Pacific Community
Communauté du Pacifique

Pacific Perioperative Practice Bundle 2

Patient Safety

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HEALTH EDUCATION & LEARNING partnerships

Introduction

All patients have the right to expect their surgical experience will be carried out safely, free from risks of harm. Ensuring the patient's safety relies on perioperative nurses, as part of the surgical team, ensuring that standards of practice are followed that will deliver a safe outcome for the patient.

Adverse events such as wrong site surgery, pressure injury, retention of instruments and equipment have been reported.[1] These adverse events are considered preventable and strategies, such as the World Health Organisation (WHO) Surgical Safety Checklist have been implemented to reduce the incidence of wrong site surgery.[2] In addition, human factors such as good teamwork and effective communication have been shown to reduce the risks of adverse events. [3]

The Pacific Perioperative Practice Bundle 2 (PPPB2): Patient Safety, comprises six standards developed specifically to address patient safety issues and human factors. They should be read in conjunction with the standards in PPPB 1: Infection Prevention and have been numbered sequentially.

The PPPB 2 standards are:

PPPB 7	Surgical safety
PPPB 8	Safe manual handling and positioning the surgical patient
PPPB 9	Sharps safety
PPPB 10	Managing accountable items
PPPB 11	Handling specimens
PPPB 12	Perioperative patient handover

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PPPB 7 Surgical safety

The accurate identification of the patient and the procedure to be performed will reduce the risk of wrong site surgery and enhance patient outcomes. Effective teamwork and communication between members of the surgical team can minimise risks of adverse events. [2, 4]

PPPB 8 Safe manual handling and positioning the surgical patient

Knowledge and skills in safe manual handling equipment and positions used for surgery will minimise the risks of injury to patient and personnel. An understanding of functional anatomy, physiology, surgical procedures and patient co morbidities will enable perioperative personnel prepare and manage patients' specific positioning requirements.[4]

PPPB 9 Sharps safety

Perioperative personnel have a high risk of sustaining injuries related to the use of sharp devices eg scalpels, hypodermic needles, with suture needles being the most common source of sharps injury in the operating room. [5,6,7] The use of personal protective equipment (PPE) specific to sharps safety, including double gloves and protective footwear will protect the nurses against exposure to blood borne diseases and sharps injury. [8, 9]

PPPB 10 Managing accountable items

Accountable items eg instruments, needles, absorbent items (swabs, sponges) by their nature are at risk of being retained in the patient and require additional risk management. All members of the perioperative team have a duty to collaborate to ensure that all items used during surgery and procedures are retrieved, accounted for and appropriately documented. Correct management of the surgical/procedural count by the instrument nurse and circulating nurse and will minimise the risk of items being unintentionally retained in the patient. [4]

PPPB 11 Handling specimens

Knowledge about the management of specimens taken during procedures will reduce the risk to the patient of adverse events, such as mislabelling and misdiagnosis. Perioperative nurses should demonstrate knowledge of the care and handling of specimens in order to reduce the risk adverse events and to optimise patient outcomes. [4]

PPPB 12 Perioperative patient handover

Effective communication can ensure that critical information about the patient is communicated during the clinical handover process. Conducting a clinical handover during all stages of the perioperative period using a standardised tool such as ISBAR, will ensure all critical information is communicated, ensuring continuity of patient care and responsibility. [3, 10, 11]

Acknowledgements

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During a six-month project in 2018, Menna Davies and Sally Sutherland-Fraser, nurse consultants from Health Education & Learning Partnerships (HE&LP), based in Sydney, Australia, collaborated with perioperative nurses from the Pacific Island Countries (PICs) to develop the six standards which comprise PPPB2: Patient Safety.

The practices outlined in the individual standards were developed with reference to the International Perioperative Nurses Federation (IFPN) Guidelines and the Australian College of Perioperative Nurses (ACORN) Standards for Perioperative Nursing, 2018. The six standards are the product of two rounds of consultation with a panel of experts representing contemporary perioperative practice in PICs.

The following individuals and teams are acknowledged for their support and commitment during the development the Pacific Perioperative Practice Bundle (PPPB)2: Patient Safety. Their involvement has been invaluable and has greatly contributed to the quality of the six standards:

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A number of additional perioperative nurses also contributed to in-country reviews of the draft PPPB2 standards and their contribution is acknowledged with thanks.

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Glossary

Term	Definition
Accountable item	Reusable instruments or disposable items eg swab/sponge/needle, which by their nature are at risk of being left inside the patient. These must be documented on the count sheet.
Body cavity	Refers to any space in the human body that • contains internal organs • or is of a size that an instrument, accountable item or other item may be unintentionally retained (eg hip joint).
Critical information	Information that is vital to the health and wellbeing of the patient that if not communicated could lead to an adverse event occurring. Information is based on the health professional's clinical judgement and tailored to individual patients. ISBAR is a tool that assists health professional that structures the critical information. (see also ISBAR)
Fixative solution	A solution which protects a specimen from damage during transit to pathology and whilst awaiting examination. An example is formaldehyde (Formalin) which is a toxic substance, requiring the use of PPE when handling. Another common example is normal saline.
Human factors	Interrelationships between people, their environment and each other which are vital for the safety of the patient eg teamwork, communication. Sometimes called 'non-technical' skills.
Identification markers	Surgeon may place a suture to mark a specific area on a tissue specimen to assist pathologist in identification or orientation (left, right etc)

