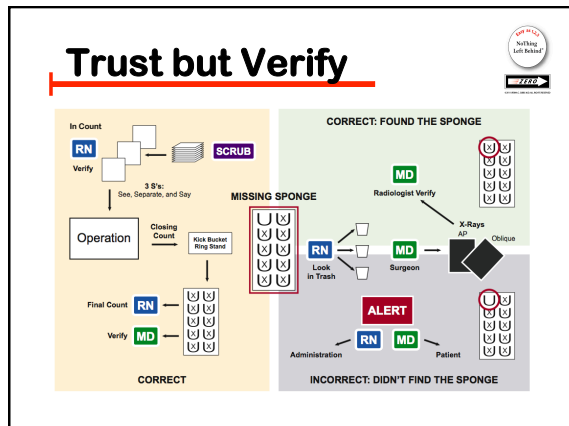
- 80% of retained sponge cases occur in the setting of a **CORRECT COUNT**
 - ➔ Problems with OR practices
- 20% occur in the setting of an **INCORRECT COUNT**
 - ➔ Problems with knowledge and communication

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50 lap pads accounted for



EASY AS 1-2-3

1. WHERE ARE THE SPONGES? ALL SPONGES "ARE HERE"

2. EASY AS

- 1 @ IN COUNT(S) ALWAYS** - CHECK SPONGES ...for packaging errors.
- 2 @ CLOSING COUNT TAKE A PAUSE FOR THE GAUZE** - ...to perform the Methodical Wound Exam.
- 3 @ FINAL COUNT SAY SHOW ME** - ...that ALL sponges are in the holders.

3. YIELD AND TAKE TIME TO RECTIFY AN INCORRECT COUNT

SURGEONS

- ✓ Stop counting the sponges immediately when you see a discrepancy.
- ✓ Ask the circulating nurse to check the sponge count.
- ✓ Do not continue the case until the discrepancy is resolved.
- ✓ Do not count sponges until you are certain you have counted all sponges.
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NURSES

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Safety Rules Poster

WHERE ARE THE SPONGES? EASY AS

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SPONGE ACCOUNTING

Incorrect Count Checklist

- Visible in every OR
- Levels the playing field
- Knowledge and Communication so all team members can do the right thing
- It's what is right not who is right... remember?

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"

Nursing Essence

- In every case where an incision is made and surgical sponges are used, the sponges **MUST** be accounted for
- Work with free sponges **ONLY** in multiples of TEN
- At the IN count the most important element is to **SEPARATE** the sponges
- At the FINAL count all the sponges (used and unused) must be in the sponge holders

NURSES EASY AS 1,2,3

SPONGE ACCOUNTING PROCESS

USE PLASTIC HANGING SPONGE HOLDERS FOR LAPS AND RAYTEX

The plastic holders for use of plastic sponges that are used for laparoscopic and Raytex Bank sponges for which the sponges are used in multiples of 2 pockets. The sponges should be placed in each pocket that sponges are placed in (sponges are placed in 2 pockets per holder) and each holder one sponges. 10 sponges. We recommend that each holder always be set up to hold 10 sponges for the sponges you are using and always label the sponges (holder) with the sponges you are using. An important step is to label the sponges (holder) with the sponges you are using. An important step is to label the sponges (holder) with the sponges you are using. An important step is to label the sponges (holder) with the sponges you are using.

- 1 CHECK SPONGES** - IN COUNT(S) Always separate the sponges in the sponge holders before the end of the case. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges.
- 2 PAUSE FOR THE GAUZE** - CLOSING COUNT Take 2 minutes between the end of the case and the start of the final count. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges.
- 3 SHOW ME** - FINAL COUNT All sponges should be counted in the sponge holders before the end of the case. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges. Do not count sponges until you are certain you have counted all sponges.

10 LAPS / 10 RAYTEX / 10 POCKETS / 10 STEPS... GET TO IT!

Surgeon Essence

- Perform a methodical wound exam in every case
- If you're told of a missing sponge, stop closing the wound and look again
- At the end of every case say "show me" and look at the sponge holders and see that there are no empty pockets

SURGEONS EASY AS 1,2,3

SPONGE ACCOUNTING PROCESS

1 CHECK SPONGES
IN COUNTS
Only use only identifiable sponges of counts.
Don't show them. Avoid use of small sponges in large counts.

3 SHOW ME
FINAL COUNT
Before you leave the OR, look at the sponge holders.
To verify that an AB, then dictate in up report. "A MWE was performed and sponges were accounted for."

2 PRUIZE 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.

Don't Just "Swish or Sweep"
A methodical examination of the operative wound may be the most effective way to check for every sponge. The glove to be checked must be carefully examined. Special focus should be given to areas of sponges that are hard to see, such as under the drape, under the table, and under the patient. Surgeons should always use SB and TOUCH during the examination when they possibly could do so with any amount of injury acceptance to easily avoid that. The sponge should be seen when there are all sponges in the surgical area.

The general process is to look and feel to the surface of the wound and separate under the drape and under the table. The sponge should be taken for procedure performed in the account of sponges. These steps should be performed before removing sponges in case retained sponges.

