Surgical implements too often left behind in patients: report

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Breakdowns in surgical team communication often at fault, watchdog group says.

(HealthDay)—You go in for surgery, and only find out later that one of the surgeon's tools—a sponge, a needle, a surgical implement—has been left behind in your body.

A rare occurrence? Not really, according to the watchdog group The Joint Commission, which is urging hospitals across America to find better ways to avoid the problem of "retained surgical items."

"Leaving a foreign object after surgery is a well-known problem, but one that can be prevented," Dr. Ana McKee, the commission's executive vice president and chief medical officer, said during an early afternoon press briefing Thursday.

Her group believes that this is an all-too-common problem—one that can even prove fatal or leave severe damage to patients, both physically and emotionally.

According to the commission, there have been more than 770 reports of retained foreign objects in surgical patients over the last seven years. These cases resulted in 16 deaths and in almost 95 percent of the cases patients had to have their hospital stay extended. The objects most often left inside patients include sponges and towels, broken parts of instruments, and stapler parts and needles or other sharp pieces.

"It is critical for organizations to develop and comply with policies and procedures to make sure all surgical items are identified and accounted for as well as to ensure there is open communication by all members of the surgical team about any concern," McKee said.

Certain patients or procedures seem more prone to having implements unaccounted for after surgery. According to McKee, these include overweight patients, more rushed or urgent procedures, having more than one surgical procedure and multiple surgical teams, or having staff turnovers during the procedure.

McKee noted that the 770 cases reported is probably only the tip of the iceberg and the actual number of these incidents may be closer to 1,500 to 2,000 each year. These mistakes can also lead to financial outlay: According to the commission, leaving objects inside patients cost as much as $200,000 in medical liability payments for each case.

But there are ways to reduce the problem. Among the commission's recommendations:

- Create a reliable, standardized operating room counting system to ensure all surgical items are accounted for.

- Develop effective, standardized policies and procedures to prevent the problem that includes counting procedures, wound opening and closing procedures, and directions on when X-rays should be done during the operation to help spot stray items.
- Team briefings and debriefings would also help, with team members feeling free to express any concerns about the safety of the patient.

Too often, "problems with hierarchy and intimidation in the surgical team, failure in communication with physicians, failure of staff to communicate relevant patient information and inadequate or incomplete staff education," are a part of the problem, the commission said.

If any discrepancy *is* found between the objects counted and those remaining after the surgery, action must be taken and placed into the record, the commission said.

According to the commission, the problem occurs nine times more often during emergency operations than in planned ones and was four times more likely to happen if the procedure was unexpectedly changed.

The Joint Commission is an independent, not-for-profit organization, the nation's oldest and largest standards-setting and accrediting body in health care.

More information: For more information on patient safety, visit the U.S. National Library of Medicine.