SurgiCount
Patient & Caregiver Safety

Achieving zero.

Agenda

• Impact of retained surgical sponges
• Technology Differentiation
• Introduction to SurgiCount
• Review of counting practice
• Q&A
Overview: Retained Surgical Sponges
Facts & Figures

- 4,000 times a year, a patient has the unexpected outcome of a RSS.
- 1/8,000 surgical procedures results in a retained surgical sponge.
- With approximately 11 occurrences per day, it is the most frequently occurring surgical never event & #1 Sentinel Event.

- 16.3% of patients sustain permanent injury as a result of RSS, devastating their quality of life.
- RSS is life threatening, at 4.5% mortality rate.
- $660,000 is the average cost to a hospital for a single RSS.

Excerpt from the article “Surgical never events in the United States”

Table IV. Patient outcome by type of surgical never event

<table>
<thead>
<tr>
<th>Patient outcomes</th>
<th>All surgical never events n = 2,353 (%)</th>
<th>Surgical retained foreign body n = 1,126 (%)</th>
<th>Wrong procedure n = 620 (%)</th>
<th>Wrong site n = 583 (%)</th>
<th>Wrong patient n = 26 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>155 (6.6)</td>
<td>51 (4.5)</td>
<td>86 (13.9)</td>
<td>16 (2.7)</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Permanent injury</td>
<td>774 (32.9)</td>
<td>184 (16.5)</td>
<td>341 (55.0)</td>
<td>242 (41.5)</td>
<td>7 (26.9)</td>
</tr>
<tr>
<td>Temporary injury</td>
<td>1,995 (50.2)</td>
<td>879 (76.1)</td>
<td>186 (30.0)</td>
<td>318 (54.6)</td>
<td>12 (46.2)</td>
</tr>
<tr>
<td>Emotional injury</td>
<td>31 (1.3)</td>
<td>12 (1.1)</td>
<td>7 (1.1)</td>
<td>7 (1.2)</td>
<td>5 (19.2)</td>
</tr>
</tbody>
</table>

*Descriptive statistics, number of observations 2,353 paid malpractice claims for surgical never events with patient outcomes.

Why do sponges get left behind?

1. **False correct count** 88% of the time there is an RSI the count is marked, CORRECT.

2. Sponges are blood-soaked and can get stuck together.

3. OR’s are busy places with many staff, interruptions, emergencies.

4. Sponges can be left from previous case creating a false correct count.

5. **Human error**: RSS’s are a result of many factors outside of your control.

6. When a count is incorrect, there is an inability to prove a sponge is really missing and no knowledge of which exact sponge are you looking for.
Techniques for Preventing RSS

- **Process Improvement**
  - Alignment with AORN Counting Guidelines
  - Process standardization

- **Education**
  - Data analysis
  - All-staff meeting/in-service

- **Adjunct Technology**
  - Remove variability & provide proof
  - Eliminate false correct counts
Mayo Clinic’s Study Using SurgiCount
(Independent and Un-sponsored)

Key results from the study include:

• During the study, 87,404 procedures were performed over 18 months using 1.9 million Safety-Sponges, none were retained.

• Use of the solution caused no workflow disruption or increase in case duration.

• Staff satisfaction was acceptable with a high degree of trust in the system.

• When asked why SurgiCount and why not detection system:
  • “Variation is the enemy of process improvement.”
  • “We had a counting problem, not a locating problem.”
The Risks Of Detection: Barcodes vs. RF Chips

- Audible-Visual Recognition
- Consistent with AORN Count Practices
- Only Offering with Unique Sponge Identification
- SurgiCount360 Database

- Documented EMI Issues with Equipment, Patients, & Staff
- Sponges not differentiated
- Doesn’t support consistent process
- Zero Usable Documentation
**Product Footprint?**

Removing mats, wands, sterile wand covers is less medical waste.

SurgiCount Adds Net Zero Waste

VS.

Millions of chips, wands, mats, cords and drapes introduced to waste stream.
Introduction to SurgiCount

History & Numbers
Significant Evidence of Clinical Efficacy

290 million+
16 million+
485+

Safety-Sponges successfully accounted for
Successful procedures
Customer hospitals

U.S. News and World Report Best Hospitals Honor Roll users
Retained sponges & documentation to prove all sponges are accounted for

Clinically proven to help eliminate retained surgical sponges
485+ Current Community, Government And Teaching Hospitals, Including 5 of the U.S. News And World Report 2015 Honor Roll Hospitals
SurgiCounter

- Small mobile device designed for hands-free use
- Rests in small docking station with extra battery

Safety-Sponges®

- Unique, barcode label, permanently fused to each Safety-Sponge
- Master Tag allows all Safety-Sponges to be tracked with a simple scan

SurgiCount360™

- Backend database that organizes reports by service, campus, and date
- E-mail alerts for exceptions
The Stryker SurgiCount Promise

- Risk-sharing and indemnification program
  - Shift product cost risk from you
  - Review any retained surgical sponge event submission and notify you of outcome
  - Provide up to $5 million in product liability indemnification
  - Rebate you the incremental cost of implementing the SurgiCount Safety-Sponge System over your previous sponge spend (three year maximum).
SurgiCount tracks each uniquely identified sponge by patient and disposition.