ISBAR	Abbreviation for *Identification, Situation, Background, Assessment, Recommendations**. A clinical handover tool used to ensure that all critical information necessary for ongoing patient care is communicated during the transfer of care between healthcare personnel. (see also Critical information). *may also be referred to as 'responsibilities' or 'requests'
Loudly	Clear, strong, audible communication
Must	Indicates a mandatory action that requires compliance
Non-invasive blood pressure cuff	An external inflatable cuff applied to the patient's upper arm and attached to a manual or automatic measuring device (sphygmomanometer) used to measure a patient's blood pressure
Neuro patties	Thin absorbent strips of varying sizes designed for use on brain tissue during neurosurgical procedures to absorb fluid. They have a radio opaque marker and a locating string attached. They are an accountable item, usually packaged in multiples of 10 or 20.
Neutral zone	A designated area on the aseptic field agreed upon by the surgical team in which sharps eg scalpels, suture needles etc are placed in a puncture proof container eg kidney dish or tray, for retrieval by the surgeon. Only one sharp item at a time is permitted within the neutral zone. This strategy is designed to reduce the risk of sharps injury during hand to hand transfer of sharps.  Diagram of neutral zone on aseptic field showing puncture proof tray to transfer sharps https://www.medline.com/media/catalog/sku/dyn/300x300/DYNJTTA1GS_HRE01.JPG

PPE	A range of equipment eg face mask, gloves, eye protection, plastic aprons worn by healthcare personnel to protect them from infectious organisms.
Progressive counting	Technique to remove accountable items eg swabs/sponges from the aseptic field during surgery in multiples of 5 or 10. This will reduce risk of infection and assist in managing large numbers of accountable items for counting purposes.
Sequential procedures	Two or more surgical procedures which occur one after another eg laparoscopy followed by laparotomy
Should	Indicates an obligation, duty or correctness. An action that should be followed unless there are sound reasons for taking a different course of action.
Simultaneous procedures	Two or more surgical procedures which occur at the same time by two or more surgical teams eg for a leg fracture and abdominal surgery on a trauma patient
Time Out	A term in the Surgical Safety Checklist requiring the surgical team to pause and confirm critical information about the patient, the procedure and associated actions prior to skin incision or commencement of a procedure. This action is aimed at reducing wrong site surgery.
Unintentionally retained item	Describes a swab, sponge, instrument accidentally left inside a patient during surgery. On occasions, it may be necessary to intentionally or deliberately leave swabs or sponges inside at patient for haemostasis. This must be noted on the count sheet and the items removed at a later operation.

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Patient Safety: Surgical safety

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

All perioperative personnel have a duty to implement checking processes to reduce the risks of adverse events and to optimise patient outcomes

Principles

1. THE CORRECT PATIENT WILL UNDERGO THE CORRECT SURGERY/PROCEDURE AT THE CORRECT SITE [1]

2. THE PERIOPERATIVE TEAM WILL EFFECTIVELY COMMUNICATE AND EXCHANGE CRITICAL INFORMATION NECESSARY FOR THE SAFE OUTCOME OF SURGERY/PROCEDURE [1]

3. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

PRINCIPLE 1: THE CORRECT PATIENT WILL UNDERGO THE CORRECT SURGERY/PROCEDURE AT THE CORRECT SITE

Rationale

Accurate identification of the patient and the procedure to be performed will reduce the risk of wrong site surgery and enhance patient outcomes.

Criteria:

The perioperative team will collectively and actively participate in a three-step surgical safety checklist, including, at a minimum:

1.1 Sign in (before induction of anaesthesia)

- confirm the patient's identity (verbally with patient, if appropriate, identification band, medical records)
- confirm the surgical procedure to be carried out (verbally with patient, if appropriate, medical records, consent form)
- confirm consent to surgical/anaesthetic procedure has been completed (verbally with patient, if appropriate medical records, consent form)
- confirm site marking is correct and visible
- note any patient allergies
- ensure that basic monitoring equipment is attached (pulse oximetry, non-invasive blood pressure cuff)
- clarify with the anaesthetist any anaesthetic risks

1.2 Time out (before skin incision or commencement of procedure):

- ensure that all team members are introduced to each other
- confirm the patient's identity (sight identification band, medical record number)
- confirm procedure and surgical site marking
- confirm antibiotic prophylaxis (if applicable)
- ensure that medical images are displayed (if applicable)
- confirm sterility of equipment
- communicate with the surgeon/anaesthetist in relation to any anticipated critical events (expected blood loss, difficult airway etc)

1.3 Sign out:

- name of the completed procedure
- confirmation that surgical count has been completed and result
- confirmation of surgical specimen(s) collected (labelling, management, transport)
- identify any post-operative issues for handover to PACU

1.4 document the surgical safety checklist (according to health facility policy)

PRINICPLE 2: THE PERIOPERATIVE TEAM WILL EFFECTIVELY COMMUNICATE AND EXCHANGE CRITICAL INFORMATION NECESSARY FOR THE SAFE OUTCOME OF SURGERY/PROCEDURE

Rationale

Effective teamwork and communication can enhance patient outcomes and minimise risks of adverse events.

Criteria

The perioperative nurses should:

2.1 participate in pre-operative briefings

2.2 confirm information with the surgical/anaesthetic team related to the preparation and progress of the procedure

2.3 raise any concerns related to patient care with the surgical/anaesthetic team

PRINCIPLE 3: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

3.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

3.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standard (2018), 'Surgical safety'.

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Patient Safety: Safe manual handling and positioning the patient for surgery

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

All personnel involved in manual handling during patient transfer and safe patient positioning during surgery have a duty to ensure the safety of both patient and perioperative personnel.

