Child Health Patient Safety Organization®

SAFETY WATCH

Stay aware of these known risks to avoid preventable harm.

Retained foreign objects or surgical items

Retained foreign objects (RFOs) or retained surgical items (RSIs) continues to be a significant procedural challenge among health care facilities. RFOs/RSIs are considered never events and are the most commonly reported sentinel events to the Joint Commission. These events occur most often in operating rooms, with guidewires and sponges being particularly frequent in pediatric cases.

Harm Range

No harm to severe temporary harm.

Causes

Several contributing factors may include:

- Lack of a dependable process for removal of foreign objects and documentation of the procedure.
- Misinterpretation or undetected RFO/RSI on imaging.
- Inadequate communication among health care providers related to accurate counts, instrument utilization, and procedural variances.

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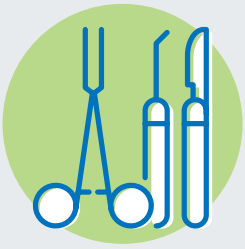

Harm

Failure to identify and remove RFOs/RSIs may lead to infection or cause patients to undergo additional interventions, such as imaging, which causes further radiation. These "never events" put health care facilities at risk of litigation and increased healthcare costs and influence the reputation of the organization.

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Immediate Recommendations

- Develop a clear and standardized approach to surgical counts that includes all instruments and soft items such as towels. Follow a protocol when a count discrepancy is noted.
- Standardize documentation of the surgical objects count and hardware removal using a uniform template in a consistent location in the electronic health record.
- Consider post-procedure imaging, especially in high-risk or emergent situations, while balancing the need to minimize radiation exposure. Evaluate whether obtaining a one-view versus two-view x-ray is appropriate for the circumstances. Remove all equipment from the imaging field to avoid difficulties in differentiating foreign objects from external devices.
- Foster accountability and direct, clear communication between health care providers perioperatively. With all team members present, articulate the final count, identify and report discrepancies, verbalize and create a visual reminder of new tools introduced into the body cavity, and communicate indications for imaging.

Resources

- Retained Foreign Objects or Surgical Items Action Alert
- AORN's Surgical Excellence Resource Center

References

- AORN Center of Excellence in Surgical Safety: Resource Center, 2024
- Schwartz, Zach, Understanding Retained Surgical Items (RSI): Importance, Prevention, and AORN Guidelines, AORN, 2024
- The Joint Commission Journal on Quality and Patient Safety, Unintentionally Retained Foreign Objects: A Descriptive Study of 308 Sentinel Events and Contributing Factors, ScienceDirect, 2019
- The HPI SEC & SSER Patient Safety Measurement System for Healthcare. Virginia Beach, VA: Healthcare Performance Improvement, LLC; 2009

Data for the Safety Watch is compiled from Child Health PSO safety analysis.

Find solutions

Members can find detailed prevention plans in Child Health PSO's Riskonnect Action Plan repository where children's hospitals share deidentified mitigation processes for various issues.

Join Child Health PSO

Over 55 children's hospitals are actively engaged with Child Health PSO, and we are currently enrolling new members. Join the only PSO solely dedicated to children's hospitals.