SAFETY ALERT
"Sharing Lessons Learned"
المركز السعودي لسلامة المرضى
SAUDI PATIENT SAFETY CENTER

# Preventing Unintended Retention of a Foreign Object in a Patient after Surgical/Invasive Procedure

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**This alert is for action by all healthcare facilities**

**This is a critical and complex National Patient Safety Alert. Implementation should be coordinated by an executive lead (or equivalent role in organizations without executive boards) and supported by clinical leaders.**

## *Description*

The unintended retention of foreign objects is considered a reportable sentinel event by many professional healthcare organizations.[1–3] It refers to any item or foreign object related to a surgical or invasive procedure that is left inside a patient regardless of whether death, permanent harm, or severe temporary harm occurred or not.[3] This includes **(1)** all cases involving the unintended retention of a foreign object in a patient, regardless of whether the retained object was discovered within a healthcare facility during hospitalization post-procedure or post-discharge, and **(2)** any item is subject to a formal counting/checking process at the start of a surgical/invasive procedure and before completing the procedure, such as swabs, needles, instruments, and guidewires. It excludes any object left for medical reasons in a patient, e.g., sutures, stents, implants, and medical devices.[3]

**Events**

- From January to December 2020, twenty-five (25) events of unintended retention of foreign objects were reported to the Saudi Patient Safety Center, representing eleven (11%) percent of the overall reported events.
- Most of these events occurred in operating rooms and labor and delivery areas.
- One event resulted in death; yet approximately ninety-six (96%) percent of the reported events resulted in additional care.
- The most common objects left behind after a procedure include the following[4]:
  - Soft goods, such as radiopaque sponges and towels and dressing gauze,
  - Needles and sharps,
  - Instruments, and
  - Small miscellaneous items, such as unretrieved device components or fragments, stapler components, parts of laparoscopic trocars, guidewires, catheters, and pieces of drains.

**Contributing Factors**

The most common contributing factors associated with the reported unintended retention of foreign objects include:

- Failure to comply with existing policies and procedures,
- Failure of staff to communicate relevant patient information,
- The absence of policies and procedures,
- Problems with hierarchy and intimidation, including ineffective upward, downward and horizontal communications,
- Inadequate or incomplete staff education, and
- Workload, including but not limited to shortage, overload and shift fatigue.

## *Recommendations*

Based on current best practices put forward by professional healthcare associations including The Joint Commission,[2] World Health Organization,[5] American College of Surgeons,[6] Association of peri-Operative Registered Nurses,[7] and other organizations and publications to guide specific challenges related to the unintended retention of foreign objects:

**Standardize procedural practices**

- Develop and implement effective evidence-based and standardized policies and procedures that apply to all operative and other invasive procedures through a multidisciplinary approach. These policies should be approved and supported by organizational leaders, reviewed periodically, revised as necessary, and available in the practice setting.
- Institute team briefings, time-outs, and debriefings as a standard part of all procedures.
- Consistent application, implementation, and strict adherence to standardized counting procedures. Counting procedures should be performed audibly and visibly by two persons engaged in the process, usually a scrub person (either technician or registered nurse) and a circulating registered nurse[7]:
  - Include counts of soft goods, needles/sharps, instruments, and small miscellaneous items, **(1)** before the procedure begins, to establish a baseline count; **(2)** before the closure of a cavity within a cavity; **(3)** before wound closure begins; **(4)** at skin closure or end of the procedure; and **(5)** at the time of relief of either one of two persons engaged in the process.
  - Verbally acknowledge and verify counts as part of a checklist.
  - Minimize distractions, noise, and unnecessary interruptions during counting procedures.
  - Establish uniform documentation of the counting procedures.
- Monitor and evaluate compliance with elements of the established policies and procedures, including but not limited to surgical checklists, appropriate documentation of surgical counts and discrepant counts.

**Effective team collaboration**

- Promote and maintain a collaborative work environment to facilitate trust and allow all members of the interdisciplinary team the opportunity to express concerns if patient safety is being compromised.

**Appropriate staffing, training, and education**

- Ensure that necessary personnel are available to perform procedures without compromising safety measures.

  Create an education model to assess competencies and promote knowledge development for all interdisciplinary team members, including but not limited to counting processes and multidisciplinary team communication.