Joint Commission Alert: Preventing Retained Surgical Items
Action urged to ensure objects are not left in patient’s body after surgery

(OAKBROOK TERRACE, Ill. – October 17, 2013) The Joint Commission today issued a Sentinel Event Alert urging hospitals and ambulatory surgery centers to take a new look at how to avoid mistakenly leaving items such as sponges, towels and instruments in a patient’s body after surgery.

Known in medical terminology as the unintended retention of foreign objects (URFOs) or retained surgical items (RSIs), this is a serious patient safety issue that can cause death or harm patients physically and emotionally. The Joint Commission has received more than 770 voluntary reports of URFOs in the past seven years. These cases resulted in 16 deaths, and about 95 percent of these incidents resulted in additional care and/or an extended hospital stay. Beyond the human toll, studies have shown that objects left behind after surgery may cost as much as $200,000 per case in medical and liability payments.

“Leaving a foreign object behind after surgery is a well-known problem, but one that can be prevented,” says Ana Pujols McKee, M.D., executive vice president and chief medical officer, The Joint Commission. “It’s critical to establish and comply with policies and procedures to make sure all surgical items are identified and accounted for, as well to ensure that there is open communication by all members of the surgical team about any concerns.”

Some actions recommended in The Joint Commission Alert include:

- Creating a highly reliable and standardized counting system to prevent URFOs – making sure all surgical items are identified and accounted for.

- Developing and implementing effective evidence-based organization-wide standardized policy and procedures for the prevention of URFOs through a collaborative process promoting consistency in practice to achieve zero defects.
Specific recommendations for counting procedures, wound opening and closing procedures and when intra-operative radiographs should be performed.

Organizations should research the potential of using assistive technologies to supplement manual counting procedures and methodical wound exploration.

Effective communication should be a standard part of the surgical procedure, including team briefings and debriefings, to allow the opportunity for any team member to express concerns they have regarding the safety of the patient, including the potential for an URFO.

Appropriate documentation should include the results of counts of surgical items, instruments, or items intentionally left inside a patient (such as needle or device fragments deemed safer to remain than remove), and actions taken if count discrepancies occur. Tracking discrepant counts is important to understanding practical problems.

Although URFOs occur in previously healthy patients during elective operations, one study shows common risk factors include overweight patients, urgent procedures, more than one surgical procedure and multiple surgical teams or multiple staff turnovers during the procedure. Occurrence of an URFO was nine times more likely when an operation was performed on an emergency basis and four times more likely when the procedure changed unexpectedly.

The Alert warns that objects most commonly left behind after a procedure are soft goods such as sponges and towels, small miscellaneous items such as broken parts of instruments and stapler components and needles or other sharps. The cases studied by The Joint Commission showed the most common root causes of URFOs are the absence of policies and procedures, failure to comply with existing policies and procedures, problems with hierarchy and intimidation in the surgical team, failure in communication with physicians, failure of staff to communicate relevant patient information and inadequate or incomplete staff education.

The warning about objects left behind after surgery is part of a series of Alerts issued by The Joint Commission. Much of the information and guidance provided in these Alerts is drawn from the Joint Commission’s Sentinel Event Database, one of the nation’s most comprehensive voluntary reporting systems for serious adverse events in health care. The database includes
detailed information about both adverse events and their underlying causes. Previous Alerts have addressed medical device alarms, risks associated with the use of opioids, health care worker fatigue, diagnostic imaging risks, violence in health care facilities, maternal deaths, health care technology, anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections and patient suicides, among others. The complete list and text of past issues of Sentinel Event Alert can be found on the Joint Commission website at www.jointcommission.org.

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