Surgical Instrument Loss in Operating Theatre

AMINA ABDEL KERIM

OPERATING THEATRE MANAGER LWCH

Objectives

- Understanding contributing factors leading to the misplacement of surgical instruments
- To discuss the effect of losing a surgical instruments.
- To discuss the training and education needs for OR and CSSD personnel to improve communications
- To give recommendations to reduce instrument loss

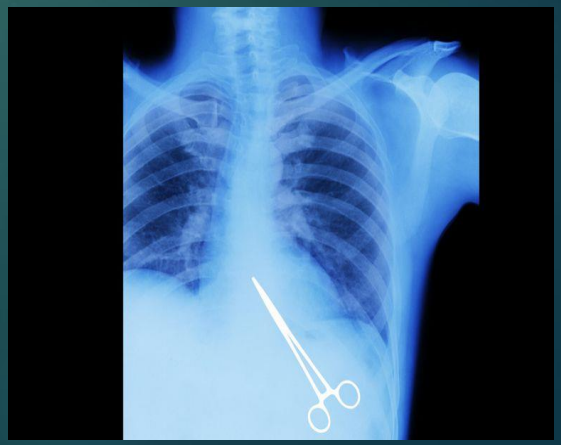
Introduction

Operating theatre staffs are reporting that a number of instrument trays are incomplete or inaccurate.

Missing or damaged instruments create confusion, lost time, and stress for staff trying to locate the missing instruments. Having organized, easy to clean, and effective tray systems can certainly help.

Effect of losing a surgical instruments

- Both CSSD and OR staffs are frustrated and morale is low. Surgeons are upset and vocal.
- Surgical cases delay and turnover time are increasing.
- Financial increase hospital costs e.g. patient will most likely require another surgery to remove the item, purchase replacement tools



Instrument Loss

- Instrument loss is a major financial burden for a healthcare facility.
- Every theatre using surgical instruments is responsible for accounting for instruments at the end of a procedure.
- There should be a process to ensure that each using department is accountable and can document that all instruments were returned to CSSD.
- Instrument loss can also be attributed to mishandling

Causes of Missing Instruments

- Surgical tools is accidentally left behind inside a patient's body during surgery
- Loss of surgical tools whether they're dropped on the floor or accidentally thrown in the trash.
- Poor or lacking communications between OR and CSSD .
- Operations; insufficient instruments, lack of processes
- Lack of training and competencies for OR and CSSD staff

Communications

- How are communications between the OR and CSSD?
- Telephone call? Email? Both? Regular meetings?
- Do all requests get documented in CSSD (i.e. phone log)?
- Are the communications accurate and specific?

A standardized inventory count process should be enforced among all operating rooms, which involves counting all surgical instruments before and after all procedures. When these guidelines are neglected, the patient’s safety is at risk.

When counts are inconsistent, the operating room staff must perform a recount and if they are unable to settle the counts, they must alert the surgeon right away and start the search process

If the counts remain unresolved, an x-ray is to be taken of the patient. When this process is not done properly, the surgical team is held responsible.

- Documentation - usual method is count sheet.
- Should be available and used for all sets/devices.
- Include instrument company name and catalog # in description (also alternate mfr. if acceptable).
- These details are critical to the correct construction of an instrument set and will assist in identifying instruments for replacement, when necessary.

- Always use proper names for instruments.
- If “nicknames” are necessary, still use proper name with “nickname” in parentheses (i.e. Vaginal retractor such as Landon retractor, Tubinger, Simms speculum).
- Using count sheets or tray lists promotes accountability and prevents delays in surgery because of missing instruments.
- As instruments are placed on the set, **enter the quantity.**
- Avoid placing instruments on set FIRST then “drawing a line” down the entire count sheet or entering the quantities at the end. **THIS IS HOW ERRORS ARE MADE.**

