PSNet
PATIENT SAFETY NETWORK

A multicenter collaborative effort to reduce preventable patient harm due to retained surgical items.

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Carmack A, Valleru J, Randall KH, et al. A multicenter collaborative effort to reduce preventable patient harm due to retained surgical items. Jt Comm J Qual Patient Saf. 2023;49(1):3-13. doi:10.1016/j.jcjq.2022.09.005.
https://psnet.ahrq.gov/issue/multicenter-collaborative-effort-reduce-preventable-patient-harm-due-retained-surgical-items

Retained surgical items (RSI) are a never event, a serious and preventable event. After experiencing a high rate of RSIs, this United States health system implemented a bundle to reduce RSI, improve near-miss reporting, and increase process reliability in operating rooms. The bundle consisted of five elements: surgical stop, surgical debrief, visual counters, imaging, and reporting.