Principles

1. PERIOPERATIVE NURSES SHOULD ASSESS AND EVALUATE MANUAL HANDLING TASKS AND TAKE MEASURES TO PROTECT THEMSELVES FROM INJURY

2. PATIENTS UNDERGOING A SURGICAL OR INVASIVE PROCEDURE SHOULD HAVE A THOROUGH ASSESSMENT BEFORE SURGERY TO IDENTIFY AND MANAGE RISK FACTORS FOR INJURIES RELATED TO PATIENT POSITIONING [1]

3. PERIOPERATIVE PERSONNEL INVOLVED IN THE TRANSFER AND POSITIONING OF THE PATIENT FOR SURGERY SHOULD HAVE THE REQUIRED KNOWLEDGE AND SKILLS TO CORRECTLY PERFORM THESE ACTIVITIES

4. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE

PRINCIPLE 1: PERIOPERATIVE NURSES SHOULD ASSESS AND EVALUATE MANUAL HANDLING TASKS AND TAKE MEASURES TO PROTECT THEMSELVES FROM INJURY

Rationale

Perioperative nurses are often required to move equipment and supplies; act as first assistants and stand for long periods of time, all of which can pose a risk of injury.

Criteria

When working in the perioperative environment, the nurses should:

1.1 use devices such as carts, trolleys and other equipment to assist in lifting, carrying or moving supplies [2,3]

1.2 maintain good body posture when moving equipment and patients ie avoid twisting, bending actions

1.3 use anti fatigue devices when available eg foot stools, sit-stand stools, comfortable foot wear [3, 4]

1.4 wear protective, lightweight radiation protective apparel when available

1.5 maintain good working height and posture if manual retraction is required to assist the surgical team during a procedure [3]

1.6 minimise lifting/holding an extremity for skin 'prepping' purposes. Other personnel or assistive devices should be used where possible [2]

PRINCIPLE 2: PATIENTS UNDERGOING A SURGICAL OR INVASIVE PROCEDURE SHOULD HAVE A THOROUGH ASSESSMENT BEFORE SURGERY TO IDENTIFY AND MANAGE RISK FACTORS FOR INJURIES RELATED TO PATIENT POSITIONING [2]

Rationale

An understanding of functional anatomy, physiology, surgical procedures and patient co morbidities will enable perioperative personnel to prepare and manage patients' specific positioning requirements.

Criteria

Prior to the commencement of the procedure, the nurses should:

2.1 review the patient's medical records for risk factors eg size, weight, procedure, co morbidities, patient limitations

2.2 confirm with surgeon/anaesthetist the position required for surgery

2.3 carry out an assessment of the patient's skin integrity

2.4 document baseline assessment of patient's skin integrity (according to health facility policy)

PRINCIPLE 3: PERIOPERATIVE PERSONNEL INVOLVED IN THE TRANSFER AND POSITIONING OF THE PATIENT FOR SURGERY SHOULD HAVE THE REQUIRED KNOWLEDGE AND SKILLS TO CORRECTLY PERFORM THESE ACTIVITIES

Rationale

Knowledge and skills in safe manual handling equipment and positions used for surgery will minimise the risks of injury to patient and personnel.

Criteria:

In preparation for the procedure, the nurses should:

3.1 ensure the operating table is appropriate for patient's needs eg size and weight

3.2 ensure appropriate mechanical transfer and positioning devices to meet the patient's needs are available eg pat slide, transfer sheets, orthopaedic table

3.3 check that all equipment used to transfer and position the patient are working correctly

3.4 ensure that additional positioning aids are available eg lateral supports, foot boards, foam wedges

3.5 ensure sufficient personnel are available to:

- safely transfer the patient to and from the operating table
- complete safe positioning procedures

When transferring the patient to and from the operating table, the nurses should:

3.6 implement safe manual handling principles (area to which patient is being transferred is slightly lower, use correct body posture)

3.7 ensure transfer devices are used correctly, according to manufacturer's instructions

3.8 avoid shearing/friction occurring during transfer

3.9 instruct the patient about transfer procedure (if applicable)

When assisting with positioning the patient for surgery, the nurses should:

3.10 protect the patient's privacy and dignity during transfer and positioning

3.11 ensure additional positioning devices are used correctly, according to manufacturer's instructions

3.12 manage physiological risk factors eg protect pressure points and bony prominences, use wedge for obstetric patients, anti-skid devices, arm supports etc

3.13 remove all potential causes of pressure eg patient gown buttons/ties, creases in sheets under patient

3.14 ensure correct body alignment was achieved prior to commencement of the procedure

3.15 monitor the patient and manage identified risks eg crush injury from equipment, pressure from team members leaning on patient, pressure from positioning aids eg straps, overstretched joints

3.16 communicate with the multidisciplinary team the need for repositioning during prolonged procedures

At completion of procedure, the nurses should:

3.17 carry out an assessment of the patient's skin integrity and document (according to health facility policy)

3.18 ensure the patient's skin is clean and dry prior to transport to PACU

3.19 ensure there are sufficient number of personnel present to safely transfer the patient

3.20 use transfer devices correctly

3.21 instruct the patient about transfer procedure (if applicable)

PRINCIPLE 4: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

4.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

4.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standards (2018), 'Safe manual handling' and 'Safe patient positioning in the perioperative environment.'

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Patient Safety: Sharps safety

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

All perioperative nurses.

This standard may also apply to other perioperative personnel (ie surgical ward interns, nurses, orderlies, ward assistants, doctors (anaesthetists and surgeons) anaesthetic technicians etc).

Principles

1. THE PERIOPERATIVE NURSES SHOULD WEAR APPROVED PERSONAL PROTECTIVE EQUIPMENT (PPE) SPECIFIC TO SHARPS SAFETY, INCLUDING DOUBLE GLOVES AND PROTECTIVE FOOTWEAR.