Date: _____ Tray#_____

ITEM	QTY.	INST. CHECK COUNT	POST SURG. COUNT
7" Ballenger Sponge Loop Straight (Sklar 74-1370)	2		
7 ½Tonsil Clamps (Jarit #450-310)	2		
7 ¼"Tonsil Clamps (Mosquito Forceps) Fine Tip (Jarit #305-332)	2		
5 1/2" Peds. Right Angle (jarit #140-218)	4		
6" Fine Tip Cvd. Halstead (Jarit # 105-119)	2		
5" Angled Gemini Clamp (Sklar 55-2855)	2		
5" Mosquito Clamp Curved (Pilling #18-1816)	6		
5" Jacobson Mosquito Clamp Curved, Petit-Point(Jarit #105-089)	2		
3 7/8" Mosquito Clamp Curved; Petit-Point (Jarit #105-091)	2		
Castaneda Anastomosis Clamps (Codman #30-9004) (jaw length 3/4")	2		

SAMPLE COUNT SHEET

- It is important for processing personnel to verify the accuracy of the number and type of instruments placed in the set.
- The OR staff depends on processing personnel to provide them with a clean, sterile, and accurate set of instruments; otherwise, the delivery of patient care can be delayed or compromised.

Missing Instruments – Where Are You?

- OR contends the instruments were sent to CSSD--now they are lost
- CSSD claims they never received them
- WHO IS TO BE BELIEVED????
- We spent hours blaming one another and no one is SOLVING the problem!!!!

- There must be accountability for instrumentation throughout the use cycle

- OR, CSSD and ALL personnel must be accountable for instrumentation

Sets Returned to CSSD with Missing Instruments

- Immediately notify the OR
- Do not get into the blame mode; instead each department should actively look for the item.
- Any sets taken out of circulation because of items missing **MUST** be communicated to OR and CSSD in writing and posted.

Education

- Education is key to the success of this process
- OR and CSSD personnel must receive Continuing Education regarding all instruments and trays
- Tray contents as well as instrument configuration on set important and must be standardize
- Develop educational program for CSSD personnel for surgical instruments

- Use textbooks and websites.
- Take photos as reference.
- Establish competencies for CSSD personnel

Recommendations to Reduce Instrument Loss

- It is the responsibility of each using department to ensure that instruments are not damaged or lost.
- Instrument sets should be kept together at the end of the case/procedure and placed back into their respective containers or baskets.

- Should have a QA tool helpful to identify and follow-up on issues.
- CSSD must accurately list all instruments on set and items missing from set.

Name of Tray:_____
Audited By:_____
Date of Audit:_____
Name of Preparer of Tray/Device:_____

QUALITY INDICATOR	YES	NO	COMMENTS
All instruments present on tray			
All instruments in good condition (e.g. any pitting, rusting, broken)			
Scissors were sharp			
Tray labeled correctly			
Wrapper intact (no holes, breaches)			
Chemical indicator on set			
Chemical Indicator in correct location			
Instruments clean			
Set was dry (no moisture)			
Other problem occurred (specify)			

The results of this QA audit was discussed with the preparer on:_____

MISSING INSTRUMENTS FORM

DATE	SHIFT	TIME	NAME OF TRAY/SET	Tray #	Item Missing - list each separately	Catalog#	Vendor	Cost	Name of OR Person Called	Action to Take

- Surgical Instrument Detector System
- https://youtu.be/ocZLVjmZ9fA
- https://youtu.be/33L8zZs_sBQ

Conclusion

- Instruments MUST be accounted .
- OR and CSSD must work together to resolve as a TEAM missing instrument issues
- BOTH sides must be accountable
- When there is a system there is greater efficiencies and less chaos.
- Everyone wins when we manage instrumentation correctly!

Referances

- Universal Medical Inc

Word of Wisdom

- **DISCIPLINE** IS A CHOICE
- IT IS SIMPLY, CONSISTENTLY CHOOSING THE HARD RIGHT OVER THE EASY WRONG

THANK YOU!!!