

Instructions: Retained Surgical Item Record Review Form

We are collecting this information to help us understand how and why items are left behind. Learning from both near misses and actual events will help us better protect our patients. This form is privileged under the Patient Safety and Quality Improvement Act as we are collecting this information to send to the California Hospital Patient Safety Organization (CHPSO). Please contact your [quality dept./risk management dept.] if you have any questions.

Please fill out this form when:

- **An item is left in the patient that is not supposed to be left there** as part of the procedure. For example, this form would be used for a staple that was dropped into the wound but not for a staple that is properly placed. Another example would be a fragment intentionally left behind because the risk of removal exceeds the risk of retention.
- **An item *almost* is left in the patient.** For example, the count is incorrect and steps are taken to find the item, which is then found in the patient and removed prior to leaving the OR.
- **A fragment is generated and retrieved.** For example, a drill bit breaks in the patient and the pieces are found and removed.
- **You identify a hazard that could result in a retained surgical item.** For example, a new model of retractor has a removable section that could be left behind, but you believe people are not aware of it and that section isn't being tracked.

Notes on completing the form

Most of this form should be completed as soon as practical after discovery of the issue. However, certain questions may best be answered later (e.g., depending upon your institution's documentation workflow, CPT code for procedure may not be known at the time of the event).

If the procedure takes place outside the OR (e.g., cardiac cath lab), the term "OR" (e.g., in "Event discovered" question) means the procedure room.

Harm score definition:

- **None** – no symptoms detected and no treatment is required.
- **Mild** – symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review or minor treatment) is required.
- **Moderate** – intervention is required (e.g., additional operative procedure; additional therapeutic treatment), or increased length of stay occurs, or it caused permanent or long term harm or loss of function.
- **Severe** – life-saving intervention or major surgical/medical intervention is required, or life expectancy is shortened or there is major permanent or long term harm or loss of function
- **Death** – on balance of probabilities, death was caused or brought forward in the short term by the incident.

How to participate

Hospitals intending to participate need to notify CHPSO by email (cmeacham@chpso.org), follow the above instructions for filling out the form for retained surgical items and near misses, and send the information to CHPSO. Please email cmeacham@chpso.org if the hospital decides to stop participation.

Methods for information transmission are listed on the back of this page.

Information should be sent by one of the following methods:

1. fax to 916-554-2299 (faxes are stored in a physically-secured machine until a password is used to print them out; send an email to cmeacham@chpsso.org notifying her that a fax has been transmitted)
2. encrypted email to cmeacham@chpsso.org (contact rjaffe@chpsso.org for instructions)
3. US mail or other courier service (e.g., Fedex) to: Colleen Meacham, CHP SO, 1215 K St Ste 800, Sacramento, CA 95814
4. contact rjaffe@chpsso.org to set up a secure transmission method not listed above