A RETAINED SPONGE AFTER SURGERY

CASE:
An 85 y/o woman with a history of metastatic cancer underwent an extensive abdominal resection. At skin closure the manual sponge count was noted as correct, however, the SurgiCount device noted one missing sponge. This discrepancy was not clearly communicated to everyone in the room and the patient was taken to the ICU before the difference in the two types of sponge counts was reconciled. After the patient left the OR, a search for the sponge was initiated but it was not found.

A CT scan was performed and the sponge could be seen behind the liver. The patient returned to the OR for sponge removal and ultimately had an extended ICU stay.

An incident report (IR) was filed.

Retained foreign items are reportable “never events.”

RCA PROCESS:
To better understand this incident and to prevent retained sponges in the future, a root cause analysis (RCA) was performed and resulted in the following findings and recommendations:

• UCSF count policy was not followed in this case → All OR staff have completed re-education.

• UCSF count policy was not followed → An ongoing audit process was implemented to assure compliance. The audit includes the 2 modalities of counting, immediate feedback to front line providers, and monitoring of audit results by senior leadership.

• Lack of communication between nursing and surgeons regarding the final count → A Surgical Debriefing was implemented at the end of every surgical case to include a structured discussion of final sponge counts as well as other issues.

• Primary nursing staff was on break during the miscount incident → A new break schedule was implemented for better continuity at critical times during long cases.

From the UCSF Patient Safety Committee and Office of GME
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