2. THE PERIOPERATIVE NURSES SHOULD MAINTAIN SAFE WORK PRACTICES WHILE HANDLING SHARP INSTRUMENTS AND NEEDLES.

3. THE INSTRUMENT NURSE SHOULD ENSURE THAT ALL SHARPS ARE SAFELY DISPOSED OF IN AN APPROVED SHARPS DISPOSAL CONTAINER AT THE COMPLETION OF EACH SURGICAL PROCEDURE

4. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

PRINCIPLE: 1 THE PERIOPERATIVE NURSES SHOULD WEAR APPROVED PERSONAL PROTECTIVE EQUIPMENT (PPE) SPECIFIC TO SHARPS SAFETY, INCLUDING DOUBLE GLOVES AND PROTECTIVE FOOTWEAR.

Rationale
The use of PPE, including double gloves and protective footwear will protect the nurses against exposure to blood borne diseases and sharps injury. [1, 2, 3]

Criteria:
Perioperative nurses should:

1.1 wear fully enclosed shoes where possible (these will provide the best protection, but may be impractical due to local climatic and environmental conditions)

1.2 wear double gloves where possible (this is best practice; however, this is dependent on availability. If limited supply of sterile gloves – double glove for surgery where there is higher risk for sharps injury eg orthopaedics)

PRINICPLE 2: THE PERIOPERATIVE NURSES SHOULD MAINTAIN SAFE WORK PRACTICES WHILE HANDLING SHARP INSTRUMENTS AND NEEDLES.

Rationale

Perioperative personnel have a high risk of sustaining injuries related to the use of sharp devices with the suture needle being the most common source of sharps injury in the operating room. [4]

Criteria
When handling needles, scalpel blades and other sharp equipment (rake retractors, drill bits etc), the nurses should:

2.1 load/unload needles and scalpel blades with care, using, for example, needle holder to avoid using fingers for this task (training in the use of a needle holder for this task must be provided to avoid injury)

2.2 pass all sharp instruments (eg needle holder, scalpels) using a puncture proof container (kidney dish, tray) to avoid hand to hand passing of sharp instrument [5]

2.3 isolate all sharps within a restricted area on the instrument table to avoid being mixed with other instruments

2.4 create a neutral zone within the aseptic field where sharps are placed for transfer (avoids two people touching sharps simultaneously)

2.5 communicate with the surgeon and other team members when a sharp is within the neutral zone [6]

2.6 keep visual contact with sharps whilst in use to ensure they are not inadvertently placed in an area that may risk harm to the patient or other team members

2.7 avoid recapping, bending or breaking needles

2.8 report and manage sharps related injuries promptly (according to hospital policy)

PRINCIPLE 3: THE INSTRUMENT NURSE SHOULD ENSURE THAT ALL SHARPS ARE SAFELY DISPOSED OF IN AN APPROVED SHARPS DISPOSAL CONTAINER AT THE COMPLETION OF EACH SURGICAL PROCEDURE

Rationale: The risk of sharps-related injury is reduced through the safe management and disposal of sharps [6, 7,]

Criteria

When disposing of sharps, the nurses must:

3.1 take responsibility for discarding all disposable sharps into designated, appropriately labelled sharps containers

3.2 discard sharps as soon as the procedure is completed

3.3 discard sharps as close to the point of use as possible

3.4 separate and isolate reusable sharp instruments from other instruments prior to and during reprocessing

PRINCIPLE 4: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

4.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

4.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standard (2018), 'Management of sharps in the perioperative environment'.

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Patient Safety: Managing accountable items during surgery and procedures

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

All members of the perioperative team have a duty to collaborate to ensure that all items used during surgery and procedures are retrieved, accounted for and appropriately documented.

Principles

1. THE INSTRUMENT NURSE AND CIRCULATING NURSE ARE RESPONSIBLE FOR THE MANAGEMENT OF ITEMS USED DURING SURGERY AND PROCEDURES IN THE PERIOPERATIVE ENVIRONMENT [1], [2,]
2. A STANDARDISED PROCEDURE FOR MANAGING AND DOCUMENTING ACCOUNTABLE ITEMS DURING SURGERY/PROCEDURE SHOULD BE FOLLOWED [3]
3. A STANDARDISED PROCEDURE FOR MANAGING AND DOCUMENTING COUNTS SHOULD BE USED DURING COMPLEX SURGERY
4. ALL ABSORBENT ACCOUNTABLE ITEMS THAT ARE USED DURING SURGERY/PROCEDURES SHOULD BE HANDLED IN A MANNER THAT REDUCES THE RISK OF THE ITEM BEING RETAINED. [3]
5. WHERE AVAILABLE, STANDARDISED INSTRUMENT TRAYS AND PROCEDURES FOR ACCOUNTING FOR INSTRUMENTS DURING SURGERY/PROCEDURE SHOULD BE FOLLOWED [3]
6. A PROGRESSIVE COUNTING AWAY TECHNIQUE TO COUNT AND REMOVE ACCOUNTABLE ITEMS FROM THE ASEPTIC FIELD MAY BE USED
7. A PROCESS SHOULD BE IMPLEMENTED IN THE EVENT OF AN INCORRECT COUNT
8. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

PRINCIPLE 1: THE INSTRUMENT NURSE AND CIRCULATING NURSE ARE RESPONSIBLE FOR THE MANAGEMENT OF ITEMS USED DURING SURGERY AND PROCEDURES IN THE PERIOPERATIVE ENVIRONMENT

Rationale

Correct management of the surgical/procedural count by the instrument nurse and circulating nurse and will minimise the risk of items being unintentionally retained in the patient.

Criteria:

Prior to commencement and during the procedure:

1.1 two (2) nurses should perform the count procedure, one of whom shall be a registered nurse. In minor procedures where no instrument nurse is present eg removal of lipoma or suturing lacerations, the count should be conducted by the circulating nurse and the surgeon

1.2 whenever possible the same two nurses should perform all counts.

1.2.1 where there is a permanent change in personnel, a complete count should be performed, and the names of all relieving nurses documented.

