

# What We Leave Behind

Retained surgical items are common, yet largely preventable.

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**“Surgical teams are often pushed to make sure everything happens on time. The pressure to perform can create a culture that takes shortcuts and inadvertently overlooks errors.”**

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Retained surgical items (RSIs) are known as “never events” per the National Quality Forum, because they are errors that are “serious, largely preventable, and harmful clinical events that should never happen.” Despite this, Constellation data show that RSIs are the third most likely cause of a surgical malpractice claim. Items are most commonly left in the abdominal, vaginal and chest cavities, and while these events are rare, their occurrence can cause significant harm to a patient’s postoperative outcome, as well as significant damage to the health care organization’s reputation and bottom line. RSIs are considered a clear violation of the standard of care and are difficult to defend.

# Half of the claims involve leaving a surgical item in an abdominal cavity, and surgical sponges account for the majority of RSIs.



So, if RSIs are considered preventable, why do they still occur? “A lot of organizations may have procedures in place regarding surgical counts, but they may not be followed for a number of reasons,” says Heather Meyer, senior risk consultant for Constellation. “Surgical care teams may get overly confident and relax safety behaviors, or may be too quick to assume a miscount has occurred rather than a medical error. There may be lack of trust within a team so no one ‘speaks up,’ or a simple case of distraction, or a gap in communication during operating room (OR) team changes.”

Time pressures also play a role. “Surgical teams are often pushed to make sure everything happens on time,” Meyer says. “The pressure to perform can create a culture that takes shortcuts and inadvertently overlooks errors.”

Key ways to help prevent RSIs, according to Meyer, happen while the patient is in the OR. Before the patient is closed up and any team member leaves the room, counting procedures must be followed and repeated if necessary. X-rays can help determine if an object remains present in the body cavity. Ideally, every team member takes accountability to prevent RSIs.

At the end of the day, it’s a team effort, Meyers says. “The surgeon may be considered the captain of the ship, but everyone in the room needs to be accountable, and a culture of safety should allow anyone on the team to speak up and be heard if they see an issue.”

Technology is also readily available to help assist the counting of surgical items—before, during and after surgery. “Technology may appear expensive at first, but considering the impact of a single RSI claim—which can be nine times the cost of the technology—it could easily pay for itself in the long run,” Meyer says.

It is key to document discrepancies such as any missing sponges, broken items such as device tips or broken wires, because postoperative patient symptoms could be connected and can be serious. Transparent communication with the patient and their family is also important: If patients are made aware of potential issues, they are more likely to be a partner in their care moving forward, helping to watch for symptoms and playing a role in deciding next steps.

## Diving Deeper into the Data

RSI claims account for 6.5% of all surgical claims and 3.2% of costs. Most of these claims involve care provided in the OR, with 77% in a hospital OR and 17% in an ambulatory surgery center OR. Half of the claims involve leaving a surgical item in an abdominal cavity, and surgical sponges account for the majority of RSIs.

Risk factors for RSIs include patients with a high body mass index, emergent/urgent procedures, unexpected changes in the procedure or technique, multiple procedures or multiple OR team changes.

The top five contributing factors\* to these claims include:

1. Technical skill and performance (97%)
  - ✓ Inadvertently leaving a sponge, wire or device tip in the patient
  - ✓ Incorrect surgical item counts
  - ✓ Lack of technology to locate all surgical items
  - ✓ Poor standardization of practice among surgeons and surgical teams
  - ✓ Human factors, including distractions in the OR
2. Clinical judgment and patient assessment issues (43%)
  - ✓ Failure to respond to repeated patient complaints
  - ✓ Failure to order diagnostic tests
  - ✓ Narrow diagnostic focus
3. Administrative (32%)
  - ✓ Failure to follow policy
  - ✓ Team training issues
4. Communication breakdowns (19%)
  - ✓ Among the team/handoffs
  - ✓ With patients and families
5. Documentation (16%)
  - ✓ Inaccurate documentation

\*Note that a claim can and often does have more than one contributing factor.

# Retained Surgical Items Claims Examined

## Human error found three years late

An orthopedic surgeon performed lumbar spine surgery on a 49-year-old man with a history of back pain.

Three years later the man returned with complaints of lumbar back pain. An MRI revealed an encapsulated soft tissue lesion with necrosis on the right side of L4-5. The orthopedic surgeon performed a removal and biopsy of the mass and it was identified as a retained surgical sponge.

The man continued to have back pain and was diagnosed with arachnoiditis. He was left with permanent back pain and partially disabled. The surgical counts in the procedure were documented as correct.

### Contributing factors:

- ✓ Administrative issue
  - Policy or protocol not followed
- ✓ Human factors error: count inaccurate
- ✓ Documentation error: count recorded as accurate

## Postoperative RSI unreported, leads to sepsis

A 72-year-old woman with a history of gastric bypass surgery 20 years earlier was evaluated by a general surgeon for complaints of a chronic cough due to diaphragmatic irritation. He recommended surgery and removed the gastric band, lysed adhesions, repaired a hernia and performed a Nissen fundoplication.

The woman developed a wound infection postoperatively and underwent multiple debridements. The infection resulted in an incisional hernia which was repaired surgically with mesh placement and she was discharged to home.

Several days later, she was readmitted through the emergency room in acute respiratory failure due to perforation of her colon. She underwent emergency laparotomy, removal of mesh and a transverse colon resection. A retained sponge was found. She developed sepsis requiring a prolonged hospitalization.

### Contributing factors:

- ✓ Administrative issue
  - Policy or protocol not followed
- ✓ Human factors error: count inaccurate
- ✓ Documentation error: sponge count documented as correct

## Undocumented RSI leads to prolonged recovery and ongoing pain

A 49-year-old woman was examined by a gynecologist for recurrent ovarian cyst problems and he recommended surgery. He performed a laparoscopic vaginal hysterectomy and bilateral salpingo-oophorectomy and documented that surgery went well and all sponge and instrument counts were accurate. Her postoperative recovery went well.

Months later when she had pain and bleeding after intercourse, she presented to the emergency room where an exam revealed a defect in the vaginal cuff with small bowel herniating through the vagina. She was taken to surgery where a surgical sponge was found in her pelvis.

She had a prolonged recovery and continued to complain of pain with intercourse.

### Contributing factors:

- ✓ Administrative issue
  - Policy or protocol not followed
- ✓ Human factors error: count inaccurate
- ✓ Documentation error: sponge count documented as correct

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