View Details which lists:
- Unique Identifier
- Type of Sponge
- Time it was scanned into the report
- Time it was scanned out of the report
Counting practices and SurgiCount
Important Counting Concepts

SurgiCount...

➢ Never replaces the Manual Count
➢ Is a parallel process to the Manual Count
➢ Integrates with your Hospital Count policy
➢ Follows the 2016 AORN guidelines for:

   Retained Surgical items & Aseptic Technique
SurgiCount Screen Sequence

1: Start
   - Open Archived Report
   - Settings
   - Battery Status: 99% CHARGING
   - 0 Reports To Download

2: Verify Date and Time
   - Month: Jan
   - Day: 02
   - Year: 10
   - Hour: 06
   - Minute: 59
   - OK

3: Options
   - Bariatric
   - Cardiac
   - Colorectal
   - ENT
   - General
   - GU
   - GYN
   - L&D
   - MXfacial
   - Neuro
   - Exit
   - More
SurgiCount Screen Sequence: Case Report
Identifiers

4:
Opening Staff
Enter staff information
Circulator

5:
Patient Information
Enter the patient's information
Patient MR

Back Space  OK  Cancel
Back Space  OK  Enter Later
Scan – Count In

12x12

COUNT IN

<table>
<thead>
<tr>
<th></th>
<th>IN</th>
<th>OUT</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>12x12</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>18x18</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

Creating sterile technique

Scanning...

STOP SCANNING

Battery: 99% CHARGING

- 12-15” away to maintain sterile technique
- Audible and Visual
- Scan – Break – Count
Match with unique-numbered sponges

<table>
<thead>
<tr>
<th>Label</th>
<th>Type</th>
<th>In</th>
<th>Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL8KOZ</td>
<td>4x4</td>
<td>13:36:15</td>
<td></td>
</tr>
<tr>
<td>AL8MQI</td>
<td>4x4</td>
<td>13:36:15</td>
<td></td>
</tr>
<tr>
<td>D6BGYU</td>
<td>8x4</td>
<td>13:36:31</td>
<td></td>
</tr>
<tr>
<td>D6EWFC</td>
<td>8x4</td>
<td>13:36:31</td>
<td></td>
</tr>
<tr>
<td>D6FT0V</td>
<td>8x4</td>
<td>13:36:31</td>
<td></td>
</tr>
<tr>
<td>D6GDYC</td>
<td>8x4</td>
<td>13:36:31</td>
<td></td>
</tr>
<tr>
<td>AL5JNE</td>
<td>4x4</td>
<td>13:36:15</td>
<td>13:36:59</td>
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<tr>
<td>AL99HZ</td>
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<td>13:36:15</td>
<td>13:37:00</td>
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<td>ALFA6G</td>
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<td>13:36:15</td>
<td>13:37:05</td>
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<td>13:37:07</td>
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<td>ALFPBE</td>
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<td>13:36:57</td>
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<td>ALH9SP</td>
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<td>ALHG32</td>
<td>4x4</td>
<td>13:36:15</td>
<td>13:36:53</td>
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<td>ALHG3E</td>
<td>4x4</td>
<td>13:36:15</td>
<td>13:36:58</td>
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<tr>
<td>D6BGZ6</td>
<td>8x4</td>
<td>13:36:31</td>
<td>13:36:40</td>
</tr>
</tbody>
</table>
Scan – Count Out

- Bucket → Scan it → Bag it
- Parallel process with manual count
- “Duplicate” & “Unknown” sponges
Closing Case Report

Validation and Documentation
**Process** driven, evidence-based solution

- Unique identification
- Electronic confirmation
- Complete documentation
SurgiCount360™ Reports

Online SurgiCount 360 Application Demo
SurgiCount360™ Email Report

Timely Email Alerts for:
- Wound Packed
- Manual Override
- Case Canceled

Subject: SURGICOUNT EXCEPTION ALERT: Wound Packed 09:57 AM

There was a sponge count discrepancy detected by your SurgiCount Safety-Sponge System on the following case:

Location: E. F. Hunter Memorial Hospital/Main OR
Closing Circulator: FCDV
Service: GYN
Patient MR: VDCVFBDC
Patient Visit ID:
Report Date/Time: Closed: 09-18-2013 09:57:45

Report Notes:
09-18-2013 - 09:57:43 (entered on SurgiCounter)
Reason for closing with missing items
Wound packed

Count Summary:
4x4 IN:10 OUT:9 LEFT:1

Packed Sponges:
AVWMOV 4x4 ^09-18-2013 - 09:56:28

** Please do not reply to this email. **

Use the Alerts/Notifications view in SurgiCount 360 Desktop for further analysis.
SUPPORT AORN COUNTING GUIDELINES
STANDARDIZE YOUR COUNTING PROCESS
INCREASE PATIENT SAFETY
INCREASE CAREGIVER SAFETY
REDUCE LITIGATION AND SETTLEMENT FEES
REDUCE READMISSION RATES
SAVE MONEY
BE RECOGNIZED
INCREASE HCAP SCORES
SET THE STANDARD
ELIMINATE RETAINED SURGICAL SPONGES

BECAUSE
ONE RETAINED SPONGE IS ONE TOO MANY

Q&A
SUPPORT AORN COUNTING GUIDELINES
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INCREASE PATIENT SAFETY
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REDUCE LITIGATION COSTS
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THANK YOU