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Quality Improvement Activity: Recognition of Complication Related to Surgery

A 57-year-old woman arrived at an inpatient hospital for a schedule total hysterectomy. Prior to admission, a diagnostic workup was performed, and the doctor diagnosed the patient with pelvic inflammatory disease. The patient is ready to be taken back for surgery, the consent was signed, allergies were determined, and the surgeon has already spoked to the patient. While taking the patient back to the operating room the nurse spiked up a conversation with the patient and a new male nurse he was orienting. They proceed to get to the correct operating room where the patient transferred to the operating bed. Once the patient was intubated the preceptor and the new nurse started positioning the patient in the correct way for the surgery. While the surgery was being performed the new male nurse noticed his preceptor disregarded important techniques required in surgery, such as not breaking sterility, keeping the proper face mask on while there is a sterile field open in the operating room and continuously talking with different individuals. Furthermore, the surgeon performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy. The surgeon stitched the patient back up and finished his part of the task, however, a count was not done prior to surgery and was not identified till after the patient was sutured. The circulating nurse and the rest of the operating team watched as the nurse scanned the patient in search of a foreign object being left inside the patient's body. Unfortunately, there were two surgical sponges left inside the patient.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above the patient came in for a scheduled procedure. The patient is not known to have any past medical history besides her new diagnosis of pelvic inflammatory disease. The patient care and environment lacked because the nurse disregarded following safety measures required in the operating room and the nurse was more focused on talking with people rather than paying attention to his patient. I would not say this is a common occurrence, however, it is not extremely rare. Scalpels, scissors, needles, clamps, surgical masks and gloves, tubes and more can be left in a patient if the surgical team is not being responsible or safe. In addition, the new male nurse following the circulating nurse should of spoke up regarding a break in the sterile field, the nurse taking off his mask, and the lack of attention the main nurse was giving.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the new male nurse not speaking up and especially the distracted circulating nurse that was irresponsible and did not follow protocol regarding the role of a circulating nurse in the operating room by not performing surgical count.

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In what way could you measure the frequency of the occurrence? (Interview nurses, examining charts, patient surveys, observations, etc.)

Surgical counting is usually done before an operation begins to prevent incidents like the one above from occurring. Leaving surgical equipment in patients has occurred and led to fatal outcomes such as, death, infection, severe pain, internal organ damage, and more. To prevent this from occurring the sterile kits used during the surgery comes with a chart of a list of everything provided in the kit plus the quantity of each item. The nurse is responsible for obtaining the chart and recording the items and doing a count before and after the surgery. If there is a miscount, then everything would be on standby until the missing object is discovered. To measure this occurrence there should be one person who reviews and keeps up with the surgeries being performed in one day. The individual can obtain copies of the surgical chart and the counts to make sure they are accurate and not overlooked or missed by the individuals in the operating room.

What evidence-based ideas do you have for implementing interventions to address the problem?

Having a staff meeting immediately discussing the importance of surgical counts and timeouts. Thereafter, requiring weekly staff meetings reemphasizing the importance and the consequences of surgical counts. Reinforcing protocols with every team, general, ortho, neuro, and cardiac and following up with the satisfaction and safety of the patient in recovery. When miscounting occurs or foreign objects being discovered within any case noted, each team member involved with the patient will be held accountable and required to contemplate their performance and come up with a way to prevent themselves from the occurrence again. The discovery of foreign objects being left in a patient should never happen in the operating room. There are multiple protocols set up to prevent the occurrence from happening, therefore, it is unacceptable. Continuous feedback and recommendations will always be applied to prevent leaving foreign objects in patient's bodies.

How will you measure the efficacy of the intervention?

Measuring the efficacy of these interventions will be fulfilled by having a white board in every operating room with labels. The circulating nurse will use a marker and count with the surgical tech before and after surgeries. If any additional tools or supplies were needed and used it will be added under its label on the white board to ensure the documentation is not missed in the count. There will be a board located where everyone can see it with the statistics of patient safety regarding foreign objects left within the body.