



Case Study

Acute Care Facility: Retained Foreign Body



Patient safety is paramount in any perioperative department. The National Quality Forum developed a list of 28 medical errors, *Never Events*, which should never happen to a patient. One of these *Events* is the retention of a foreign object in a patient after surgery or other procedure.

AORN Works, Inc. was contacted to assist a facility that experienced several incidences of retained foreign objects (surgical sponges).

CLIENT: Acute Care Facility, Perioperative Services

ENGAGEMENT: Onsite Consultation

PURPOSE OF THE CONSULTATION: AORN Works, Inc. was engaged to assess the existing perioperative patient safety culture, to evaluate any proposed changes and to provide recommendations for process improvement consistent with national standards and practices.

PROCESS: Consultants conducted a patient safety assessment including analysis of perioperative operations, patient safety culture, clinical practice, staff education, infection control practices and instrument processing.

RECOMMENDATIONS:

1. Modify the existing count policy to reflect specific steps to be followed by every staff member **every** time.
2. Develop a policy regarding how sponges are handled when discarded from the field.
3. Develop clear expectations for the nurse educator.
4. Provide remedial education regarding the correct positioning of surgical drapes in addition to areas of clinical practice found to be non-compliant with AORN Standards Guidelines and Recommended Practices.
5. Address multiple environmental issues which impact infection control practices.

RESULTS:

1. Improved teamwork was observed between members of leadership team.
2. There have been no further incidences of retained items.
3. Staff was compliant with revised “count” policy.
4. Clear expectations and goals have been implemented for the perioperative educator.
5. Clinical practice issues have been addressed; PI monitors are in place to measure compliance.
6. Improvements to the environment were underway.

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