1.2.2 when a nurse is temporarily relieved (tea/lunch break), the names of the relieving nurses should be documented, but it is not necessary to conduct a complete count

1.3 if the count is interrupted, the count should be restarted

PRINICPLE 2: A STANDARDISED PROCEDURE FOR MANAGING AND DOCUMENTING ACCOUNTABLE ITEMS DURING SURGERY/PROCEDURE SHOULD BE FOLLOWED

Rationale

A standardised procedure for managing and documenting accountable items will minimise the risks of items being retained unintentionally in the patient

Criteria

The instrument nurses and circulating nurses should:

2.1 perform a minimum of two (2) counts of accountable items ie initial and final counts

2.1.1 when a body cavity has been opened, an additional count(s) should be performed at the closure of the body cavity and any additional body cavities

2.2 perform counts:

- prior to commencement of procedure ie the initial count
- at closure of a cavity, including a cavity within a cavity (i.e uterus)
- at commencement of wound closure
- at skin closure ie the final count

2.3 document all counts on an approved health facility document ('count sheet') which should also include the names of personnel performing the counts

2.4 document and initial all counted items immediately

2.5 open only the minimum number of accountable items deemed necessary to the surgery/procedure

2.6 count each individual item loudly and simultaneously whilst visualising the item

2.7 where possible, ensure items remain intact within their inner packaging, so they do not become separated prior to counting

2.8 separate each item during the counting procedure

2.9 check the integrity of the item (x ray detectable marker is present in swabs, sponges etc)

2.10 remove the entire package of items from the aseptic field if an incorrect number is noted. (these should be bagged, marked and isolated from the aseptic field)

2.11 remove from the operating/procedure room, accountable items accidently dropped/contaminated and not include these items in the count

2.12 document accountable items deliberately retained in the patient (eg sponges for haemostasis) on the count sheet, with final totals reflecting number of items retained. Similar documentation will be required when accountable items are removed at a later date, with final totals reflecting number of items removed

2.13 ensure that the results of closure counts are communicated loudly to the surgeon

2.14 ensure that no accountable items leave the operating room prior to completion of procedure. If an accountable item is required for transportation of a specimen intraoperatively, it must be documented on the count sheet

2.15 document on the count sheet if no count was required for the procedure

PRINICPLE 3: A STANDARDISED PROCEDURE FOR MANAGING AND DOCUMENTING COUNTS SHOULD BE USED DURING COMPLEX SURGERY

Rationale
A standardised procedure for managing and documenting accountable items during complex surgery involving simultaneous or sequential procedures and more than one surgical team, will minimise the risks of items being retained unintentionally in the patient.

Criteria
When two or more procedures are undertaken simultaneously, with one instrument nurse and one circulating nurse involved, the nurses should:

3.1 use one count sheet

When two or more procedures are undertaken simultaneously, with one instrument nurse and one circulating nurse involved and it becomes difficult to separate the accountable items used by both teams, the nurses should:

3.2 use one count sheet

When two or more procedures are undertaken simultaneously and an additional instrument nurse and circulating nurse are involved: the nurses should:

3.3 use separate count sheets for each procedure

When sequential procedures are undertaken (two stage procedures) and the operating room *is cleared of instruments, equipment and rubbish* between each procedure, the nurses should:

3.4 conduct new counts for each procedure and document using *two* separate count sheets

When sequential procedures are undertaken (two stage procedures) and the *same set up* is being used or *remains* in the operating room, the nurses should:

3.5 continue the same count. This will require the use of a second count sheet. The final count of the first procedure is carried over to become the first count of the second procedure. Keep both count sheets together in the patient's record eg staple together

PRINCIPLE 4: ALL ABSORBENT ACCOUNTABLE ITEMS THAT ARE USED DURING SURGERY/PROCEDURES SHOULD BE HANDLED IN A MANNER THAT REDUCES THE RISK OF THE ITEM BEING RETAINED

Rationale:
The appropriate use of absorbent accountable items (eg swabs, sponges etc), contributes to the prevention of items being unintentionally retained.

Criteria

When handling absorbent accountable items (eg swabs, sponges etc), the instrument nurse should ensure the items:

4.1 contain an x ray detectable marker

4.2 are not cut (see also 4.6, 4.8, 4.9)

4.3 are never used as a wound dressing

4.4 are not used to wrap articles for sterilisation

When managing throat packs, the anaesthetist is responsible for the insertion of the throat pack and recording on the anaesthetic record. The circulating nurse should ensure:

4.5 the insertion and removal is documented on the count sheet

When managing gauze rolls, tapes, vessel loops, the instrument nurse and circulating nurse should ensure (in addition to 4.1, 4.3, 4.4):

4.6 if they are cut, this is recorded on the count sheet

When managing cotton wool balls, the instrument nurse and circulating nurse should ensure (in addition to 4.1, 4.3, 4.4):

4.7 they are not used for skin antisepsis ('prepping')

4.8 if they are divided for use during surgery, the segments are counted and documented

When managing neuro patties and eye strolls, the instrument nurse and circulating nurse should ensure (in addition to 4.1, 4.3, 4.4):

4.9 if they are divided for use during surgery, the segments are counted and documented

PRINCIPLE 5: WHERE AVAILABLE, STANDARDISED INSTRUMENT TRAY LISTS AND A CHECKING PROCEDURE TO ACCOUNT FOR INSTRUMENTS DURING SURGERY/PROCEDURE SHOULD BE FOLLOWED

Rationale

Standardisation of instrument trays and corresponding tray lists will assist in accounting for all items used and minimise the risks of instruments being retained

Criteria

The instrument nurse and circulating nurse should:

5.1 ensure instrument trays contain a standardised type and number of instruments

5.2 ensure a tray list corresponding to the contents is present

5.3 use the tray list to check and document the completeness of the contents
- prior to the commencement of the procedure
- at the closure of body cavities (if required)
- at the completion of the procedure

