Child Health Patient Safety Organization

Patient Safety Action Alert

December 2017

Take Action to Reduce Risk of Similar Harm

Procedural Mishaps: Retained Foreign Objects / Retained Surgical Items

Child Health PSO has identified a safety concern related to retained foreign objects/ retained surgical items. This alert was developed after conducting a common cause analysis of the Child Health PSO database. In collaboration with industry experts, including the Children's Hospital Association (CHA) Operating Room Directors Forum and pediatric surgeons, various themes were identified that organizations should consider including in their standardized count policy for surgical and other invasive procedures to prevent future occurrence.

Resultant Harm

Harm continues to occur to children due to retained foreign objects / retained surgical items in the operating room and all other areas where invasive procedures are conducted. Without standardized processes (e.g., time-outs, counts), and in the absence of a high reliability culture, serious harm, including perforation, infection, emotional issues and death can occur.

Fundamental Issue

Surgical and other invasive procedures for pediatric patients are complex for a variety of reasons. Adding to that complexity is the concern for retained surgical items in patients because some items may not be included in the standardized count process. For example:

- Medical equipment/supplies altered to accommodate pediatric use
- New surgical items
- Additional instruments, medical supplies or devices added after the procedure begins
- Items found in surgical kits
- Guidewires and equipment/device fragments

Recommended Actions

- Conduct a risk assessment on the prevention of retained foreign objects/ retained surgical instruments using the risk worksheet to identify possible gaps in practice that may result in patient harm. The worksheet is not intended to address items intentionally left in a patient (e.g., items too harmful to retrieve).
- Review CHA's *Guidelines for the Prevention of Retained Surgical Items* to determine if your hospital's policy should be updated to address issues identified in this alert or risk worksheet.

What can I do with this alert?

- Forward to the recommended target audiences for evaluation.
- Include in your Daily Safety Brief.
- Create loop-closing process for evaluating risks and strategies implemented to decrease risk of repeat harm.
- Let us know what is working and what additional information you need.

Leverage your PSO membership

Learn from each other to reduce patient harm and Serious Safety Events.

Contact Us

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This alert is approved for general distribution to improve pediatric safety and reduce patient harm. This Alert meets the standards of non-identification in accordance with 3.212 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO.

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Additional Resources

- American College of Surgeons. Revised statement on the prevention of unintentionally retained surgical items after surgery, 2016. http://bulletin.facs.org/2016/10/revised-statement-on-the-prevention-of-unintentionally-retained-surgical-items-after-surgery/
- Association of periOperative Registered Nurses. Recommended practices for prevention of retained surgical Items, 2014. https://www.r2library.com/Resource/Title/1888460830
- Children's Hospital Association, Operating Room Directors Forum. Guidelines for the prevention of retained surgical items, Rev. 2017. https://www.childrenshospitals.org/-/media/files/quality/pso/cha_or-directors_guidelines_prevention-of-retained-surgical-items_dec2017.pdf
- NoThing Left Behind®: A National Surgical Patient-Safety Project to Prevent Retained Surgical items. http://nothingleftbehind.org/
- The Joint Commission Sentinel Event Alert, Issue 51, October 17, 2013. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_51_urfos_10_17_13_final.pdf
- WHO Guidelines for Safe Surgery: Safe Surgery Saves Lives, 2009. http://apps.who.int/iris/bitstream/handle/10665/44185/9789241598552_eng.pdf;jsessionid=72BFEB7BFC6ED3CACD2676B6C78EE0C7?sequence=1
- CMS Manual System, Pub 100-03 Medicare National Coverage Determinations, 2009. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R101NCD.pdf

Target Audiences

- Ambulatory Care
- Clinical Educators
- Clinical Leaders
- Emergency/Urgent Care
- Legal/Risk Management
- Medical Leaders
- Nursing Leaders
- Organizational Leaders
- Patient Safety
- Primary Care
- Quality Improvement
- Specialty Care Services
- Surgical Leaders

Contributors

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Has a patient experienced an event at your organization that could happen in another hospital?

- Child Health PSO members should submit event details into the Child Health PSO portal.
- Contact Child Health PSO staff to share risks, issues to assess, and mitigation strategies with member hospitals.

Nearly 60 children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.