Samford University
Ida Moffett School of Nursing

Implementing Whiteboard Use To Eliminate Unintended Retained Foreign Objects

Kelley Rae Trump, DNP, RN

UNINTENDED RETAINED FOREIGN OBJECTS
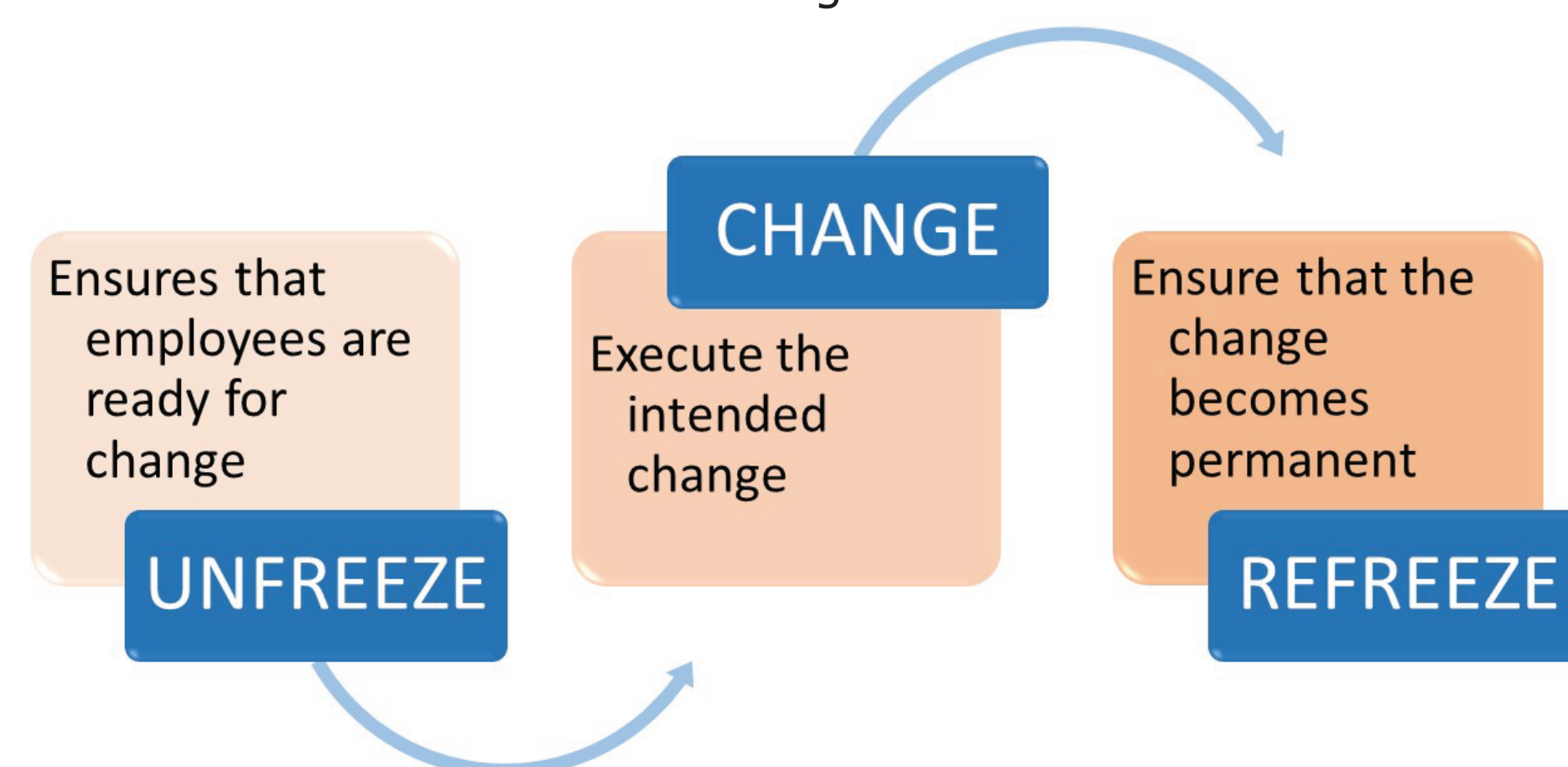The Joint Commission

PROJECT PURPOSE

- To implement Whiteboard (WB) use
- To increase the accuracy of the surgical count
- To eliminate Unintended Retained Foreign Objects (URFOs)
- To increase patient safety and improve patient outcomes

- URFOs are the number one sentinel event reported to The Joint Commission (TJC)
- Prevention of URFOs is a top patient safety priority
- In 2017 two patients were discharged with URFOs out of 6,548 surgery cases: quadruple the national average of 1 in every 14,000 cases
- Surgical counting errors occurred due to a breakdown in communication
- Root cause analysis showed the surgical count recorded as "correct"
- The identified problem was inaccurate surgical count