5.4 ensure that instruments with component parts (self-retaining retractors) are inspected for completeness and separate components documented as necessary to reduce risk of retention

5.5 sign and manage the storage of the tray list (according to health facility policy)

PRINCIPLE 6: A PROGRESSIVE COUNTING AWAY TECHNIQUE TO COUNT AND REMOVE ACCOUNTABLE ITEMS FROM THE ASEPTIC FIELD MAY BE USED

Rationale:

A progressive counting away technique assists with managing large numbers of used accountable items and promotes standard precautions

Criteria:

The *instrument* nurse should:

6.1 segregate used accountable items within the aseptic field in preparation for counting away

6.2 open out and separate all accountable items that are to be counted away

6.3 count items loudly with the circulating nurse in multiples of five (5) or ten (10) (as per original packaging)

6.4 perform two (2) consecutive counts prior to handing off the items

6.5 hand off items from aseptic field to circulating nurse using standard precautions

The c*irculating* nurse should:

6.6 don PPE (gloves, eye protection)

6.7 prepare plastic bags or suitable container to receive used items

6.8 count items loudly with the instrument nurse

6.9 receive the accountable items, then seal the bag/container, and write the number of items on the bag/container. Retain the bag/container in the OR for subsequent counting procedures

PRINCIPLE 7: A PROCESS SHOULD BE IMPLEMENTED IN THE EVENT OF AN INCORRECT COUNT

Rationale:

In the event of an incorrect count, a process must be implemented to ascertain whether the missing items have been retained inside the patient.

Criteria

The *instrument* nurse should:

7.1 immediately report any discrepancy in the count to the surgeon

7.2 request the surgeon to conduct a thorough search of the procedure site

7.3 work with the circulating nurse to carry out a thorough search of the aseptic field and operating room environment

The *circulating* nurse should:

7.4 immediately report any discrepancy in the count to the operating room supervisor/manager (according to health facility policy)

7.5 conduct a thorough search of the environment (rubbish and linen bags, the floor, open all bags/containers to re-count those accountable items from progressive counts)

7.6 organise for an x ray be taken prior to patient leaving the operating room or at earliest opportunity (according to health facility policy)

7.7 document incident (according to health facility policy)

PRINCIPLE 8: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

8.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

8.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standard (2018), 'Management of accountable items used during surgery and procedures' and International Federation of Perioperative Nurses (IFPN) *'Guideline for surgical counts - sponges, sharps, and instruments.'*

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FURTHER READING AND RESOURCES

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Patient Safety: Handling specimens

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

Perioperative nurses should have knowledge about the care and handling of specimens in order to reduce the risk adverse events (mislabelling, misdiagnosis) and to optimise patient outcomes

Principles

1. SPECIMEN HANDLING SHOULD BE ASSESSED AND PLANNED PRIOR TO THE COMMENCEMENT OF THE SCHEDULED PROCEDURE/LIST

2. CORRECT PATIENT AND SPECIMEN IDENTIFICATION SHOULD BE CONFIRMED TO MINIMISE THE RISK OF AN ADVERSE OUTCOME FOR THE PATIENT

3. THE PERIOPERATIVE NURSE SHOULD ENSURE THAT CORRECT COLLECTION AND HANDLING METHODS ARE IMPLEMENTED FOR THE PROTECTION OF THE SPECIMEN

4. SPECIMEN CONTAINERS SHOULD BE ACCURATELY LABELLED

5. DOCUMENTATION METHODS SHOULD BE ESTABLISHED TO ENSURE SPECIMEN ACCURACY AND ACCOUNTABILITY.

6. TRANSFER AND TRANSPORT METHODS SHOULD BE ESTABLISHED TO ENSURE THE INTEGRITY OF THE SPECIMEN/S.

7. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

PRINCIPLE 1: SPECIMEN HANDLING SHOULD BE ASSESSED AND PLANNED PRIOR TO THE COMMENCEMENT OF THE SCHEDULED PROCEDURE/LIST

Rationale
Patient assessment and assembling all equipment required to manage specimens prior to commencement of procedure will ensure timely collection of the specimens and reduces the risk of specimen errors.

Criteria:

Prior to commencement of the procedure, the nurses should:

1.1 ensure there is a selection of specimen containers, fixative solutions, specimen labels/stickers, pathology request forms bio hazard bags (if used) or protective plastic bags for transporting the specimen container

1.2 ensure a supply of PPE (mask, gloves) available for handling/transporting specimens

1.3 alert the pathology or relevant department if a specimen is to be transported urgently

PRINICPLE 2: CORRECT PATIENT AND SPECIMEN IDENTIFICATION SHOULD BE CONFIRMED TO MINIMISE THE RISK OF AN ADVERSE OUTCOME FOR THE PATIENT

Rationale

Correct patient and specimen identification can prevent adverse outcomes for the patient through misdiagnosis, delay or errors in treatment.

Criteria

On removal of the specimen from the patient, the instrument nurse should immediately confirm with the surgeon:

2.1 the name of the specimen

2.2 any identification markers or anatomical features to be documented

2.3 fixative solution required [1]

PRINCIPLE 3: THE PERIOPERATIVE NURSE SHOULD ENSURE THAT CORRECT COLLECTION AND HANDLING METHODS ARE IMPLEMENTED FOR THE PROTECTION OF THE SPECIMEN

Rationale:

The integrity of the specimen must be ensured through correct handling, collection and preservation. The specimen must be protected at all times to prevent damage, drying or deterioration due to extremes of temperature.

