

One, Two, Three, Four Steps to Reduce RSIs

Retained surgical items are a [never event](#) and a risk of any invasive procedure. Risk factors for retained surgical items include distraction, communication breakdowns, confusion, and an emergent procedure or last-minute change in procedure. Likewise, “production pressure,” the pressure to increase productivity or throughput, tends to be a factor in such events.

It is the responsibility of the organization at its highest levels to set the tone that nothing may usurp quality of care—pressure to increase productivity and pressure to complete a procedure promptly for matters of convenience should not compromise patient safety. As often as possible, the procedure should not proceed until all components of initial safety protocols, including initial counts, have been completed. The organization is also responsible for ensuring that counts occur with regards to as many invasive procedures as possible. This way, if an emergency arises, instruments and soft goods are accounted for.

ECRI Institute PSO offers “[Four Ws of Instrument Counts](#)” (login required) to help to clarify staff members’ roles and responsibilities during and in support of an instrument or soft good count.

The Four Ws of Instrument Counts

Standardization and communication are the two most important factors in RSI prevention, and staff members will look to organization policies for the appropriate protocol and techniques regarding instrument and soft-good counts. Therefore, organizations should spell out very clearly the following “Four Ws”:

1. Who counts? Ensure that responsibility for the actual counting process is clearly designated to specific roles on the care team.
2. What is counted? Verify that policies clearly state which items are to be counted, such as sponges and soft goods, sharps, and miscellaneous items.
3. When should counts occur? Specify the appropriate times or intervals at which counts should occur.
4. Where should counts occur? Ensure that all care team members understand that counts are to occur in their presence, in the procedure area, and with their participation as appropriate.

[Contact us](#), and let us demonstrate how we can help you



In Memoriam for Joel J. Nobel, M.D., ECRI Institute Founder and President Emeritus

Sadly, we announce the passing of ECRI Institute's founding father and president emeritus, Joel J. Nobel, M.D. His remarkable vision and work led to many patient safety and technology improvements. He developed ECRI Institute's overall policies and programs, such as its healthcare technology assessment, product evaluation, risk management, and technical assistance services. A physician, innovator, and pioneer, Dr. Nobel led the organization for more than 30 years. While there is no way to know the full impact of his contributions to patient safety, we know that the world is a better place because of Joel. To read more about Dr. Nobel and his contributions to patient safety, see the [ECRI Institute press release](#) and [his obituary in the August 20, 2014, Philadelphia Inquirer](#).



How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at psa@ecri.org or call (610) 825-6000, ext. 5558.