

Prevention of RSI

GAP ANALYSIS

Quickly assess current RSI Prevention practices in your ORs. Please answer the questions in the appropriate columns to help identify the gaps. Add your notes in the last column as your team begins the program to earn the **AORN Center of Excellence in Surgical Safety: Prevention of RSI**.

	Number	Yes/ Always	No/ Never	Don't know/ Sometimes	Comments/ Next Steps
Number of ORs in your facility?					
A) Inpatient Perioperative Services					
B) Ambulatory Perioperative Services					
C) Labor & Delivery					
D) Interventional Radiology					
E) Other					
Do you have a prevention of retained surgical items policy at your facility?					
A) Is the prevention of retained surgical items policy followed?					
Identify the number of retained surgical items in the past five years?					
A) Were critical investigations conducted?					
B) Are the results of the root cause analyses available?					
Identify the number of near miss incidences of retained surgical items in the past five years?					
A) Were critical investigations conducted?					
B) Are the results of the root cause analyses available?					
Do you use adjunct technology in your department?					
Do you use adjunct technology in your facility (eg, labor and delivery, interventional radiology)?					
Number of adjunct technology units currently in your department?					
A) Number of adjunct technology units needed?					



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Number of adjunct technology units currently in your facility?							
A) Number of adjunct technology units needed?							
Do you use pocketed sponge holders with a contrasting background color in your department?							
A) Number of pocketed sponge holders needed?							
Do you use pocketed sponge holders with a contrasting background color in your facility (eg, labor and delivery, interventional radiology)?							
A) Number of pocketed sponge holders needed?							
Is there yearly mandatory prevention of unintentionally retained surgical items education?							
A) Nurses and technologists?							
B) Surgeons?							
C) Anesthesia providers?							
D) Surgical assistants?							
Can you identify from your investigation a person(s) who would "champion" a prevention of surgical items program in your facility?							
Name(s)							
What are the obstacles to the implementation of a prevention of surgical items program in your facility?							