Criteria

When handling the specimen, the *instrument nurse* should:

3.1 ensure the specimen is safely stored on the instrument table prior to handing off the specimen to the circulating nurse eg placed in a container or on a moist swab

3.2 ensure only one specimen is present on the aseptic field and instrument table at any time

3.3 instruct the circulating nurse to prepare a specimen container to receive the specimen

3.4 double check the labelling on the specimen container with the circulating nurse *prior* to handing off the specimen eg view and read out loud the patient identification and specimen name

3.5 hand off the specimen as soon as possible following removal from the patient [1,2]

PRINCIPLE 4: SPECIMEN CONTAINERS SHOULD BE ACCURATELY LABELLED

Rationale
The incorrect labelling of specimens can lead to adverse outcomes for the patient through misdiagnosis, delay or error in treatment [1,2]

Criteria

Prior to receiving the specimen, the *circulating nurse* should:

4.1 select a specimen container appropriate for the specimen eg size, type of specimen

4.2 label the specimen container as instructed by the instrument nurse, ensuring the following identification information (at a minimum) is included:
- 4.2.1 name of patient, medical record number, date of birth
- 4.2.2 name of specimen (no abbreviations to be used)
- 4.2.3 identification makers (if any)

4.3 place the label on the container (not the lid) *prior* to receiving the specimen

4.4 confirm the identification details (as above in 4.2) with the instrument nurse

4.5 receive the specimen wearing PPE and maintaining aseptic technique [1, 2]

PRINCIPLE 5: DOCUMENTATION METHODS SHOULD BE ESTABLISHED TO ENSURE SPECIMEN ACCURACY AND ACCOUNTABILITY.

Rationale:
A chain of custody using accurate specimen documentation, will reduce the risk of error from the time the specimen is removed from the patient until the pathology examination is completed [1,2]

Criteria:

The nurses should ensure:

5.1 a pathology request form is prepared for the specimen

5.2 the correct patient identification and specimen name is included on the pathology request

5.3 the surgeon completes the pathology request form and any additional requirements (according to hospital policy) [1,2]

5.4 specimen details are confirmed with the surgeon during 'sign out' procedure

PRINCIPLE 6: TRANSFER AND TRANSPORT METHODS SHOULD BE ESTABLISHED TO ENSURE THE INTEGRITY OF THE SPECIMEN/S.

Rationale:

Establishing routine methods of specimen transportation, can reduce the risk of error caused by mishandling of specimens [1].

Criteria

The nurses should:

6.1 ensure the specimen and associated patient identification be removed from the operating room immediately after each procedure (reduces risk of potential mix up with subsequent patients/specimens)

6.2 wear PPE if pouring fixative solution into specimen container and when transporting the specimen

6.3 secure the lid of specimen container to prevent leakage during transportation

6.4 place specimen container into pre-labelled bio hazard bag (if unavailable, use a plastic bag to secure specimen container)

6.5 ensure pathology form accompanies the specimen

6.6 keep specimen and labelling out of sight of public waiting areas during transportation/storage to maintain patient privacy and confidentiality

6.7 protect specimen against loss or damage during transport or storage due to exposure to vermin or extremes of temperature

6.8 place specimen container and pathology form in designated collection point

6.9 complete documentation of specimen details into specimen register or as per local policy [1,2]

6.10 ensure specimens, particularly fresh specimens, are transported to the pathology laboratory as soon as possible or alternative storage is undertaken to ensure integrity of the specimen is maintained

PRINCIPLE 7: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

7.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

7.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standard (2018), 'Specimen identification, collection and handling'.

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2. Australian Commission on Safety and Quality in Health Care (ACSQHC). (2017). *The National Safety and Quality Health Service (NSQHS) Standards: Health associated infection* [Internet]. Sydney: ACSQHC. Retrieved from: www.safetyandquality.gov.au/our-work/healthcare-associated-infection.

Patient Safety: Perioperative patient handover

Scope of Standard

All perioperative environments where the surgical patient is treated.

Scope of Responsibility

All perioperative nurses and other members of the multidisciplinary team who are engaged in the clinical handover of patient care.

Principles

1. THE PERIOPERATIVE TEAM WILL EFFECTIVELY COMMUNICATE AND EXCHANGE CRITICAL INFORMATION NECESSARY FOR THE SAFE OUTCOME OF SURGERY/PROCEDURE

2. NURSES SHOULD CONDUCT A PRE-OPERATIVE CHECK OF THE PATIENT ON ADMISSION TO THE PERIOPERATIVE ENVIRONMENT

3. NURSES SHOULD CONDUCT A CLINICAL HANDOVER OF THE PATIENT ON ADMISSION TO THE PACU

4. NURSES SHOULD CONDUCT A CLINICAL HANDOVER OF THE PATIENT ON RETURN TO THE WARD

5. THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

PRINCIPLE 1: THE PERIOPERATIVE TEAM WILL EFFECTIVELY COMMUNICATE AND EXCHANGE CRITICAL INFORMATION NECESSARY FOR THE SAFE OUTCOME OF SURGERY/PROCEDURE

Rationale

Effective communication can ensure that critical information is communicated during the handover process. and can enhance patient outcomes. [1]

Criteria

During the clinical handover process the perioperative nurse should:

1.1 introduce themselves to the nurse participating in the handover, including their role in the care of the patient

1.2 conduct a verbal clinical handover using a consistent structured process [2]

1.3 confirm critical information with the nurse receiving clinical handover

1.4 raise any concerns related to patient care with the nurse during the clinical handover process

1.5 complete relevant documentation (according to health facility policy)

PRINICPLE 2: NURSES SHOULD CONDUCT A PRE-OPERATIVE CHECK OF THE PATIENT ON ADMISSION TO THE PERIOPERATIVE ENVIRONMENT

Rationale

Conducting a pre-operative check of the patient on admission to the perioperative environment will reduce the risks of adverse events, for example, wrong site surgery and ensure all information relevant to the patient's care is communicated to the perioperative team.

