CHPSO
California Hospital Patient Safety Organization

Retained Surgical Items (RSI)

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Outline

- Differing definitions for RSIs
- Different solutions for different types
- Current project to identify causes and cures for retained surgical items
  - Project description
  - Early results
  - How to participate

Differing definitions

CDPH (SB1301)

- Retention of a foreign object in a patient after surgery or other procedure,
  - excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

NQF serious reportable events

- **Unintended** retention of a foreign object in a patient after surgery or other invasive procedure,
  - Excluding objects present prior to surgery intentionally left in place (e.g., piece of glass in the foot)
  - Excluding objects intentionally implanted
  - **Excluding objects intentionally left in because risk of removal exceeds risk of retention**

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- Unintended retention of a foreign body after surgery or other invasive procedure
- **And** "near misses"
  - A fragment is generated and retrieved
  - An item *almost* is left in the patient
  - A hazard is identified that could result in a retained surgical item
- Broader to accelerate learning

Different solutions for different types

Broad categories

- Soft goods
- Instruments
- Sharps
- Small miscellaneous items (SMI)
- Unretrieved device fragments (UDF)

Different solutions

- These different types often tracked and accounted for differently
- Much better understanding of how to reduce risk of retained soft goods and instruments
- Less known how to avoid unretrievable sharps (e.g., micro-needles), SMIs and UDFs

Project to identify causes and cures

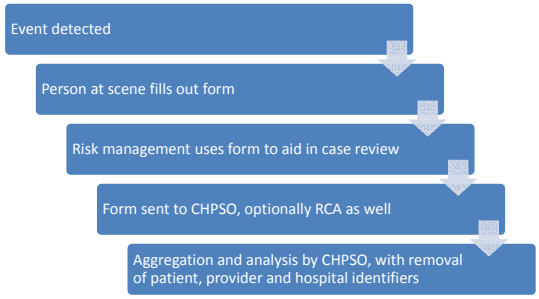
CHPSO Event Collection Project

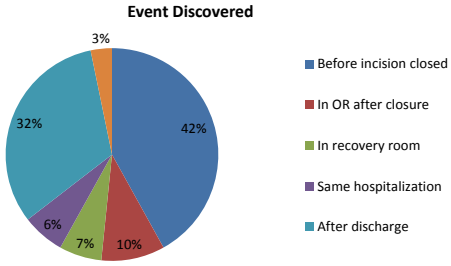
- Members only
  - Member list at www.chpso.org/members.php
- Reports are Patient Safety Work Product
  - Confidential
  - Privileged
- Identifiers are removed before sharing information
- Illinois, Michigan, Missouri, North Carolina and Tennessee agreed to participate with us
- Sponges are *not* a focus—odds and ends are

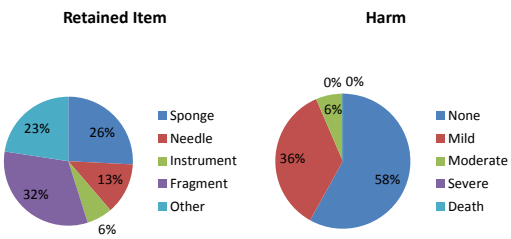
When to report to CHPSO

- **An item is left in the patient that is not supposed to be left there** as part of the procedure. For example, this form would be used for a staple that was dropped into the wound but not for a staple that is properly placed.
- **An item *almost* is left in the patient**. For example, the count is incorrect and steps are taken to find the item, which is then found in the patient and removed prior to leaving the OR.
- **A fragment is generated and retrieved**. For example, a drill bit breaks in the patient and the pieces are found and removed.
- **You identify a hazard that could result in a retained surgical item**. For example, a new model of retractor has a removable section that could be left behind, but you believe people are not aware of it and that section isn't being tracked.
- Can report past events as well as current. Main collection period ends October 1.

Report flow

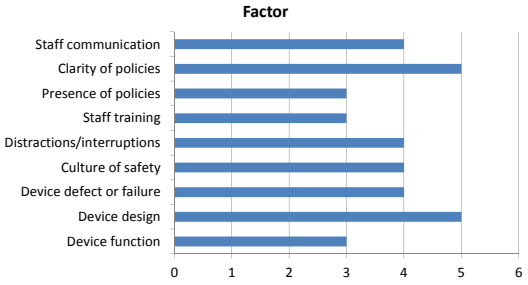

Event detected
Person at scene fills out form
Risk management uses form to aid in case review
Form sent to CHPSO, optionally RCA as well
Aggregation and analysis by CHPSO, with removal of patient, provider and hospital identifiers


Event Discovered
3%
42%
32%
6%
7%
10%
Before incision closed
In OR after closure
In recovery room
Same hospitalization
After discharge


Retained Item
23%
26%
13%
32%
6%
Sponge
Needle
Instrument
Fragment
Other

Harm
0% 0%
6%
36%
58%
None
Mild
Moderate
Severe
Death

Most common factors



Observations

- Bits and pieces predominate
  - Don't necessarily know how to reduce incidence currently
  - Are certain devices more likely to fail?
  - Are certain procedures more risky?
- Out-of-OR sources significant
  - Early sepsis treatment
    - More emergency central lines
    - Perhaps less-trained personnel

Questions

- rjaffe@chpso.org
- www.chpso.org
- Nothingleftbehind.org