'Never' Is A Dangerous Word

Surgical professionals are working under increased pressure in the O.R., and having more to do in less time often means an increased risk of making a mistake--even if it's a mistake that should 'never' happen. Technology is the answer in changing that.

by Amanda McGowan, Editor, *Surgical Products*

My name is Amanda McGowan and I've taken over as the editor of *Surgical Products* magazine. I'm excited to take on this new role, and proud to contribute to a magazine that continues to bring the latest surgical technologies to its readers.

Technology in the surgical world is constantly changing, evolving and improving. As a publication that works to showcase these innovations, it only seems appropriate that we do the same. In the coming issues of *Surgical Products*, you may notice a different look and layout to the magazine and online at www.surgicalproductsmag.com [1]. We will work to provide enhanced editorial, covering the issues, trends, product developments, and more to provide the information you need to make your O.R. safe and efficient. Of course, throughout this progression, we will continue to bring you the latest, exciting product developments in the surgical field.

Your feedback as a reader is always welcomed and encouraged. As we embark on these changes, I would love to hear what you would like to see in *Surgical Products* to make it as useful, stimulating and relevant as possible. If you notice we are missing something along the way, please let us know. If you have a new development coming down the pike, or are doing something exciting at your facility, I would love to hear more about it.

In this edition of the *Surgical Products e-Focus*, we delve into technologies that will help prevent 'never events.' 'Never events,' as defined by the Centers for Medicare & Medicaid Services (CMS), are a list of events that are no longer reimbursed to hospitals by Medicare if they occur.

You will read in the remainder of this e-newsletter about four never events specifically associated with surgery:

- Retained foreign objects [2]
- Pressure ulcers [3]
- Surgical site infections [4]
- Wrong surgery [5]

While these are just a few on the list of CMS never events, these events hit close-to-

home for most surgical professionals.

A colleague asked me the other day to think about how much busier I am today than I was five years ago. How much more do I have going on? My answer: a lot more. Professionals in the surgical world feel the same. Having more to do in less time often means the increased risk of making a mistake--even if it's a mistake that should 'never' happen.

Luckily, technology has evolved along with our workloads, to make handling more tasks a little bit easier-and in the surgical field, helping in preventing 'never events.' From an RFID system to detect surgical sponges to a new hybrid surgical marking ink, the technology evolution has come through to help the team in the O.R. do their jobs better, prevent never events, and keep the minds of patients at ease.

What's your take? Email comments to amanda.mcgowan@advantagemedia.com [6]

Source: www.cms.hhs.gov [7]

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