On admission to the perioperative environment, the nurse admitting the patient should work with the ward nurse to conduct a clinical handover of the patient using a comprehensive, standardised pre-operative checklist (according to health facility policy). The use of a structured tool such as ISBAR is recommended[1, 2] (see Appendix for example).

Criteria:

On admission to the perioperative environment, the nurse admitting the patient should:

2.1 confirm responses verbally with the patient (carer/parent), if appropriate and check against identification band, medical records, consent form

2.2 document responses on pre-operative checklist (according to health facility policy)

2.3 ascertain/clarify additional information from the ward nurse as necessary

2.4 sign pre-operative checklist (according to health facility policy)

PRINCIPLE 3: NURSES SHOULD CONDUCT A CLINICAL HANDOVER OF THE PATIENT ON ADMISSION TO THE PACU

Rationale

Conducting a standardised clinical handover of the immediate post-operative patient on admission to PACU will ensure all relevant anaesthetic, procedural information and nursing care is communicated to the PACU nurses, emphasising a continuity of care and responsibility. [3]

On arrival in PACU, the nurse accompanying the patient should conduct a clinical handover of the patient with the PACU nurse, using a structured tool such as ISBAR (see Appendix for example).

Criteria

On arrival in PACU, the nurse accompanying the patient should:

3.1 conduct a verbal clinical handover with the PACU nurse using a consistent structured process

3.2 confirm critical information with the PACU nurse participating in the clinical handover

3.3 raise any concerns related to patient care with the PACU nurse during the clinical handover process

3.4 complete relevant documentation (according to health facility policy)

PRINICPLE 4: NURSES SHOULD CONDUCT A CLINICAL HANDOVER OF THE PATIENT ON RETURN TO THE WARD

Rationale:

Conducting a standardised clinical handover of the post-operative patient to the ward nurses will ensure all relevant information about the procedure and immediate post-operative care is communicated, ensuring continuity of care and responsibility.[4, 5]

On arrival in the ward, the perioperative nurse accompanying the patient should conduct a verbal handover with the ward nurse, using a structured tool such as ISBAR and documented according to health facility policy (see Appendix for example).

Criteria

On arrival in the ward, the perioperative nurse accompanying the patient should:

4.1 conduct a verbal clinical handover with the ward nurse using a consistent structured process

4.2 confirm critical information with the ward nurse participating in the clinical handover

4.3 raise any concerns related to patient care with the ward nurse during the clinical handover process

4.4 complete relevant documentation (according to health facility policy)

PRINCIPLE 5: THE STANDARD IS REVIEWED EVERY THREE YEARS AND WHEN NEW EVIDENCE IS AVAILABLE.

Rationale

Documentation of procedural steps is a foundation for best practice, ensures consistency of practice and provides a tool for care planning.

Criteria

5.1 The standard should be stored in the unit practice manual and easily accessible for staff reference.

5.2 A SIGN-OFF SHEET should be provided in the unit practice manual for staff to indicate when they have read the standard and any related local policies.

ACKNOWLEDGEMENTS

We wish to acknowledge that this standard has been developed with reference to the Australian College of Perioperative Nurses (ACORN) Standard (2018), 'Management of the post anaesthetic care unit.'

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APPENDIX: EXAMPLE OF USE OF ISBAR AS CLINICAL HANDOVER TOOL[1]

The table is a guide only using examples of critical information that may be included in the clinical handovers. Further critical information may be included specific to your patient's condition.

ISBAR	PRE-OPERATIVE HANDOVER ON ADMISSION TO THE OPERATING THEATRE	HANDOVER FROM OPERATING ROOM TO PACU	HANDOVER FROM PACU TO THE WARD
INTRODUCTION	• patient identity and preferred name	• patient identity and preferred name	• patient identity and preferred
SITUATION	• surgical procedure to be carried out • consent to surgical/anaesthetic procedure has been completed • site marking (if applicable) is correct and visible	• details of procedure completed and anaesthetic type • specimens taken (if applicable)	• details of procedure completed and anaesthetic type • specimens taken (if applicable)
BACKGROUND	• patient allergies • relevant medical history • pre-operative issues (eg anxiety, physical limitations, hearing or visual impairment, pressure injury) • administration of any pre-operative medication (eg anti-hypertensive drugs, insulin etc) • medical records, x rays are present	• patient allergies • significant intraoperative events (eg blood loss, use of tourniquet) • pre-operative issues (eg anxiety, physical limitations, hearing or visual impairment) • pressure injury • medical records, x rays are present	• patient allergies • vital signs and any special observations (eg extremity, neurological) carried out in PACU • patient's progress and current condition • significant intraoperative events (eg blood loss, use of tourniquet) • pre-operative issues (eg anxiety, physical limitations, hearing or visual impairment) • pressure injury • medical records, x rays are present
ASSESSMENT	• fasting status • removal of prosthesis (eg dentures, contact lenses, hearing aids etc) • removal or securing of jewellery (eg wedding bands, earrings, neck chains, cultural/religious items) • skin integrity status	• dressings and drains in situ and specific care required • IV fluid in progress (if applicable) • post-operative orders re analgesia, nausea, IV, fluids, care of any drains, catheters etc • skin integrity status	• IV fluids, dressings, drains, catheters in situ, any specific care carried out in PACU and post-operative orders for ongoing management • post-operative medications administered in PACU (analgesia, anti-emetics), effectiveness and ongoing post-operative orders • skin integrity status
RECOMMENDATIONS	• whereabouts of patient's relatives, belongings (if applicable)	• whereabouts of patient's relatives, belongings (if applicable) • whereabouts of surgeon/anaesthetist if assistance required • discharge information	• whereabouts of patient's relatives, belongings (if applicable) • whereabouts of surgeon/anaesthetist if assistance required • discharge information