PSNet
PATIENT SAFETY NETWORK

Preventing unintended retained foreign objects.

December 23, 2016
Preventing unintended retained foreign objects. Sentinel event alert. 2013;(51):1-5.
https://psnet.ahrq.gov/issue/preventing-unintended-retained-foreign-objects

Sentinel event alerts are issued periodically by The Joint Commission to identify common or emerging patient safety problems and provide organizations with approaches for addressing these issues. A retained foreign object (RFO)—surgical materials or equipment unintentionally left in a patient's body after completing the operation—is a never event that can have serious clinical consequences. Despite being long recognized as a critical—and preventable—error, RFOs continue to occur, with nearly 800 cases being reported to The Joint Commission between 2005 and 2012. This alert makes several recommendations to help prevent RFOs, including focusing on enhancing the reliability of the traditional manual count of instruments and materials used during a procedure, improving safety culture in the operating room through interventions (e.g., teamwork training), and investigating technological approaches (e.g., bar coding of surgical sponges) to ease identification of potentially missing objects before patients are harmed.