

ABSTRACT

TITLE

Retained Surgical Items: An Organizational Commitment to Mindfulness of a Never Event

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PRINCIPLES

Sense making during uncertainty or the unexpected
Decision making, error management

SITUATION

Retained Surgical Items are a Joint Commission “Never Event”. They are particularly inexplicable as they often defy simple logic. The incidence of these events is unknown, but is estimated to occur in roughly 1 in every 5000 surgical procedures. The author reports 16 cases of Retained Surgical Items in a five year period, six occurring in a thirteen month time span. The organization sought to make sense of the nature of these events and to pursue high reliability strategies to mitigate their occurrence.

OSF Healthcare System is over 130 years old. It began in an era devoid of telephones and automobiles. Over the course of a century, each of the facilities developed independently of each other and its own unique culture. It has only been in the past 25 years that we have begun to think and act more like a healthcare system. The facilities in our organization range from a 20 bed critical care hospital to a 600 bed tertiary care facility hence, "a unique structure at each facility". Perhaps a better choice of words than structure could be clearer.

METHODS OF IMPLEMENTATION

The organization pursued a strategy of sense making through (1) an analysis of each Retained Surgical Item event, (2) an understanding of the surgical culture at each operating unit via the Agency for Healthcare Research and Quality Cultural Survey, (3) a literature review and identification of potential healthcare industry risk mitigation practices, (4) recognition of the cost of poor quality in terms of risk and financial costs, (5) a metric to help understand whether actions can impact an infrequent event, (6) and a system-wide meeting for collective teaching and learning as well as promoting deference to expertise.

In response to the IOM report, *To Err is Human*, our organization established the OSF Patient Safety Collaborative in August, 2001, which was modeled after the Institute of Healthcare Improvement. In

2003, we systematically began a database for all sentinel events and other serious events whereby each of the operating units reported to the corporate office.

RESULTS

The early events were sometimes not reported because of the concern for retaliation, some of the reports had a paucity of soluble information, and the database was poorly maintained at the corporate level. In learning from these gaps (and after having one of our facilities incur immediate jeopardy), OSF Healthcare developed a "Serious Event Reporting" structure. All events have since been standardized such that root cause analyses were thorough and credible. There is a standardized reporting format. A key component of the Serious Event Reporting structure was to use signal detection (identifying the events) PLUS signal response (the individual hospitals in our system were notified of an event AND, as part of a feedback loop, reported back to the corporate structure whether they provided improvements to prevent, trap or mitigate the chance of a similar event occurring at their facility.

After reviewing the actions taken by the operating units, the Board recognized that despite the actions that had been taken at the level of the operating units, the organization was at risk of incurring additional Retained Surgical Items. The Board's decision was to have each facility pursue a course of high reliability by taking the following actions: (1) enhance the culture of the surgical microsystem (2) implement a mitigation program to screen and radiograph patients at high risk of incurring a Retained Surgical Item (3) count all sharps, sponges, instruments and retained surgical items and (4) gain additional understanding and experience of a human factors based approach towards reducing the incidence of retained sponges.

In recognition of the weaknesses associated with an analysis of early events, a Serious Event Reporting system was enhanced. Responses to the Board directed actions varied by operating unit as there is a unique structure at each facility that affects human performance and social interactions. A performance metric and matrix has been developed for Board mindfulness.

CONCLUSIONS

Retained Surgical Items are unexpected and dramatic events that have implications deep into a healthcare organization. An integrated healthcare system demonstrated a better understanding of the nature of these events. The organization faced challenges towards changing the culture to become a High Reliability Organization. The robustness of the new reporting system helped the Board understand what was really going on in the organization.

DISCLOSURES

None