GUIDELINE *ESSENTIALS*

KEY TAKEAWAYS

Retained Surgical Items

TAKEAWAY	EXPLANATION
All perioperative team members are responsible for the prevention of unintentionally retained surgical items (RSIs).	• RSIs are preventable events of which the incidence can be reduced by implementing a consistent interdisciplinary approach that aims to reduce RSI risks and contributing factors. **1.1.** • Systems that involve accounting for items used in the patient during operative or other invasive procedures are team-based activities that comprise input from multiple perioperative team members. **1.1.** • Improving teamwork and communication in an effort to foster a just culture focused on patient safety is part of a systems approach to reducing surgical errors such as RSIs. **1.2.** • Team training may prevent RSIs by reducing the risk for human error (eg, safety omissions) while improving team communication and attitudes. **1.3.**
Minimize distractions, noise, and interruptions during the surgical count.	• Distractions and multitasking have been identified as contributing factors for RSIs. **1.4.** • Distractions cause attention to be diverted from the counting task. Distractions may include music, nonessential conversation, personnel entering the OR, ringing telephones, multitasking, and background noise. **1.4.** • Time pressures to quickly finish the surgical procedure (ie, rushing the count) is a form of interruption that can lead to a count error. **1.4.**
Use a standardized process for surgical counts.	• Establishing a system that accounts for all surgical items opened and used during a procedure constitutes a primary and proactive strategy to prevent patient harm. **1.1.** • Variation in counting practices and differences in count recording among providers increase the risk for error. Use of a consistent, standardized practice has been shown to reduce the reports of incorrect counts and rates of overall serious reportable events. **2.1.** • Ideal RSI prevention measures are standardized, transparent, verifiable, and reliable. Deliberate, consistent application of and adherence to standardized procedures is necessary to prevent RSIs. **1.1.** • Measures to reduce variability and create a consistent standardized practice include implementing new count procedures, audits, education, standardization of dry-erase

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	boards, streamlining of instrument sets, and updating of count sheets. **2.1.** • Concurrent viewing and audible counting by two team members, one of whom is the RN circulator, may lessen the risk of inaccurate counts. **2.6.** • NEW Items should be separated, pointed out, and audibly counted by the scrub person when they are on the sterile field and by the RN circulator when they are off the sterile field. Separating and pointing out items on the sterile field while counting may reduce the risk of miscounting because an item is not seen. **2.7.**
NEW Use a standardized procedure to prevent retention of foam pieces used with negative-pressure wound therapy devices.	• NEW Individuals removing foam pieces may be unaware of how many pieces of foam are in the wound. Establishing a standard procedure to communicate the location and plan for the eventual removal of foam pieces is critical to prevent an RSI. **7.1.** • NEW Managing dressings used in negative-pressure wound therapy may involve team members from across the facility and in facilities to which patients may be discharged. An interdisciplinary team to establish a standardized procedure for management of foam pieces should include physicians, nurses, wound care nurses, infection preventionists, quality and risk managers, materials management personnel, and other stakeholders as needed (eg, home health care nurses, manufacturers' representatives). **7.1.1.** • NEW Leaving the foam pieces as large as possible to limit the number used and cutting the foam only when necessary to fit it into the wound may reduce the risk of retention of foam pieces. **7.3.** • NEW Clear documentation of the number of foam pieces used in the wound may reduce the risk of an RSI by providing information to individuals changing or removing the dressing. Patients may have numerous dressing changes during which foam pieces are changed, and updating the information in the patient's medical record on the number of foam pieces in the patient's wound is important. Having documentation that is accessible during numerous transitions of care is also important. **7.4.**
Use adjunct technology devices to supplement manual counting procedures for soft goods.	• There is significant potential for inaccurate counts with the use of manual counting practices. Discrepancies may involve a misplaced item, miscounting, addition errors, and documentation errors. Use of adjunct technology does not replace manual counting procedures but it may help identify counting discrepancies. **9.3.**

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	• Surgical sponges are the most commonly retained items. • NEW The use of RF detection adjunct technology may identify or reduce - near misses; - count discrepancies (eg, miscounted or misplaced soft goods); - time spent searching for soft goods or resolving count discrepancies; - the number of radiographs taken, associated time and costs, and patient exposure; - additional procedures to remove a retained sponge; - costs; and - the potential for contamination of personnel going through waste receptacles to find a sponge. **9.2.2.** • NEW If use of adjunct technology may be waived in specific instances or procedures, outlining the details in facility policy and procedure can help provide clarity to personnel providing care. **9.3.1.** • Devices that use radio-frequency technology should be used with caution in patients who have pacemakers, implantable cardioverter defibrillators, and other electronic medical devices. **9.3.6.**
Use a systems approach to performance improvement for prevention of unintentionally retained surgical items.	• Systems and human factors play a significant role in contributing to RSIs. Therefore, focusing on behavioral changes (eg, compliance with policies and procedures, effective hand-over communication) and education about risk-reduction strategies unique to the setting during the adoption of systems may reduce the incidence of errors and improve accounting for surgical items. • A systems approach to preventing RSIs includes using standardized counting and reconciliation procedures, methodical wound exploration, radiological confirmation, adjunct technology, team training, and enhanced communication. • Focusing on systems for RSI prevention, rather than blaming individuals, aims to reduce the incidence of RSIs by improving systems to prevent predictable human errors. **13.2.** • Error and near miss reporting is the first step to addressing error reduction. There are a number of analysis methods (eg, root cause analysis, appreciative inquiry) available to health care organizations that may be used to conduct a critical investigation of adverse events. **13.5.**

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