Outline

Define the Problem

What	Problem(s)	Retained sponge after surgery
When	Date	September 18, 2009
	Time	~11:00 a.m.
	Different, unusual, unique	Patient obese; blood loss
Where	State, city	California
	Facility, site	Women Infant & Children (WIC) Services
	Unit, area, equipment	Abdomen
	Task being performed	Elective Cesarean section

Impact to the Goals

Patient Safety	Risk of death, serious injury	
Employee Impact	Disciplinary action	
Compliance	Failure to follow hospital policy/procedure	
Organization	Fine	$50,000
Patient Services	Sponge retained in patient's abdomen	
Environmental	None	
Property, Equip, Mtls	Second surgery to remove sponge	?
Labor, Time		
	This incident	$50,000+
Frequency	~0.7% of surgeries	
	Annualized Cost	?

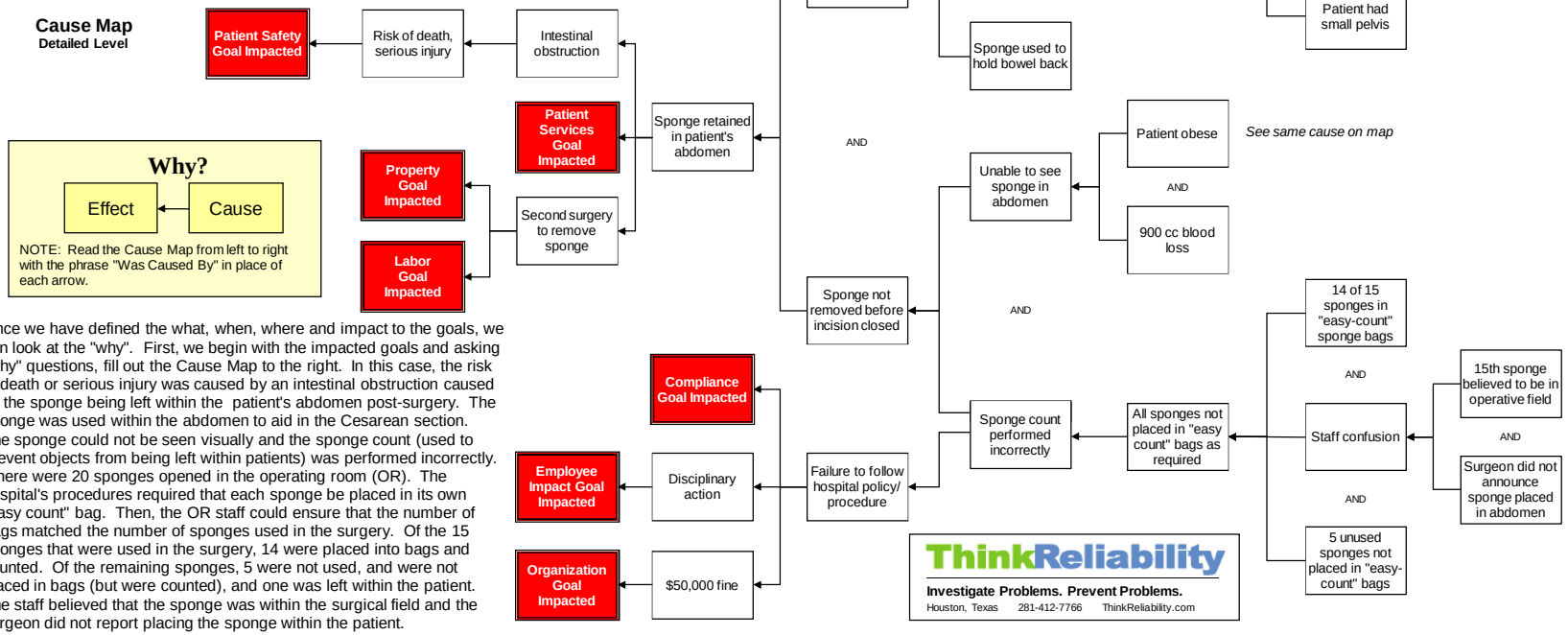
Retained Surgical Sponge
California
2009

In May, the California Department of Public Health (CDPH) fined nine California hospitals for noncompliance which was likely to cause serious injury or death. One of these hospitals was fined for leaving a surgical sponge inside a patient's abdomen after a Cesarean section.

In this case, there was a risk of death or serious injury to the patient, which is an impact to the patient services goal. Two of the employees involved received disciplinary action, which impacts the employee impact goal. The compliance goal was impacted because hospital policy/procedure was not followed. The organization goal was impacted because of the $50,000 fine levied by the CDPH. The patient services goal was impacted because a sponge was left inside the patient. The property and labor goals were impacted due to the second surgery performed to remove the sponge.

Cause Map

Detailed Level



Once we have defined the what, when, where and impact to the goals, we can look at the "why". First, we begin with the impacted goals and asking "why" questions, fill out the Cause Map to the right. In this case, the risk of death or serious injury was caused by an intestinal obstruction caused by the sponge being left within the patient's abdomen post-surgery. The sponge was used within the abdomen to aid in the Cesarean section. The sponge could not be seen visually and the sponge count (used to prevent objects from being left within patients) was performed incorrectly. There were 20 sponges opened in the operating room (OR). The hospital's procedures required that each sponge be placed in its own "easy count" bag. Then, the OR staff could ensure that the number of bags matched the number of sponges used in the surgery. Of the 15 sponges that were used in the surgery, 14 were placed into bags and counted. Of the remaining sponges, 5 were not used, and were not placed in bags (but were counted), and one was left within the patient. The staff believed that the sponge was within the surgical field and the surgeon did not report placing the sponge within the patient.

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