Open Book
Learning from close calls and adverse events

Preventing retained items – laparoscopic surgery

This report aims to alert providers to the key findings of two recent reviews, with emphasis on the changes implemented to prevent recurrence. Providers are advised to consider this report, and whether the changes being made are relevant to their own systems.

This report is relevant to staff in:

- operating theatres
- quality and risk management.

Incident

In two similar incidents in separate hospitals, the tissue specimen in its removal bag was left in the patient at the end of a laparoscopic procedure. A subsequent procedure was needed in both cases to remove the specimen and bag.

Chronology

- The specimens excised during surgery were put into bags intended to help remove the specimens at the end of the procedure.
- In both cases, the equipment used as the bag was not part of the equipment count, and its absence was not noticed at the end of the procedure.
- In one case, a string attached to the specimen bag (a reminder of the bag being inside the patient) was inadvertently cut, so there was no visible reminder that the specimen was in the patient.
- In both cases, the specimen bottle intended to contain the specimen for sending to pathology was labelled before receipt of the specimen.
- In both cases, the surgical safety checklist sign-out procedure did not involve all relevant team members.

Actions subsequently taken

- Any item to be used inside a patient will now be part of the equipment count.
- Artery forceps will be applied to the string connected to the specimen bag as a reminder that the specimen is still in the patient.
- A specific time to perform sign-out will be used to ensure all theatre staff are engaged in sign-out.
- The specimen bottle will be labelled and the specimen book completed only after the specimen has been received.

Health Quality & Safety Commission comment

- The Commission's Reducing Perioperative Harm programme[1] notes that hospitals which have the fewest cases of retained items have a specified time for sign-out, for example, during the count immediately prior to skin closure.
- The US Joint Commission has guidelines[2] on preventing unintended retained foreign objects, which quotes research estimating current practices for counting sponges have a 10–15 percent error rate.

[1] www.hqsc.govt.nz/our-programmes/reducing-perioperative-harm/surgical-safety-checklist
[2] www.jointcommission.org/assets/1/6/SEA_51_URFOs_10_17_13_FINAL.pdf