THEORETICAL FRAMEWORK

- Lewin's Change Management Theory guides theoretical framework
- Unfreezing, Change, and Refreezing stages
  - o Decrease resisting forces
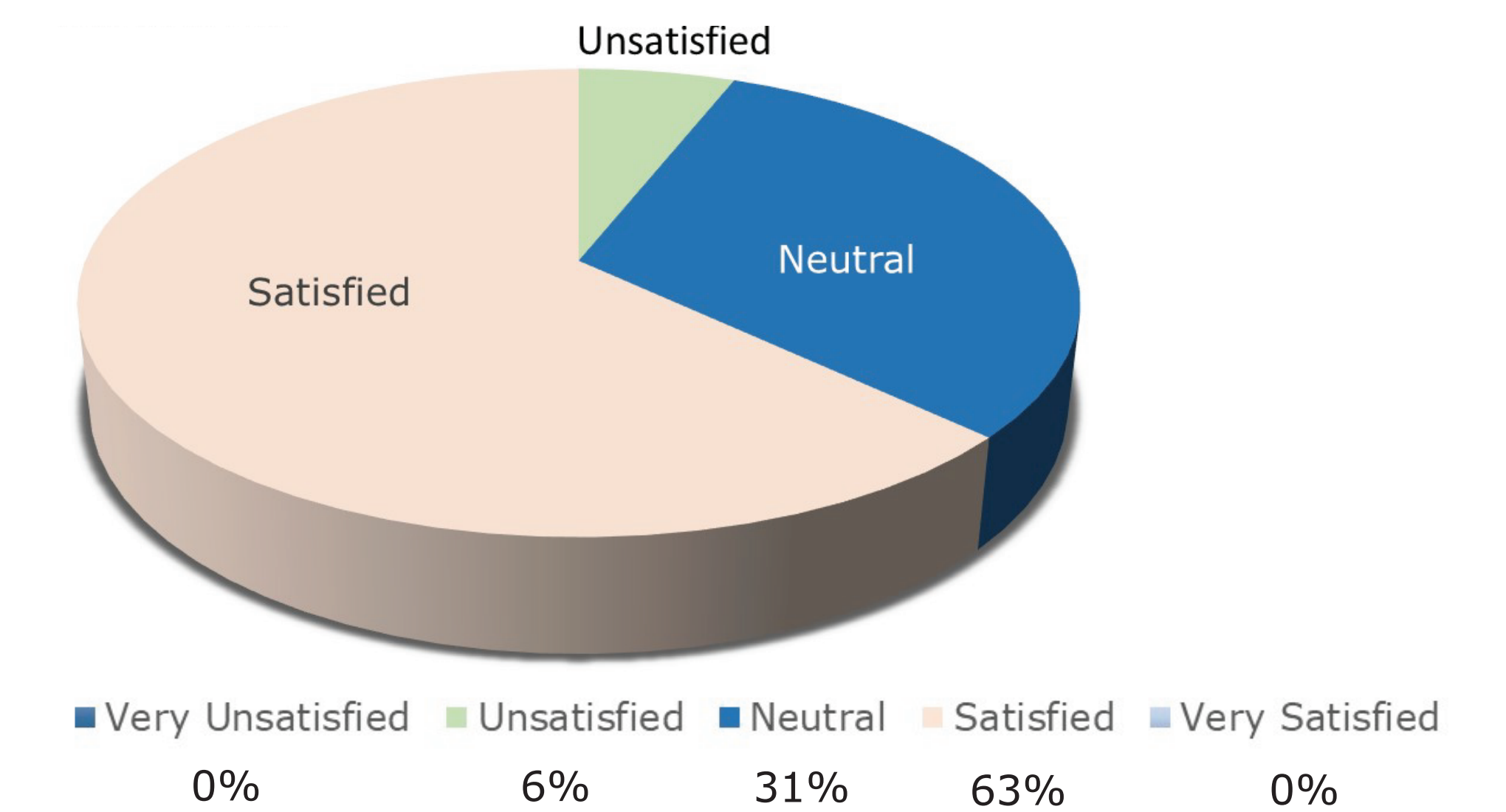 - o Increase driving forces
  - o Overcome resistance to change

CHANGE
Execute the intended change

Ensures that employees are ready for change
UNFREEZE

Ensure that the change becomes permanent
REFREEZE

CONTACT INFORMATION
Kelley Rae Trump DNP, RN
784 E. 850 S. Centerville, UT 84014
Ktrump62@gmail.com

METHODOLOGY

PROJECT DESIGN

- Setting
  - o 5 operating room suites
  - o For-profit Ambulatory Surgical Center (ASC)
- Task force included:
  - o Director of Nursing
  - o Quality Improvement Director
  - o Interdisciplinary operating room (OR) staff
- Best Evidence located, assessed, and critically analyzed
- GAP analysis conducted

PLANNING

- GAP analysis presented to the medical executive committee
- An evidence-based plan using whiteboard approved
- Whiteboards increase the culture of safety in the OR

