Hospitalizations involving a lost sponge or instrument cost more than $60,000 on average, and related malpractice suits can cost hospitals between $100,000 and $200,000 per case, according to a March 8 USA Today article on retained surgical items (RSIs).

“For many hospitals, lost sponges and other surgical items aren’t considered a pressing concern,” the article states. “And because symptoms often don’t occur for months, even years, many of the cases are never tracked back to the institution where they originated. So the people who are responsible may not realize they have a problem.”

Recent fines for cases of RSIs and advocacy efforts by patient safety experts, however, reflect a different perspective (see cover story). And when RSIs occur, it’s not unusual to see a headline like the one on the USA Today article: “What Surgeons Leave Behind Costs Some Patients Dearly.”

The number of retained surgical sponges has dropped over time, but the number of small miscellaneous items (SMIs) left in patients and unretrieved device fragments (UDFs) has risen, according to Verna Gibbs, MD, professor of clinical surgery at the University of California at San Francisco.

The focus should shift from counting to accountability; surgical items must not only be counted but also accounted for, she says. “The nurse or surgical technologist should actually look at the equipment. Some parts are separable, and some aren’t radio-opaque, so OR staff must be able to recognize components, not just count.”

Items such as guide wires are easy to overlook. “Every time a catheter insertion kit is used, an item should be added to the checklist that says, ‘Is the guide wire in the kit at the end of the procedure?’” she says.

“Every perioperative record should have a checkbox for small miscellaneous items, just like what is used for sponges, needles, and instruments, and the SMIs should be accounted for in every case,” she adds.

With ever more new devices being used, it’s hard to be familiar with all of the components. “Hospitals should be providing inservices for nurses and surgical technologists, allowing them to meet each week and examine equipment,” Dr Gibbs says.

She is working on a classification system for SMIs and UDFs, distinguishing between those retained after being used in the OR vs non-OR cases. The non-OR cases are further separated into those retained in an intravascular vs interstitial space. Manufacturing defects, repeated use, and operator error can cause devices to break. The classification system, Dr Gibbs hopes, will help provide feedback and develop action plans for the providers using these devices.

Perhaps more concerted efforts will someday truly make RSIs—and sensational headlines—“never events.”

—Elizabeth Wood

Reference