Behind the Drapes: Zero Retained Surgical Items in the Operating Room

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Culture of Excellence

INTRODUCTION

BACKGROUND

- ❑ Retained Surgical Items (RSI): A critical safety concern
- ❑ RSIs = "Never Events"
  - Preventable
  - Serious patient safety risks
  - Leads to harms, legal issues, higher costs

- ❑ National Guidelines
  - Association of perioperative Registered Nurses (AORN) & Joint Commission Recommendations:
    - Standardized surgical count
    - Use of adjunct technologies

Adjunct Technology: Radiofrequency Identification (RFID)- Wand

- ❑ Barriers
  - Variability in practice
  - Communication breakdown
  - Workflow interruptions

Clinical Question

In perioperative settings (Main Operating Room (MOR) and Ambulatory Surgery Center (ASC), how does the implementation of a standardized, evidence-based RSI prevention protocol, compared to existing practices, impact the rate of RSI events and compliance with surgical count procedures?

METHODS

Development of Evidence-Based Protocol

- ❑ In November 2024 multidisciplinary approach was implemented to develop the protocol
- ❑ Protocol was developed based on AORN Guidelines, literature and frontline staff input
- ❑ Standardized count procedure for consistency
- ❑ Integrated RFID sponge tracking for traceability
- ❑ Staff education, training, and competency validation
- ❑ Real-time auditing and feedback for compliance

Implementation of Evidence-Based Protocol

- ❑ Collected baseline data from (January 2019-December 2024) on RSI (RFI)
- ❑ Conducted gap analysis on existing workflows
- ❑ Designed system-wide approach using EBP
- ❑ Engaged key stakeholders and champions early
- ❑ Phased rollout in Main OR and ASC
- ❑ Provided education and training for all staff
- ❑ Performed weekly observational audits and real time feedback

Weekly Observational Audits

AORN Center of Excellence in Surgical Safety+RSI
Compliance Audit - Week 1
Data Collection: Direct Observation

Instructions: For all weekly audits for each OR, please mark "YES" if the OR was 100% compliant or "NO" if the OR was not. The audit is designed to be flexible to your work schedule. Please attempt to audit your facility's ORs as many times a week as you can. If you are unable to get to each OR on the days you audit, simply mark the OR as "NOT OBSERVED" for each column. To ensure you complete the audit form correctly, the number of ORs your facility has must be noted at the top of each sheet at step number one in this audit form. The total number of ORs in your facility, must also be the same number of rows of data you have each week of auditing. For example, if you have 10 ORs in your facility, you must have 10 rows of data listed in each sheet of the audit form. Keep in mind, to be considered for the Center of Excellence: Prevention of RSI recognition, your facility will need 90-100% compliance rate by the final week (week 12) of auditing.

STEP 1: Please answer the following questions:

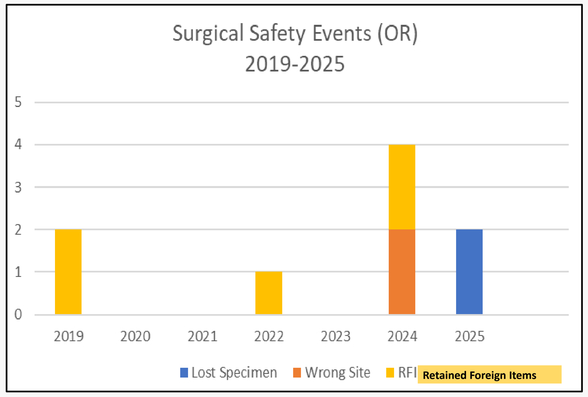
1) How many RSI adjunct technology device/s do you have? *	12	(Select from drop-down menu in blue cell)
*Should be equal to the number of ORs you have (1 RS adjunct technology device per OR or per procedure room)		
2) How many operating rooms are in your facility?	12	(Select from drop-down menu in blue cell)
3) Dates for this audit data collection	Start: 2/10/2025	
	End: 2/16/2025	

STEP 2: For each operating room in your facility, please answer "Yes", "No" or "Not Observed" for each metric (#1 - 6). Example below.

	COMPLIANCE AUDIT METRICS					
RESULTS	100%	100%	100%	100%	100%	100%
	1	2	3	4	5	6
OR	The standardized counting sequence is followed (eg, proximal to distal from the patient, smallest to largest soft goods)	Items being counted are viewed concurrently by two individuals, one of whom is the RN circulator, and counted audibly.	The scrub person separates and points out items on the sterile field while audibly counting.	The RN circulator separates and points out items off the sterile field while audibly counting.	Adjunct technology is used during the procedure according to the manufacturer's instructions for use and facility policy and procedure.	The final count is not complete until all items used during closing are removed and returned to the scrub person.
1	Yes	Yes	Yes	Yes	Yes	Yes
2	Yes	Yes	Yes	Yes	Yes	Yes
3	Yes	Yes	Yes	Yes	Yes	Yes
4	Yes	Yes	Yes	Yes	Yes	Yes
5	Yes	Yes	Yes	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	Yes
7	Yes	Yes	Yes	Yes	Yes	Yes
8	Yes	Yes	Yes	Yes	Yes	Yes
9	Yes	Yes	Yes	Yes	Yes	Yes
10	Yes	Yes	Yes	Yes	Yes	Yes
11	Yes	Yes	Yes	yes	Yes	Yes
12	Yes	Yes	Yes	Yes	Yes	YES
13						
14						
15						

RESULTS/CONCLUSION

RESULTS



RSI (RFI) EVENTS:	IMPROVED COMPLIANCE:
Zero RSI Jan-Nov 2025	▪ Standardized counts (verified by audits) ▪ RFID sponge tracking 90%+ of applicable cases

CONCLUSION

- ❑ Standardized, evidence-based protocol improved patient and staff engagement
- ❑ Success driven by multidisciplinary collaboration and continuous education
- ❑ Initiative earned AORN Center of Excellence in Surgical Safety: Prevention of RSI designation

IMPLICATIONS FOR PRACTICE

Perioperative Nursing Implications

- ❑ Nurses and scrub technologists are key to RSI prevention through vigilance and teamwork
- ❑ Follow safety protocols and maintain strong communication
- ❑ Use adjunct technology (RFID) effectively
- ❑ Ongoing education and competency validation are essential
- ❑ Advocate for policies and lead by example to sustain a safety culture

Award: Center of Excellence in Retained Surgical Item

REFERENCES