Back to Basics: Counting Soft Surgical Goods 0.8 CE

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Purpose/Goal

To provide the learner with knowledge of best practices related to counting soft surgical goods.

Objectives

1. Discuss common areas of concern that relate to perioperative best practices.
2. Discuss best practices that could enhance safety in the perioperative area.
3. Describe implementation of evidence-based practice in relation to perioperative nursing care.

Accreditation

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Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

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ABSTRACT

Retained surgical items (RSIs) pose serious consequences for patients and are a significant threat to patient safety. Perioperative team members are morally and ethically responsible for the prevention of RSIs and should understand how to reduce the risk of occurrence. The prevention of RSIs does not rest in the hands of one individual. It is a multidisciplinary endeavor that aims to reduce the risk of RSIs, and team members should hold each other accountable. This Back to Basics article focuses on the process of counting soft surgical goods, which are the most common RSIs. *AORN J* 103 *(March 2016) 298-301.*
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Key words: *retained surgical items, counting, surgical sponge, patient safety.*

A retained surgical item (RSI) is a serious patient safety issue, and prevention is a top priority for perioperative team members. Perioperative team members are morally and ethically responsible for the prevention of RSIs and should understand how to reduce the risk of occurrence. AORN recently updated the "Guideline for prevention of retained surgical items"[1] based on a systematic review of the evidence to provide comprehensive guidance for the prevention of RSIs.

The most common RSI is the surgical sponge; it is most often left in the abdomen and pelvis, although there have been reports of retained sponges in the thorax, spine, head, neck, brain, and extremities.[2] Surgical sponges can be retained almost anywhere, from natural orifices to the smallest incisions; therefore, the surgical team should count these items in all procedures in which they are used.[2] This Back to Basics article reviews the means of preventing retained soft surgical goods.

A retained surgical sponge is called a *gossypiboma*, which comes from the Latin word *gossypium* meaning *cotton* and the Swahili word *boma* meaning *place of concealment*.[3] Surgical sponges may be retained for years before they are discovered and have caused significant and long-term health problems for patients. The human body responds to a retained sponge by initiating an inflammatory response, followed by a fibrous response resulting in adhesions, granulomas, or encapsulation.[4] Patients can experience abscesses and fistulas, and in one rare case, a patient developed a malignant fibrous histiocytoma from a retained surgical sponge that went undetected for 32 years.[5] The exact mechanism of the development of the cancer is not known, but the researchers stated that the retained surgical sponge may have induced the cancer in the manner of an inflammatory response after a long latent period. The patient subsequently died from the cancer.[5]

Currently, no law states how surgical teams should prevent RSIs or what methodologies they should use. The law, based on the doctrine of *res ipsa locquitur* (ie, the thing speaks for itself), does require that personnel be accountable for preventing RSIs and that surgical items not intended to remain in the patient be removed.[6] All members of the surgical team are accountable for preventing RSIs and providing safe care, and all can be held liable in cases of litigation resulting from an RSI.

HOW-TO GUIDE

The prevention of RSIs does not rest in the hands of one individual. It is a multidisciplinary endeavor that aims to reduce the risk of RSIs, and team members should hold each

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