Know the risk factors for retained foreign bodies

By Barbara A. Campione, RN, CNOR

Retained foreign bodies can have catastrophic results for patients. Patient complications include: hospital readmission or prolonged stay, additional surgical procedures, infection or sepsis, bowel obstructions or perforation, or death. Numbers of annual cases range anywhere from 1 in every 1,000 procedures to 1 in every 19,000 procedures.[1]

Retained foreign bodies commonly occur during an emergent procedure when the surgical team's efforts are completely focused on saving the patient's life. In that scenario, speed is essential and taking the time to perform a surgical count may not be an option. Other situations or factors that may lead to a retained foreign body include unplanned changes in the surgical procedure, patients with increased body mass, and procedures involving increased blood loss.

The importance of following policy

Developing and implementing effective policies and procedures for surgical counts,[1] including documentation and actions to be taken when the count is incorrect, is essential to prevent retained foreign bodies (see *Factors that impact surgical count accuracy*).

Even when appropriate policies and procedures have been developed and implemented, the patient is still vulnerable if the staff doesn't follow them scrupulously. Perioperative nurses must remember that they are the patient's advocate during any surgical procedure.

When an event occurs

Aside from the obvious concern for the patient's well-being, there are serious legal ramifications that must be considered. Cases involving retained foreign bodies are clearly perceived as negligence and carry a high percentage of litigation.

Per the Joint Commission, a retained foreign body during surgery is a reviewable sentinel event.[2] The following steps should be taken if this situation occurs:

- Report the incident if required by state regulations. Reporting the sentinel event to the Joint Commission, while not mandatory, is strongly recommended. An unreported sentinel event discovered by the Joint Commission can adversely impact a facility's accreditation.
- Conduct a timely, credible, and thorough root cause analysis to fully explore and identify the contributing factors.
- Develop an action plan that identifies the steps that the organization will take to reduce the risk of such an event happening again. The plan must address responsibility for implementation, oversight, timelines, and should include a way to measure the success of the action plan strategies. **OR**

Factors that impact surgical count accuracy

- Failure to develop and implement an effective policy and procedure for surgical counts
- Failure to follow the policy and procedure
- Disruptions during the performance of surgical counts
- Change in personnel during a procedure and the lack of proper hand-off procedure (surgical count not performed by incoming and outgoing staff)
- Staff fatigue, especially during lengthy and emergent cases
- A knowledge deficit about performance of surgical counts by any team member
- Failure to use X-ray detectable items (such as sponges)
- Failure to count all components of an instrument (all removable parts) and failure to inspect all items for completeness (a broken needle may easily lead to a retained foreign body)

REFERENCES

1. Berger PS, Sanders G. Objects retained during surgery: human diligence meets systems solutions. *Patient Safety & Quality Healthcare.* September/October 2008. http://www.psqh.com/sepoct08/objects.html.

2. The Joint Commission. CAMAC Refreshed Core. January 2009. SE3-SE7.

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