1. Examine all four quadrants of the abdomen with attention.
 - a. Empty the sponges.
 - b. Check the sponges of the bar and document the sponges.
 - c. Empty the sponges and document the sponges.
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Radiology Guidelines

Exam	Views	ROI	Comments
MRI Cranium	AP & Lateral	Top of skull to below Mastoid and inferior orbit	Include the top and bottom of the skull.
MRI Cervical	AP & Oblique (2V)	From C1 to C7 Anterior to posterior Anterior (APV) and Posterior (PPV) The Oblique may be the best.	This may require more than one film for the AP and PPV views.
MRI Abdomen/Pelvic	AP & Oblique (2V)	Diaphragm to Pubis and inferior orbit	This may require more than one film for the AP and PPV views.
MRI Thoracic	AP & Lateral (2V)	Inferior chest to above orbit and inferior orbit Anterior to posterior Spiral entrance should be noted and noted on AP.	The AP view may be a single film 14x17 if the film is 14x17. The Lateral view should be noted and noted on AP.
MRI Spinal	AP/PA & Lateral	Cervical Neck to Sacrum Lateral: Anterior to posterior Anterior (APV) and Posterior (PPV) The Oblique may be the best.	Include the top and bottom of the skull.
MRI Cervical	AP & Lateral	Cervical Neck to C7 Anterior to posterior Anterior (APV) and Posterior (PPV) The Oblique may be the best.	This may require more than one film for the AP and PPV views.

- Region of Interest specifics
- Instructions for radiology techs to take correct images
- Information to help get it right

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**
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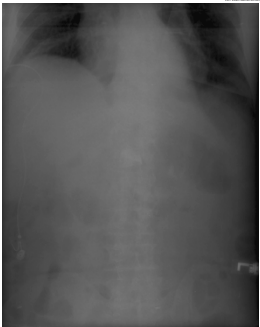
Case

Intraoperative Xray

- "There isn't anything easily seen."
- "But it's not a complete view"
- "OK - Let's take another film to see the diaphragm"

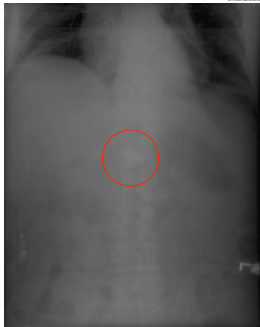
Repeat OR Film

- “There isn’t anything there. The film is negative. Let’s get out of here.”



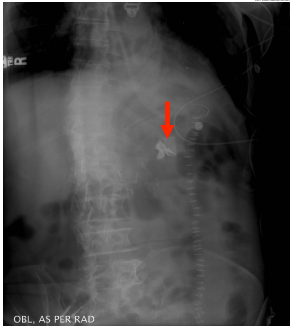
Repeat OR Film

- “Could there be something in the midline there?”
- “No, Its just the spinous process”




ICU film

- Oblique view
- Return to OR for removal



OBL. AS PER RAD

Incorrect Count Checklist



- Visible in every OR
- Levels the playing field
- Knowledge and Communication so all team members can do the right thing
- It’s **what** is right not who is right... remember?

SURGEONS →

← **BECOME**
DEGAUZE

“PAUSE FOR THE GAUZE”

123

SHOW ME PLEASE

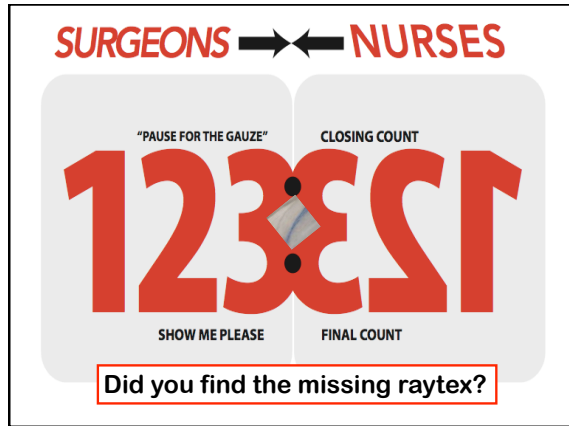
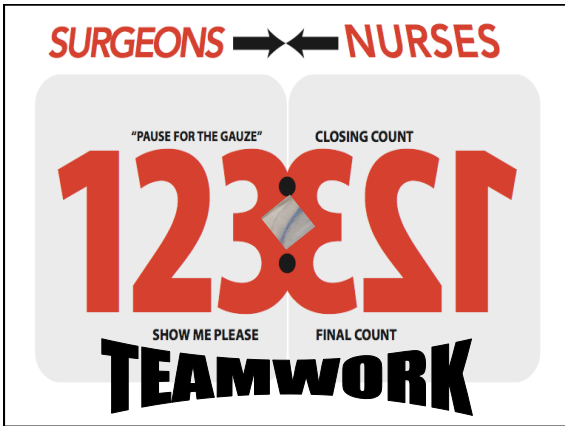
← **NURSES**

321

← **20-0-0-V-B**
RMGG-B

CLOSING COUNT

FINAL COUNT



Patient Safety First...
a California Partnership for Health

**Time to Coordinate Efforts
to Prevent Retained
Surgical Items**

There is NO excuse

SAFER SURGERY

Verna C. Gibbs M.D.

www.nothingleftbehind.org