IMPLEMENTATION

- Project management team formed
- New surgical count policy developed and approved
- Surgical counts now recorded as correct or incorrect
- Staff champions identified and trained
- Champions decrease resistance and improve compliance
- Education materials and standardized template developed
- Interdisciplinary team members participate in the count

GAP ANALYSIS REVEALED

- Double standard identified
- Local hospital uses whiteboards, but ambulatory surgical center does not
- Both facilities owned by HCA
- Surgical staff often work at both facilities
- Incongruent surgical count process leads to mistakes

MountainWest SURGICAL CENTER
O.R. COUNT BOARD

Patient Name:		Allergies:
Procedure:		
Rays:		
Laps:	Baby Laps:	Peanuts: Other:
Needles:	Blades:	
Bovie Tips:	Hypos:	
Packs: In / Out	Cottonoids:	
Notes:		
Medication on Sterile Field:		

RESULTS

OR STAFF POST-USE FEEDBACK

Unsatisfied
Satisfied
Neutral

■ Very Unsatisfied	■ Unsatisfied	■ Neutral	■ Satisfied	■ Very Satisfied
0%	6%	31%	63%	0%

OBSERVATIONAL DATA

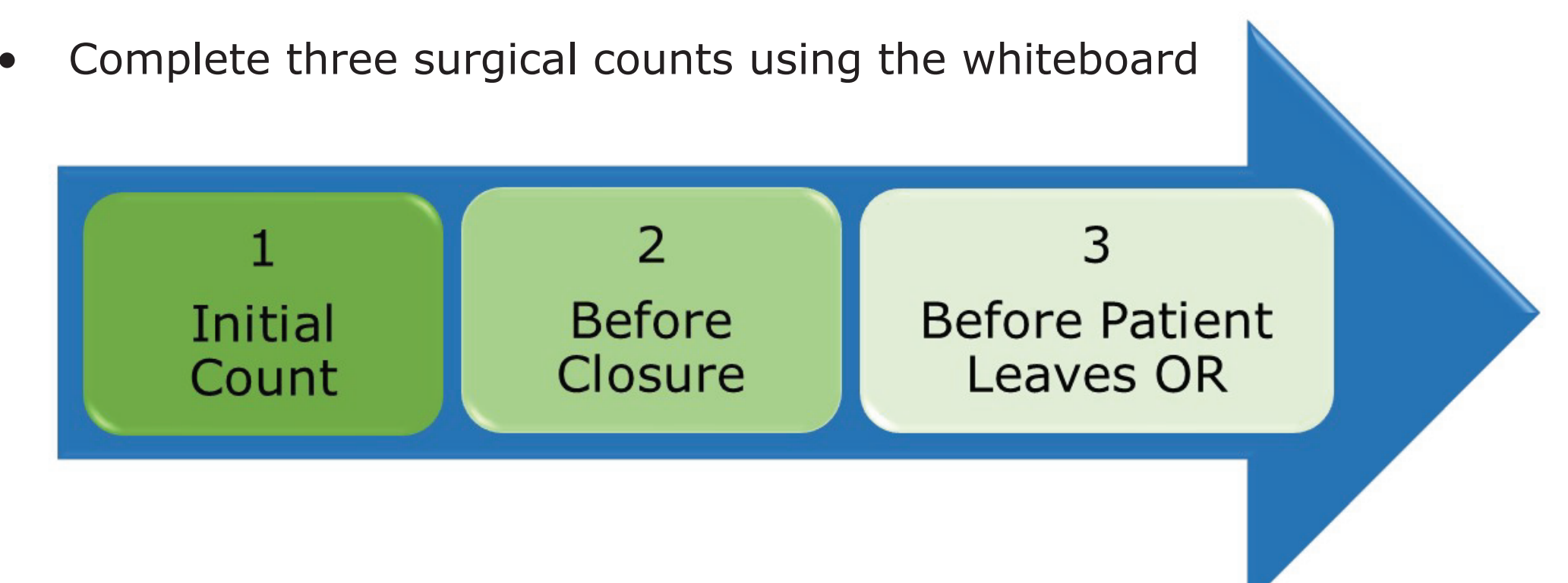|	
Name & Allergies	81%
Initial count	81%
Initial count before the cut	69%
Count changed for new supplies or medications	81%
Kept current and used as reference point	88%
Closing count before closing of wound	100%
Counts audible	100%
Unnecessary activity and distractions	75%
Whiteboard legible	100%
Staff change	33%
Initial, pre-closure, and end counts completed?	87%

PRACTICE IMPLICATIONS

OUTCOMES

- **No incidence of URFOs since implementation**
- Whiteboards met ASC's top safety priority of eliminating URFOs
- Standardized the surgical count process at both local HCA facilities

CONCLUSION

- Improved manual surgical count process
- Increased patient safety and improved patient outcomes
- Inclusion of all interdisciplinary team members
- Reduction of the risk of unintended retained foreign objects

RECOMMENDATION

- Complete three surgical counts using the whiteboard

1 Initial Count	2 Before Closure	3 Before Patient Leaves OR